

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

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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.

APRIL-JUNE 1995

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CITE AS

47 Van Natta ____ (1995)

In the Matter of the Compensation of
PAMELA R. NAGEL, Claimant
WCB Case No. C5-00512
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On March 1, 1995, 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 proposed CDA states that claimant was employed by a noncomplying employer (NCE). Therefore, pursuant to ORS 656.054, claimant's claim was referred to the SAIF Corporation for processing. (P. 2, Lns. 13-16).

ORS 656.236 provides that the "parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim * * *." Additionally, a CDA must contain signature lines for all the "parties" to the agreement. (DIF (currently DCBS) Bulletin No. 217 (Revised) May 16, 1991). Here, the CDA contains a signature line for SAIF's representative, SAIF's counsel, claimant, claimant's counsel, the noncomplying employer, and DCBS Collections Manager. Notwithstanding the signature line for the NCE, the CDA was not signed by the NCE.

We have previously held, under similar circumstances, that an NCE is a party to the CDA. Isabel Campa, 47 Van Natta 217 (1995). In Campa, we held that the NCE's failure to sign the CDA would still permit approval of the CDA because the DCBS Collections Manager indicated that it would not seek recovery of claim costs from the NCE. Therefore, we reasoned that because the NCE had no pecuniary interest in the CDA, its signature on the CDA was unnecessary.

Here, the NCE did not sign the CDA. However, included with the agreement was a letter from the NCE's attorney documenting a conversation between the attorney and the Department. That letter confirms that, although the NCE continues to contest its liability for the claim, it agrees that the CDA proceeds represent a reasonable disposition. Furthermore, the letter acknowledges that the NCE does not object to the Department and SAIF entering into the CDA with claimant.

After reviewing the NCE's attorney's letter, we perceive its position to be as follows. The NCE continues to challenge the conclusion that it is responsible for claimant's claim as a subject Oregon employer without workers' compensation coverage. Nevertheless, the NCE recognizes that SAIF and the Department are presently authorized to process the claim, including the execution of the CDA for the consideration stated in that agreement. Finally, if it is ultimately successful in overturning its responsibility determination, the NCE will not be responsible for reimbursement of the Department's claim costs. However, if it is ultimately unsuccessful in overturning such a responsibility determination, the NCE acknowledges that it is liable for providing reimbursement to the Department for the CDA proceeds.

Based on our interpretation of its position, we find that the NCE has approved the CDA and agrees that the provisions therein are reasonable. Consequently, we hold that the CDA is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). We also hold that the CDA is not unreasonable as a matter of law. Therefore, the parties' CDA is approved. An attorney fee of \$3,875, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID P. BECKNELL, Claimant
WCB Case No. 94-00371
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Lipton's order that declined to award temporary disability benefits after December 16, 1993. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

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

Rather than earning \$11.14 per hour at his light duty job, claimant was earning \$14.11. (Ex. 7, Tr. 12).

On August 31, 1993, claimant compensably injured his right hand. On September 1, 1993, claimant underwent surgery for the work injury. (Exs. 1, 2). Claimant was released from work as of September 1, 1993. (Ex. 1). He returned to modified work on October 5, 1993. (Ex. 7, 9).

After leaving the employer's employ, claimant applied for and received unemployment benefits. (Ex. 10, Tr. 11).

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his right hand on August 31, 1993. He was earning \$13.48 per hour at the time of injury. Claimant was released from work as of September 1, 1993, and he returned to light duty work on October 5, 1993. Claimant was earning \$14.11 per hour at his light duty job.

On December 16, 1993, claimant was offered the choice of resigning or being fired for giving a non-employee his employer's 800 telephone number. Claimant chose to resign.¹ The insurer did not pay temporary disability benefits after claimant's employment was terminated.

Relying on Dawes v. Summer, 118 Or App 15 (1993), the Referee concluded that claimant was not entitled to temporary disability benefits because he was terminated for reasons not related to his injury. On review, claimant argues that he is entitled to temporary total disability (TTD) from the date of his termination. We disagree with both the Referee and claimant and find that claimant is entitled to temporary partial disability (TPD) following his termination.

Claimant's claim is in open status. Therefore, the issue presented is claimant's procedural entitlement to temporary disability. ORS 656.268(3) applies to the termination of procedural TTD.

Here, claimant was released from work on September 1, 1993, the date of his surgery. The insurer began paying TTD from September 2, 1993. (Ex. 6). Claimant returned to modified work on October 5, 1993. Pursuant to ORS 656.268(3)(a), the insurer was entitled to terminate claimant's TTD when he returned to modified work. Furthermore, there is no evidence that claimant's attending physician, Dr. Combs, subsequently released claimant from work, an action which would have triggered the reinstatement of TTD. OAR 436-30-036(1). Therefore, claimant is not entitled to TTD after his return to modified work.

On the other hand, although claimant was not subsequently released from work, he also was not released to regular work. He remained released to modified work at the time of his termination.

¹ The parties dispute whether claimant resigned or was terminated on December 16, 1993. Given the employer's representative's testimony that claimant would have been fired if he had not resigned, we find that, for all practical purposes, claimant was terminated for reasons unrelated to the compensable injury. (Tr. 19).

When a claimant is released to modified work at or above his or her regular wages, the claimant is entitled to TPD, even though the actual rate of TPD may be computed to be zero. Sharman R. Crowell, 46 Van Natta 1728, 1729 (1994) (citing Kenneth W. Metzker, 45 Van Natta 1631, 1632 (1993) and Valorie L. Leslie, 45 Van Natta 929 (1993), rev'd on other grounds Leslie v. U.S. Bankcorp, 129 Or App 1 (1994)). Here, because claimant was released to modified work effective October 5, 1993, although at a wage greater than his regular at-injury wage, he was temporarily and partially disabled as of that date. Therefore, he is entitled to TPD, albeit perhaps at the rate of zero once his TPD is calculated. Sharman R. Crowell, supra; Joseph M. Lewis, 47 Van Natta 381 (1995).

In reaching this conclusion, we apply the court's holding 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 TPD because she had been discharged from her modified job for reasons unrelated to her compensable injury. Computing the claimant's TPD under former 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 former 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 may be of great, little, or no importance in determining whether the worker has a diminution in "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.

Here, as in Stone, claimant was terminated from a modified job for reasons unrelated to the compensable injury. At the time of his termination, claimant was unable to perform his regular job. As in Stone, claimant is entitled to TPD following his termination.² Because claimant is entitled to TPD, he is now entitled to a calculation of the TPD rate by the insurer based on his proportionate loss of earning power at any kind of work. OAR 436-60-030; Stone v. Whittier Wood Products, supra. We note that, in making this calculation, the insurer is permitted to deduct the unemployment benefits claimant received subsequent to his termination in the manner set forth in Timothy O. Logsdon, 46 Van Natta 1602 (1994). Eulalio M. Garcia, 47 Van Natta 96 (1995). Accordingly, we reverse the Referee's decision regarding TPD, and direct the insurer to calculate claimant's TPD under the court's guidance in Stone. See OAR 436-60-030.

ORDER

The Referee's order dated April 19, 1994 is affirmed in part and reversed in part. That portion of the order that found claimant not entitled to temporary partial disability (TPD) benefits is reversed. The insurer is directed to calculate claimant's TPD as previously set forth in this order and to pay claimant TPD at the calculated amount beginning December 16, 1993 and continuing until such benefits may be terminated pursuant to law. Claimant's counsel is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed.

² The insurer argues that the Referee correctly relied on Dawes v. Sumner, supra, in finding that claimant was not entitled to temporary disability following his termination. The insurer asserts that the Dawes court reaffirmed its decision in Safeway Stores v. Owsley, 91 Or App 475 (1988). In Dawes, the court summarized Owsley as holding "that a claimant is not entitled to temporary disability benefits when the claimant leaves work for reasons not related to the compensable injury." Dawes, supra, 118 Or App 20 n.6. In both Dawes and Owsley, the claimants were terminated from modified work for reasons unrelated to their injuries and the court determined that they were not entitled to temporary disability benefits following their termination. We find that Dawes and Owsley do not support the insurer's position.

In both Dawes and Owsley the claims had been closed; therefore, the issue was substantive entitlement to temporary disability. Here, the claim has not been closed and the issue is procedural entitlement. Thus, Dawes and Owsley are distinguishable on that basis. On the other hand, the Stone decision, the most recent decision of the three cases, is directly on point in that it deals with procedural entitlement to temporary disability after termination from a modified job for reasons unrelated to the injury. In light of such circumstances, we find Stone to be controlling.

In the Matter of the Compensation of
JAMES CRAWLEY, Claimant
 WCB Case No. 94-01681
 ORDER DENYING RECONSIDERATION
 Schneider, Hooten, et al., Claimant Attorneys
 Babcock & Associates, Defense Attorneys

Market Refrigeration, Inc., the alleged subject employer, requests reconsideration of our March 6, 1995 Order on Review which held that claimant was an Oregon subject worker for Market Refrigeration. Contending that we lacked subject matter jurisdiction to review claimant's appeal of the Referee's order, Market Refrigeration seeks reconsideration of our decision and dismissal of claimant's request for Board review.

We have previously ruled that the Board retains appellate review authority over a referee's decision involving a hearing request from a Director's "nonsubjectivity" determination under OAR 436-80-060(3). Douglas Fredinburg, 45 Van Natta 1619 (1993). Consistent with the Fredinburg rationale, we reject Market Refrigeration's contention that we lacked subject matter jurisdiction over claimant's appeal of the Referee's decision concerning a Director's "nonsubjectivity" determination.¹

Consequently, the motion for reconsideration is denied. Issuance of this order neither abates nor extends the parties' rights of appeal from our March 6, 1995 order.

IT IS SO ORDERED.

¹ Enclosing another referee subjectivity decision (which contained a statement of appeal rights indicating that dissatisfied parties should petition for judicial review under ORS 183.480 and 183.482), Market Refrigeration contends that our acceptance of appellate jurisdiction over this dispute is inconsistent with that other referee subjectivity decision. We disagree. The other referee decision involved an appeal of a Director's "noncomplying employer" order which had found the worker to be a subject worker and the employer to be a subject employer. Pursuant to ORS 656.740(4)(c), appellate authority over such a decision rests with the Court of Appeals. Miller v. Spencer, 123 Or App 635 (1993); Ferland v. McMurtry Video Productions, 116 Or App 405 (1992). In contrast, the present dispute did not arise from a Director's "noncomplying employer" order, but rather from a Director's "nonsubjectivity" determination. As explained in Fredinburg, the appellate review provisions of ORS 656.740(4) are not applicable when considering appeals from Director's "nonsubjectivity" determinations. Likewise, in accordance with the reasoning expressed in Fredinburg, appellate review authority rests with this forum.

April 4, 1995

Cite as 47 Van Natta 612 (1995)

In the Matter of the Compensation of
JOSE M. ELIZONDO, Claimant
 WCB Case No. 93-13920
 ORDER ON REVIEW
 Schneider, Hooten, et al., Claimant Attorneys
 John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Crumme's order which: (1) affirmed the Director's order that found him ineligible for further vocational assistance; and (2) declined to assess a penalty and related attorney fee for the self-insured employer's allegedly unreasonable termination of his vocational assistance. On review, the issues are vocational assistance, penalties and attorney fees.

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

On review, claimant contends that he is entitled to additional vocational training. He argues that the Director's rule, former OAR 436-120-085(2),¹ exceeds the statutory authority delegated to the Director under ORS 656.340(12). We disagree.

¹ Former OAR 436-120-085(2) has since been amended and renumbered to OAR 436-120-440(2). WCD Admin. Order 058-1994.

Former OAR 436-120-085(2) provides:

"Training of any and all kinds is limited to an aggregate duration of 16 months, subject to extension to 21 months by the Director for a worker with an exceptional disability. An 'exceptional disability' means the complete loss, or loss of use, of two or more limbs. Such extent of disability shall be the standard for determining whether other disabilities are exceptional under this section."

ORS 656.340(12) provides:

"Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary disability compensation for a maximum of 16 months, subject to extension to 21 months by order of the director for good cause shown. The costs related to vocational assistance training programs may be paid for periods longer than 21 months, but in no event may temporary disability benefits be paid for a period longer than 21 months."

Contrary to claimant's argument, ORS 656.340(12) does not establish a minimum entitlement to vocational training for 16 months. Rather, it authorizes the payment of temporary disability compensation for up to 16 months for "worker[s] actively engaged in training." Consequently, we do not find that the Director acted beyond his authority under ORS 656.340(12).

There is no statutory requirement that a claimant must receive vocational training for a minimum period of 16 months. On the contrary, the extent of vocational training is a matter which the legislature has delegated to the Director. For example, ORS 656.340(7) provides:

"Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training." (Emphasis supplied.)

In addition, ORS 656.340(9)(c) provides that the Director shall adopt rules providing "[s]tandards for the nature and extent of services a worker may receive, for plans for return to work and for determining when the worker has returned to work..." The statutory provisions invest the Director with discretionary authority over the extent of training that may be provided to an injured worker. Pursuant to that authority, the Director promulgated former OAR 436-120-085(2) which sets forth a 16-month minimum for vocational retraining, with an extension to 21 months for workers with an "exceptional disability." We conclude that the rule does not exceed the Director's discretionary authority under ORS 656.340(7) and (9)(c).

Because we find on the merits that claimant is not entitled to further vocational training, we need not address the insurer's argument that claimant waived a challenge to the Director's rules by not raising that challenge before the Director.

ORDER

The Referee's order dated March 30, 1994 is affirmed.

In the Matter of the Compensation of
MARTIN J. FOWLER, Claimant
WCB Case No. 94-06058
ORDER ON REVIEW
Gary D. Taylor, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Schultz's order that upheld the insurer's denial of claimant's cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable 1991 right hip injury claim. In July 1993, claimant underwent right hip surgery by his treating orthopedic surgeon, Dr. Wasilewski. Some time after the surgery, Dr. Wasilewski prescribed physical therapy. In September 1993, claimant began performing upper body weightlifting as part of his physical therapy. In late November 1993, while weightlifting, claimant experienced the onset of neck and left shoulder pain. A March 1994 MRI showed a herniated disc at C6-7.

The insurer denied the compensability of claimant's cervical condition. The Referee upheld the denial. Although accepting as credible claimant's testimony regarding the injurious event, the Referee found that the claim failed due to a lack of evidence establishing causation and because the weightlifting had not been prescribed by Dr. Wasilewski. On review, claimant asserts that there is persuasive medical evidence that the physical therapy was the major contributing cause of his cervical condition and that it was not necessary for the physical therapy to be prescribed by his treating physician.

Following the Referee's order, the court issued Barrett Business Services v. Hames, 130 Or App 190 (1994). There, the court held that, when a worker sustains 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). Id. at 193.

Here, we disagree with the Referee that specific physical therapy must be prescribed by the treating physician in order for a consequential condition to be compensable. Rather, as discussed by the court in Hames, the dispositive question is whether or not the medical service is reasonable and necessary treatment for the compensable injury. Although the fact that the treating physician has prescribed a particular physical therapy would be probative evidence that it is reasonable and necessary treatment, the entire record should be examined to determine whether this burden was carried.

Here, based on the entire record, we find persuasive evidence that the weightlifting was reasonable and necessary treatment for claimant's right hip injury. First, although not specifically referring to weightlifting, Dr. Wasilewski had prescribed physical therapy. (Ex. 41). The weightlifting activity was directed and overseen by the physical therapist rather than performed on claimant's own initiative. (Ex. 40A-2 through 10). Furthermore, when Dr. Wasilewski was later informed by claimant that he had been participating in upper body weightlifting during physical therapy, Dr. Wasilewski specifically prescribed such activity in treating the right hip injury. (Ex. 48). Most importantly, although acknowledging that there had been no specific prescription for weightlifting, Dr. Wasilewski later characterized such therapy as an "integral part" of claimant's recovery from the original injury and indicated that it was "reasonable for the physical therapist to pursue" weightlifting prior to the time that Dr. Wasilewski actually prescribed such a program. (Exs. 52, 55).

Based on this evidence, we find that the weightlifting activity was reasonable and necessary treatment for claimant's right hip injury. We proceed to address whether claimant showed that such therapy directly resulted in the cervical condition.

Only one physician who examined claimant's neck provided an opinion regarding causation.¹ Dr. Knoebel, an orthopedic surgeon who examined claimant on behalf of the insurer, indicated that claimant's neck was injured in November 1993 while he was lifting weights during physical therapy. (Exs. 49-11, 53, 54).

Although Dr. Knoebel also indicated that the cervical condition was not related to the original injury, such opinion was based on the fact that claimant's injury occurred before the weightlifting program had been prescribed by Dr. Wasilewski. Thus, this portion of Dr. Knoebel's opinion was based on a legal judgment. As such, we give it little weight. Inasmuch as Dr. Knoebel did indicate that, as a medical matter, the weightlifting caused the cervical condition, we find his un rebutted opinion to be sufficient to prove causation.

The insurer asserts that claimant did not carry his burden of proof because his testimony at hearing that his neck was injured when a cable on the weightlifting machine snapped was not credible. Specifically, the insurer asserts that we should find such testimony not credible because it was not corroborated by any documentary evidence.

The Referee stated that the lack of corroboration of claimant's testimony regarding the injurious event "militate[d] against claimant's case." Nevertheless, he found claimant to be credible based on demeanor. That finding is entitled to deference on review. Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991).

Although there is no documentary evidence showing that claimant reported the injury in the particular manner testified to at hearing, the history reported by Dr. Widell and Dr. Knoebel was that the onset of neck pain was sudden while he was lifting weights. (Exs. 48, 49-3). Thus, claimant's testimony was consistent with the history provided to the physicians to the extent that his neck was injured during a specific event. In view of such consistency, and the deference we give to the Referee's finding, we also consider claimant to be credible.

Claimant proved that his consequential neck condition was a direct result of lifting weights during physical therapy. Furthermore, he showed that such activity was reasonable and necessary treatment for his compensable injury. Hence, he proved the compensability of his neck condition. Barrett Business Services v. Hames, *supra*.

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

ORDER

The Referee's order dated August 26, 1994 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of \$3,500, to be paid by the insurer.

¹ Dr. Wasilewski did report that claimant "apparently" injured his neck while engaging in work hardening activities during physical therapy. (Ex. 52). We find the opinion is entitled to little weight since Dr. Wasilewski's treatment was limited to the right hip. The record does not contain an opinion from Dr. Widell, who treated claimant's neck condition.

In the Matter of the Compensation of
WCB Case No. 94-04476
JOSEPH M. LEWIS, Claimant
ORDER ON RECONSIDERATION
Schneider, Hooten, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Claimant and the self-insured employer request reconsideration of our March 7, 1995 order that: (1) directed the self-insured employer to pay claimant temporary partial disability (TPD) benefits beginning July 16, 1993 and continuing until such benefits may be terminated pursuant to law; (2) for the employer's unreasonable claim misclassification, awarded claimant a penalty equal to 25 percent of the amount of temporary disability compensation due from July 22, 1993 until the November 16, 1993 Determination Order, payable in equal shares to claimant and his attorney; and (3) awarded claimant's counsel 25 percent of the increased temporary disability compensation created by the order, not to exceed \$3,800, payable directly to claimant's attorney.

In his reconsideration request, claimant argues that, because he presented evidence at hearing regarding the proper TPD rate, the Board should address that issue or, at a minimum, establish his pre- and post-injury earning power. Claimant also argues that the Board erred in limiting the basis for an attorney fee for obtaining the reclassification of his claim to temporary disability compensation. We disagree with both contentions.

First, we decline to address the rate issue for the reasons stated in our prior order. Furthermore, we note that, at hearing, claimant's counsel expressly stated that the issue under consideration was the "entitlement to TPD." (Tr. 4; emphasis added), and that claimant raised the TPD issue only two days before hearing. (Tr. 5). For these additional reasons, we conclude that the employer must first calculate the rate of that compensation.

Second, we reject claimant's attorney fee argument for the reasons set forth in our prior order. In doing so, we have considered claimant's argument that O'Neal v. Tewell, 119 Or App 329 (1993) supports his assertion that he is entitled to a fee based on future permanent disability compensation that may be awarded. We disagree. O'Neal concerned the propriety of limiting a fee under ORS 656.386(2) to those cases in which an attorney was instrumental in obtaining compensation, not, as is the issue here, what compensation may serve as the basis for an attorney fee under that statute. Consequently, we find O'Neal inapposite.

In its reconsideration request, the employer urges us to reconsider our conclusion that the employer unreasonably misclassified the claim as nondisabling. The employer asserts that, because Sharman R. Crowell, 46 Van Natta 1728 (1994), which we cited in our prior order in addressing the misclassification issue, did not issue until after the employer classified the claim, its action was not legally unreasonable at the time. We agree.

In Sharman R. Crowell, supra, after suffering a compensable injury, the claimant was released to light duty work at her regular wage. The carrier accepted the claim was nondisabling. After a hearing, a referee determined that the claim should have been classified as disabling. On review, the employer argued that under OAR 436-30-045(5)(a) and (d), which provide that a claim is "disabling" if temporary disability compensation is "due and payable," or if the worker is released to and doing a modified job at reduced wages from the job at injury, the claimant was not entitled to reclassification because she had returned to modified work at her regular wage and, therefore, she had failed to prove that temporary disability was "due and payable."

We disagreed, noting that, under Stone v. Whittier Wood Products, 124 Or App 117 (1993), TPD is measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. Because OAR 436-30-045(5)(a) and (d) equate disability with reduction in post-injury wages, we found the rules inconsistent with Stone and declined to give them any effect. Id. at 1728. Instead, relying on cases establishing that, although a claimant is released to modified work at or above his or her regular wage, a claimant is temporarily and partially disabled,

although the actual TPD rate may be zero, we concluded that the claimant's claim was disabling. Id. at 1729.¹

Here, the employer reasonably relied on OAR 436-30-045(5)(a) and (d) as justification for its decision to classify claimant's claim as nondisabling. Because our holding in Crowell, which declined to give effect to those rules, did not issue until after the hearing in this matter, we conclude that the employer's failure to reclassify the claim was not unreasonable. See Marie E. Kendall, 47 Van Natta 335 (1995) (order on reconsideration) (carrier's conduct held reasonable where case law at the time supported the propriety of that conduct); Maria R. Porras, 42 Van Natta 2625 (1990) (penalty and attorney fee not appropriate when carrier's reliance on a former rule was reasonable). Consequently, we withdraw that portion of our prior decision that assessed a penalty for the employer's misclassification of claimant's claim.

Accordingly, our March 7, 1995 order is withdrawn. On reconsideration, as modified and supplemented herein, we adhere to and republish our March 7, 1995 order, effective this date. The parties' rights of appeals shall begin to run from the date of this order.

IT IS SO ORDERED.

¹ In his response to the employer's reconsideration request, claimant asserts that, when his claim was classified, case law supported classification of a claim as disabling based solely on a release to light duty work. Specifically, claimant asserts that the cases we cited in Sharman R. Crowell, *supra*, namely, Kenneth W. Metzker, 45 Van Natta 1631 (1993) and Valorie L. Leslie, 45 Van Natta 929 (1993), *rev'd on other grounds Leslie v. U.S. Bankcorp*, 129 Or App 1 (1994) support this proposition. We disagree.

Metzker and Leslie held that, when a claimant is released to modified work at or above his or her regular wage, the claimant is temporarily and partially disabled, even though the actual TPD rate may be zero. Claim classification was not at issue in those cases; neither case addressed the import of OAR 436-30-045(5)(a) and (d), which specifically provide that a claim is "disabling" only if temporary disability is "due and payable" or if the worker is released to and doing a job at reduced wages from the job at injury. Sharman R. Crowell, which issued after the classification of claimant's claim, was the first post-Stone case to address those rules. Because, before Crowell issued, the rules supported the employer's classification of this claim as nondisabling, we reject claimant's argument.

April 4, 1995

Cite as 47 Van Natta 617 (1995)

In the Matter of the Compensation of
LUCILLE G. MAJOR, Claimant
 WCB Case No. 94-05848
 ORDER ON REVIEW
 Douglas D. Hagen, Claimant Attorney
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of Referee Neal's order which: (1) upheld the insurer's denial of her cervical and low back consequential condition claim; and (2) declined to award an assessed attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

While employed as a bartender, claimant developed right heel pain. She then filed a claim that the insurer accepted as right plantar fasciitis. Claimant later developed cervical and low back pain for which she received treatment from a chiropractor, Dr. Fish. Dr. Rotter, an internist, also provided treatment. Both Dr. Fish and Dr. Rotter related claimant's spinal complaints to an altered gait due to her right heel pain. Dr. Stewart, an examining orthopedist, however, opined that claimant's cervical and lumbosacral strains were not related to her right foot condition.

The Referee upheld the insurer's denial of claimant's low back and cervical conditions under ORS 656.005(7)(a)(A), reasoning that claimant had failed to sustain her burden of proving that her compensable right heel injury was the major contributing cause of her consequential spinal conditions. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). In reaching this conclusion, the Referee found the medical opinion of Dr. Stewart more persuasive than the opinions of Drs. Fish and Rotter, primarily because the latter physicians did not confirm that claimant's compensable plantar fasciitis was the major contributing cause of her neck and low back strains.

On review, claimant concedes that she must prove major causation under ORS 656.005(7)(a)(A). However, claimant asserts that the Referee improperly evaluated the medical evidence and should have found Dr. Fish's and Dr. Rotter's medical opinions sufficient to satisfy her burden of proof. We agree.

Inasmuch as claimant is alleging that her low back and cervical conditions developed as a consequence of her compensable right heel injury, we find that the medical causation question is complex, requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). 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). In this case, we find no persuasive reason not to defer to the medical opinions of the physicians who treated claimant for her spinal complaints.

As previously noted, the Referee discounted the opinions of Drs. Rotter and Fish because neither doctor stated that claimant's right heel injury was the major contributing cause of her low back and cervical conditions. However, it is well-settled that the use of "magic words" is not required. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). It is sufficient if the medical evidence as a whole supports the conclusion that claimant's compensable right foot condition was the major contributing cause of claimant's consequential conditions. See Richard B. Caulkins, 46 Van Natta 1178, 1180 (1994), aff'd, Medite Corporation v. Caulkins, 133 Or App 258 (1995). Here, we find that the medical evidence from Drs. Rotter and Fish satisfies claimant's burden of proof.

In a June 6, 1994 letter to claimant's counsel, Dr. Rotter stated that claimant had developed cervical and lumbar spinal strain and sprain due to a compensatory effect from her foot injury. (Ex. 20A). Dr. Rotter explained that claimant's altered gait had created imbalances along her vertebral column which had caused her spinal symptoms. Although Dr. Rotter never used the words "major contributing cause," his opinion and accompanying explanation support a finding that claimant's right foot condition was the major contributing factor in her spinal complaints.

Dr. Rotter's opinion is supported by Dr. Fish's comments in his April 16, 1994 medical report, in which he also concluded that claimant's back and neck pain was of a "compensatory nature." (Ex. 18-2). In combination with Dr. Rotter's medical opinion, Dr. Fish's medical opinion is persuasive evidence that claimant's right foot condition is the major contributing cause of her consequential spinal conditions.

The insurer contends that it was not unreasonable for the Referee to discount the medical opinions of Drs. Rotter and Fish because they are not orthopedists like Dr. Stewart. However, that a physician is not a specialist does not mean that his opinion is not entitled to any weight. See Barrett v. Coast Range Plywood, 294 Or 641, 649 (1983); Keith J. Prondzinski, 46 Van Natta 290, 291 (1994). In this case, given Dr. Rotter's and Dr. Fish's familiarity with claimant's low back and cervical conditions, we find that any deficiencies in expertise are more than offset by their advantageous position of being an attending physician.

The insurer also notes Dr. Rotter's concurrence with Dr. Stewart's opinion that claimant's obesity was the major contributing cause of claimant's current right foot condition. (Exs. 16, 19). However, the compensability of claimant's current right foot condition is not at issue. The only issue is whether claimant's altered gait from her right foot injury is the major contributing cause of her consequential spinal conditions. On this issue, we find the medical evidence from the attending physicians, Drs. Fish and Rotter, to be more persuasive than that of Dr. Stewart, whose opinion on causation is limited to a one sentence statement that low back and neck problems are not related to her right foot condition. (Ex. 20-2). We find Dr. Stewart's unexplained opinion to be unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

In conclusion, we find that the most persuasive medical evidence supports a finding that claimant's right foot condition is the major contributing cause of her consequential low back and cervical conditions. Thus, we disagree with the Referee's decision upholding the insurer's denial. Accordingly, we set aside the insurer's denial and remand the claim to the insurer for processing.

Attorney Fees

At hearing, the parties stipulated that claimant's tips should have been included in her temporary disability rate. The parties further stipulated claimant's temporary disability should not have been terminated in December 1993, that the first installment of temporary disability in November 1993 was paid late and that claimant and her counsel were entitled to a penalty under ORS 656.262(10) for improper termination and late payment of temporary disability.

The parties, however, submitted to the Referee the issue of whether the insurer's failure to include claimant's tips in her rate of temporary disability was unreasonable. Conceding that there are no other amounts due on which to base a penalty under ORS 656.262(10), claimant sought an award of attorney fees under ORS 656.382(1) for the insurer's allegedly unreasonable resistance to the payment of compensation. Finding that the insurer did not act unreasonably, the Referee declined to award an assessed attorney fee under ORS 656.382(1).

On review, claimant continues to assert that the insurer's failure to include her tips in her temporary disability rate was unreasonable. We agree.

OAR 436-60-025(5)(d) sets forth the manner of calculating temporary disability for tipped employees as follows:

"For workers employed where tips are a part of the worker's earnings insurers shall use the wages actually paid, plus the amount of tips required to be reported by the employer pursuant to Section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater."

We agree with the insurer that it is not clear from the form 801 that claimant was a tipped employee because the word "tips" was crossed out in space 56 of that form. (Ex. 4). However, we still conclude that the insurer should have known that claimant received tips. Claimant's W-2 form clearly indicates that claimant received tips that were reported to the Internal Revenue Service. (Ex. 22). Inasmuch as the employer is required to assist in the processing of a claim pursuant to ORS 656.262(1), the employer should have provided the insurer with information concerning claimant's tips. Moreover, claimant testified that she contacted the insurer's claims examiner to inform him that tips should be included in her temporary disability rate. (Trs. 9, 11). Yet, there is no evidence that the insurer contacted the employer to confirm the correct wage as it is required to do under OAR 436-60-025(3).

Thus, we find that the insurer's conduct was unreasonable. See Bobbie J. Robitaille, 42 Van Natta 2639 (1990) (Where employer could not reasonably have been unaware of the claimant's tips, failure to include them in wage rate was unreasonable). Therefore, we conclude that the Referee erred in failing to award an assessed fee under ORS 656.382(1) for the insurer's unreasonable resistance to the payment of compensation.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services concerning the unreasonable temporary disability calculation issue is \$350, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue and the value of the interest involved.

Claimant is also entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$3,000, to be paid by the insurer. In reaching this conclusion, we have 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 August 12, 1994 is reversed. The insurer's denial is set aside, and the claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded \$3,000 for services at hearing and on Board review regarding the compensability issue, to be paid by the insurer. That portion of the Referee's order which declined to award an attorney fee for the insurer's allegedly unreasonable claim processing is also reversed. Claimant's counsel is awarded an attorney fee of \$350 for the insurer's unreasonable conduct, to be paid by the insurer.

April 4, 1995

Cite as 47 Van Natta 620 (1995)

In the Matter of the Compensation of
CURTIS R. POTHIER, Claimant
WCB Case No. 94-05450
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee Kekauoha's order that set aside its partial denial of claimant's psychological condition. On review, the issue is compensability.

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

SAIF does not dispute that claimant has a genuine psychological condition. However, it asserts that claimant's mental condition is not compensable because it was caused by "the processing of his claim," rather than "the physical injury itself." (App. Br. at 2). See Douglas R. Baar, 46 Van Natta 763; on recon 46 Van Natta 963 (1994) (an attending physician's opinion that the major contributing cause of the claimant's hypertension condition was the compensable injury and the attendant claims procession failed to meet the claimant's burden of proving that the injury itself was the major cause of that condition); see also David R. Brawner, 46 Van Natta 1108 (1994).

Claimant's attending physician, Dr. Martin, opined that the major contributing cause of claimant's psychological condition was the compensable injury he suffered in June 1990. (Ex. 33). The Referee relied on Dr. Martin's opinion in finding that claimant's compensable injury was, itself, the major contributing cause of claimant's consequential psychological condition. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Inasmuch as we adopt the Referee's reliance on Dr. Martin's medical opinion, we find that claimant's circumstances are distinguishable from our holdings in Douglas R. Baar, supra, and David R. Brawner, supra. In particular, although aware of claimant's alleged problems with vocational assistance and other aspects of his injury claim, Dr. Martin did not identify those claim processing difficulties as a part of the major contributing cause of claimant's psychological condition.

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 fee for claimant's attorney's services on review is \$1,750, to be paid SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief 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.

ORDER

The Referee's order dated September 2, 1994 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of \$1,750, payable by the SAIF Corporation.

In the Matter of the Compensation of
BOBBY P. TANKERSLEY, Claimant
WCB Case No. 94-01456
ORDER ON REVIEW
Swanson, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Hazelett's order that affirmed a Director's order finding claimant not eligible for vocational assistance. On review, the issue is vocational assistance. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable claim as a result of a September 1990 motor vehicle accident. Between May 1993 and August 1993, claimant attended a head trauma rehabilitation program. As part of that program, claimant worked as a maintenance worker.

In December 1993, the insurer notified claimant that he was ineligible for vocational services. Claimant requested review by the Director. The Director's order also found claimant ineligible for vocational assistance, concluding that claimant did not have a substantial handicap to employment. The Referee found that the Director's order did not fall under those categories in ORS 656.283(2) for setting it aside and, thus, affirmed.

Claimant asserts that the Director and Referee erroneously applied former OAR 436-120-025(1) based on the finding that claimant was a seasonal worker at the time of injury. According to claimant, he was a permanent full-time employee and, because he showed that his regular employment paid between \$9 and \$10 per hour, he proved a substantial handicap to employment.

Although not clear, it appears that claimant is correct that the Director relied on former OAR 436-120-025(1) in finding whether claimant had a substantial handicap to employment. The Director's order computed claimant's wage at injury to be \$4.30 per hour based on finding that claimant earned \$5,150 in wages and unemployment compensation during the 37 weeks prior to the injury. The order also found that a "suitable wage" was \$4.75. It appears that the Director compared the wage-at-injury of \$4.30 with the "suitable wage" of \$4.75 and, because the latter was within 20 percent of the former, found that claimant had no substantial handicap to employment.

A worker is eligible for vocational assistance if, in part, there is a "substantial handicap to employment." ORS 656.340(6)(a); former OAR 436-120-040(3)(c) (WCD Admin. Order 11-1987). A "substantial handicap to employment" exists when the worker, because of the injury, lacks the necessary capacities, knowledge, skills and abilities to be employed in "suitable employment." ORS 656.340(6)(b)(A); former OAR 436-120-005(10). Thus, in determining claimant's eligibility for vocational assistance, we must decide if he is able to perform "suitable employment."

As we explained in Keith D. Kilbourne, 46 Van Natta 1837 (1994), which issued after the Referee's order, the former rules contained two provisions pertaining to "suitable employment," former OAR 436-120-005(6)(a)(A) and former OAR 436-120-005(6)(a)(B). However, because subsection (A) explicitly referred to "determining eligibility" for vocational assistance and subsection (B) explicitly cited to "providing" such benefits, only former OAR 436-120-005(6)(a)(A) applied to cases involving initial determinations of eligibility. Id. at 1838. Furthermore, we found that, because former OAR 436-120-005(6)(a)(B) was the only rule that provided for application of former OAR 436-120-025, that rule also was relevant only for purposes of providing vocational assistance. Id. at 1839.

As we found above, the Director relied on former OAR 436-120-025 in determining that claimant was not eligible for vocational assistance. Because this case concerns claimant's initial eligibility for such

benefits, we conclude that application of former OAR 436-120-025 was a violation of its rules and its decision therefore may be modified.¹ See ORS 656.283(2)(a); Keith D. Kilbourne, supra.²

Former OAR 436-120-005(6)(a)(A) provided that "suitable employment includes a wage within 20% of the wage currently being paid for employment which is the regular employment for the worker." "Regular employment" is the kind of employment held by the worker at the time of injury or the worker's customary employment. Id. Thus, we first consider the "wage currently being paid" for claimant's regular work.

At the time of injury, claimant worked as a truck driver for a farm. Claimant attempted to prove through testimony at hearing that such work currently paid between \$9.50 and \$10.00 per hour. We agree with the Referee that such testimony was not persuasive. Claimant stated that he had contacted three truck drivers in obtaining such information. (Tr. 45 (Day 2)). However, claimant could recall only the first name of one person and the last of name of another; claimant also could not specify the companies for whom two of the drivers worked. (Id. at 53-54).

Thus, in the absence of reliable evidence regarding the current wage of claimant's regular employment, we use claimant's at-injury wage for purposes of determining "suitable employment" under former OAR 436-120-005(6)(a)(A). See Thomas A. Jarrell, 47 Van Natta 329 (1995); David M. Morris, 46 Van Natta 2316 (1994). Based on the 801 form, claimant's at-injury wage was \$6 per hour.

We next consider whether claimant had the necessary capacities, knowledge, skills and abilities to perform "suitable employment." Former OAR 436-120-005(10). After claimant completed the head trauma rehabilitation program, the closing evaluation identified numerous jobs that claimant could perform for 8 hours per day. (Exs. 8, 10, 12, 13-11). There also was evidence that claimant's treating physician had concurred with the report. (Ex. 15-3). Thus, we conclude that claimant had the necessary capacities, knowledge, skills and abilities to perform such positions.

There is no direct evidence, however, regarding the wage for each of the jobs. Adele Bostwick, a vocational rehabilitation counselor, assessed claimant's eligibility for vocational assistance on behalf of the insurer. Ms. Bostwick based her evaluation on an average at-injury wage of \$3.83 per hour, noting that "this would be less than minimum wage, an hourly wage being \$4.43" per hour. (Ex. 15-4). Ms. Bostwick concluded that, based on the jobs identified by rehabilitation program, claimant did not have a substantial handicap to employment. (Id. at 4-5). As noted above, the Director's order similarly based its finding that claimant was not eligible for vocational assistance because his average at-injury wage was less than minimum wage.

Thus, both Ms. Bostwick and the Director used the minimum wage to evaluate claimant's eligibility. In the absence of direct evidence regarding the wage of the jobs shown to be appropriate for claimant's abilities, we find the approach taken by Ms. Bostwick and the Director sufficient evidence that the potentially suitable work paid minimum wage. Thus, we compare this figure against the regular work wage of \$6 per hour to determine if the employment is "suitable."

Whether minimum wage is considered to be \$4.43, the amount used by Ms. Bostwick, or \$4.75, the figure cited by the Director, those wages are not within 20 percent of the current wage for claimant's "at-injury" job of \$6 per hour. Therefore, on this record, we conclude that claimant is not capable of performing "suitable employment." See former OAR 436-120-005(6)(a)(A). Consequently, he proved a "substantial handicap to employment." See ORS 656.340(6)(a); former OAR 436-120-040(3)(c). Therefore, we conclude that claimant is eligible for vocational assistance.

ORDER

The Referee's order dated June 30, 1994 is reversed. The Director's order dated January 27, 1994 is modified to find claimant eligible for vocational assistance. The insurer is directed to provide vocational assistance to claimant in a manner consistent with the applicable Director's rules and statute. Claimant's attorney is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed \$3,800, payable by the insurer directly to claimant's counsel.

¹ In view of this conclusion, we do not address claimant's argument that former OAR 436-120-025 conflicts with ORS 656.340(5).

² Although a signatory to this order for purposes of stare decisis, Board Chair Neidig refers the parties to her dissent in Keith D. Kilbourne, supra.

In the Matter of the Compensation of
OPAL M. ANDERSEN, Claimant
WCB Case No. 94-02469
ORDER ON REVIEW
Stunz, Fonda, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Hazelett's order that upheld the SAIF Corporation's denial of her occupational disease claim for a low back condition. On review, SAIF objects to the Referee's "notice" of facts based on his unannounced, personal observation of the employer's premises. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the Referee "NOTICE FACTS."

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, the parties discussed the possibility of having the Referee view claimant's worksite. However, claimant's counsel objected to a walk-through view, while SAIF's counsel objected to a view limited to the exterior of the employer's premises. (Tr. 53-60). Apparently, after the hearing, and out of the presence of the parties or their attorneys, the Referee conducted an unannounced "drive-by" view of the exterior of the employer's premises. The Referee then made "notice" findings detailing his observations.

SAIF objects to the Referee's "NOTICE FACTS." That objection has merit.

Although the parties and the Referee discussed various options for conducting a view, no consensus was reached; then, the Referee viewed the premises on his own at some undisclosed time. Under the circumstances, we find that the Referee's unannounced view was not consistent with his obligation to conduct the hearing in any manner that will achieve substantial justice. See ORS 656.283(7); see also John M. Ames, 44 Van Natta 684, on recon 44 Van Natta 916 (1992) (noting referee's obligations under ORS 656.283(7), Board excluded from evidence post-hearing medical report that referee had solicited in effort to more fully develop the medical record). Furthermore, in light of the general rule that a jury view is not evidence, but rather a tool to assist the judge or jury in gaining a better understanding of the issues involved and the evidence actually adduced during trial, e.g., Ernst v. Broughton, 213 Or 253, 257-58 (1958); Port of Newport v. Haydon, 4 Or App 237, 242 (1970), we conclude that, in any event, the Referee should not have made any findings regarding the view. Cf. OAR 438-85-860 (setting forth standards for conducting views in safety cases).

For all these reasons, SAIF's objection to the Referee's "NOTICE FACTS" is well-taken. Accordingly, we conclude that the Referee's view was an abuse of discretion. Thus, we conduct our review without consideration of the "NOTICE FACTS."

COMPENSABILITY

Claimant asserts that the Referee erred in concluding that she had failed to establish that her work activities were the major contributing cause of her current low back pain and, therefore, that she had failed to establish a compensable occupational disease claim. We disagree.

Claimant bears the burden of proving that her work activity is the major contributing cause of her low back condition or its worsening. ORS 656.802(2). To the extent that claimant's current low back condition claim is based on her preexisting low back condition, she must prove a pathological worsening of the preexisting condition to prevail. Weller v. Union Carbide, 288 Or 27 (1979).¹ To the

¹ Claimant refers us to Scarratt v. H.A. Anderson Construction Co., 108 Or App 554, 557-58 (1991), which holds that disabling symptoms of an underlying disease and symptoms that require medical services are compensable if they are caused by an occupational injury, even if the underlying disease has not worsened. Because this case involves an occupational disease, not an injury, Scarratt is inapposite.

extent that claimant's current low back condition claim is solely the result of her work activities, and is not related to her preexisting condition, she must establish that those activities are the major contributing cause of her current low back condition. ORS 656.802(2). Claimant has not met either burden.

Two experts have rendered opinions regarding the cause of claimant's current low back condition. Dr. Bowman examined claimant on SAIF's behalf. He found that claimant had a preexisting degenerative back condition, but no evidence of a pathological, as opposed to a symptomatic, worsening in that condition as a result of her work activities. (Ex. 23-3).

Dr. Johnson, treating physician, initially concurred with Dr. Bowman's report. (Ex. 24). Thereafter, however, in response to a detailed statement of facts drafted by claimant's counsel, Bowman agreed with the statement, "[O]n a more likely than not basis, the major contributing cause of [claimant's] pain IS the result of her job activities * * *." (Id. at 2; emphasis in original).

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We find persuasive reasons not to do so here.

First, Dr. Johnson did not address whether claimant's current low back condition had pathologically, rather than symptomatically, worsened. Weller, supra. Therefore, we find it insufficient to establish claimant's claim under a "worsened preexisting condition" theory.

Second, Johnson did not explain his change of opinion when he concluded, in his final report, that claimant's pain was caused, in major part, by her work activities. Moe v. Ceiling Systems, 44 Or App 429 (1980). Under the circumstances, we find Dr. Johnson's reports insufficient to establish the compensability of claimant's current low back condition as solely the result of her work activities.

For these reasons, we agree with the Referee that claimant has failed to establish the compensability of her low back condition as an occupational disease. Accordingly, we affirm the Referee's decision upholding SAIF's denial of that condition.

ORDER

The Referee's order dated July 5, 1994 is affirmed.

April 5, 1995

Cite as 47 Van Natta 624 (1995)

In the Matter of the Compensation of
PHILIP ESTES, Claimant
 WCB Case No. 93-15273
 ORDER ON REVIEW
 Nancy F.A. Chapman, Claimant Attorney
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian and Gunn.

The insurer requests review of that portion of Referee Myzak's order which awarded a \$3,000 assessed attorney fee under ORS 656.386(1) for claimant's counsel's efforts in obtaining the "pre-hearing" rescission of a "de facto" denial of claimant's neck injury. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

After claimant's counsel filed a hearing request, the insurer accepted claimant's neck injury claim more than 90 days after notice of the claim. Several issues were submitted to the Referee for disposition based solely on the documentary record. They were claimant's entitlement to an assessed

attorney fee under ORS 656.386(1) and penalties and attorney fees for untimely acceptance of the claim and for unreasonable resistance to the payment of compensation based on the insurer's failure to timely provide discovery.

Although finding that the insurer was repeatedly late in providing discovery, the Referee concluded there was no basis for awarding a penalty or assessed attorney fee for unreasonable resistance to the payment of compensation because all amounts of compensation due were paid without delay or other resistance. The Referee, however, assessed a \$3,000 attorney fee under ORS 656.386(1) for claimant's counsel's efforts in obtaining acceptance of claimant's claim.

On review, the insurer contends that the amount of the Referee's attorney fee award was excessive, citing the amount of the attorney awards granted in Betti Haley, 46 Van Natta 206 on recon 46 Van Natta 1001 (1994) (\$150) and Shaun Donovan, 45 Van Natta 878 (1994) (\$500) for rescissions of "de facto" denials in those cases. The insurer asserts that the Referee improperly based her award in part on claimant's counsel's efforts in obtaining untimely provided discovery. It argues that the Referee should have limited the basis for her attorney fee award to the "compensability" issue.

Claimant's counsel asserts that she obtained a significant benefit for claimant by securing acceptance of his claim and that her attempts to obtain full discovery were essential to the effective representation of claimant with respect to the compensability issue.

While there is merit to claimant's contentions, the record does not contain evidence of the specific amount of time claimant's counsel directed to obtaining acceptance of claimant's cervical claim, including that devoted to discovery efforts. Moreover, this record does not persuasively establish the extent to which claimant's efforts in obtaining discovery influenced the insurer's decision to accept the claim.

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 under ORS 656.386(1) for claimant's attorney's services concerning the "de facto" denial issue is \$1,500. In reaching this conclusion, we have particularly considered the value of the interest involved, the complexity of the issue, the time devoted to the issue (as represented by the record), and the risk that claimant's counsel might go uncompensated. We modify the Referee's award accordingly.

ORDER

The Referee's order dated June 14, 1994, as reconsidered on July 29, 1994, is modified. In lieu of the Referee's \$3,000 attorney fee award for obtaining the rescission of the insurer's "de facto" denial, claimant's counsel is awarded an assessed attorney fee of \$1,500, payable by the insurer. The remainder of the Referee's order is affirmed.

Board Member Gunn dissenting.

Once again the Board tinkers with a Referee's award of attorney fees, substituting its subjective judgment for that of the Referee. Once again I am compelled to dissent.

My position regarding attorney fee disputes is well-known. See e.g. Richard Lester, 47 Van Natta 419 (1995) (Board Member Gunn dissenting); Lois J. Schoch, 46 Van Natta 1816 (1994) (Board Member Gunn dissenting). In almost all cases, the Board is an inappropriate forum in which to resolve issues concerning the amount of attorney fees to which claimant's counsel is entitled. The Referee, having observed claimant's counsel in action, is in a much superior position to accomplish this task.

Moreover, the Board's habit of modifying attorney fee awards merely encourages parties to bring these disputes to this forum, whose attention should be focused on weightier matters. I am not alone in my concern about the Board's habit of second-guessing attorney fee awards. See Patricia L. Row, 46 Van Natta 1794 (1994) (Board Member Hall dissenting).

While the attorney fee in this case is higher than is typically awarded, I cannot say that the Referee abused her discretion, which is the standard by which we should evaluate this issue. Accordingly, I would affirm the Referee's attorney fee award.

In the Matter of the Compensation of
HOPE C. PANAGES, Claimant
WCB Case No. 94-04833
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Nichols' order that upheld the insurer's denial of claimant's injury claim for a broken nose, bruises and scratches. On review, the issue is whether claimant's injuries arose out of and occurred in the course of her employment.

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

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. Under that statute, four elements must be satisfied: (1) the claimant must be an active participant; (2) in assaults or combats; (3) that are not connected with the job assignment; and (4) that amount to a deviation from customary duties. Kessen v. Boise Cascade Corp., 71 Or App 545 (1984). Claimant asserts that the first and third elements have not been satisfied in this case. We disagree.

Claimant was a clerk in a grocery store. She and Woodard, her supervisor and co-clerk, were on duty when an intoxicated young woman, Chavez, entered the store. Chavez made racially-derogatory comments about claimant, after which claimant and Chavez exchanged words. Chavez left the store, with claimant following and asking, "You got a problem?" Claimant then "got in [Chavez'] face." After Chavez left the area, Woodard called the police, who contacted Chavez and told her not to return to the store.

A couple of hours later, Chavez and a companion returned to the store. Chavez was verbally abusive to both Woodard and claimant, and made further racially-derogatory comments about claimant. Claimant and Woodard told Chavez to leave the store. Claimant, followed by Woodard, escorted Chavez and her companion out of the store. Woodard stopped near the entrance to the store, while claimant continued to follow Chavez, until Chavez was near a friend's car in the parking lot. Claimant and Chavez continued to argue. (Tr.120, 121, 125, 132, 146-47). At that point, claimant and Chavez engaged in a physical fight, the two pulling, pushing, hitting and kicking each other. (Tr. 56, 57, 59, 62, 101, 102, 103, 122). Woodard again called the police, who eventually cited Chavez for criminal trespass. Claimant sustained a broken nose, bruises and scratches.

Claimant and Woodard had been told to call police if a problem developed at the store. (Tr. 91; see Tr. 160). Claimant's work duties did not include following Chavez to the parking lot. (Tr. 92; see Tr. 160).

Claimant first asserts that she was not an "active participant" in the physical altercation with Chavez, because she did not instigate the fight. We disagree.

A claimant may be an "active participant" if she assumes an active or aggressive role in the fight, and if she has an opportunity to withdraw from the encounter and not participate in the fight, but fails to withdraw. See Irvington Transfer v. Jasenosky, 116 Or App 635, 640 (1992). Although the evidence is not clear regarding who started the physical fight, it is clear that claimant participated in the fight by pushing, pulling, hitting and kicking Chavez and pulling her hair. Furthermore, the evidence reveals that claimant had, but did not avail herself of, the opportunity to withdraw from the altercation. Under the circumstances, we find that claimant was an "active participate" in the fight with Chavez. Jasenosky, supra.

Claimant next asserts that her conduct "was unquestionably connected to her job assignment." (Claimant's Appellant's Brief at 9). In support of this argument, claimant asserts that she was, in conformity with Woodard's "wishes and desires," following Woodard's lead in telling Chavez to leave the premises and in escorting Chavez off the property. (Id. at 10). Then, claimant asserts, her conduct during the physical fight was defensive, i.e., an attempt to ward off Chavez' attack. We are not persuaded by claimant's argument.

First, the record establishes that both claimant and Woodard had been instructed to call police if problems developed, and that claimant's work duties did not include following customers out into the parking lot. Second, we find that Woodard did not solicit claimant's behavior, beyond claimant's telling Chavez to leave the premises. We find no persuasive evidence that Woodard, either expressly or impliedly, directed claimant to follow Chavez out into the parking lot, or to engage in verbal sparring or physical combat. That Woodard followed claimant and stopped near the store's entrance, while claimant continued on into the parking lot, undercuts claimant's argument that she was acquiescing in Woodard's "wishes and desires." Finally, we find the record does not support claimant's assertion that, during the physical fight itself, she was acting solely to fend off Chavez' attack; there is persuasive evidence that both women were acting offensively during the fight. Accordingly, we reject claimant's argument that her conduct, which resulted in her injuries, was connected with her work duties. Cf. Christopher E. Eisterhold, 46 Van Natta 2324 (1994) (when the claimant had been instructed not to engage in physical altercation with persons who came on the employer's premises and to call police if problems developed, the claimant was outside bounds of employment when she was injured while chasing a van, an occupant of which had shot her with a paint ball while the claimant was sweeping the employer's parking lot).

For these reasons, we agree with the Referee that claimant's injuries occurred outside the scope of claimant's employment. Therefore, we affirm the Referee's decision upholding the insurer's denial of claimant's injury claim.

ORDER

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

April 5, 1995

Cite as 47 Van Natta 627 (1995)

In the Matter of the Compensation of
GEORGIA E. WILSON, Claimant
WCB Case No. 94-05318
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

The insurer requests reconsideration of those portions of our March 7, 1995 Order on Review that: (1) reinstated the Order of Reconsideration and corrected it to award claimant 2 percent (3.84 degrees) scheduled permanent disability for loss of use or function of her left arm, rather than her right arm; and (2) awarded an assessed fee of \$1,000 for services at hearing regarding the permanent disability issue. For the following reasons, we adhere to our prior conclusions.

The insurer argues that there is no evidentiary basis for our determination that there was a scrivener's error. We disagree. In our order, we reviewed claimant's medical records, claimant's testimony and the medical arbiter panel's report in detail. In light of claimant's medical history showing that her symptoms were limited to her left elbow, the arbiter panel's own reference to symptoms only in the left elbow and claimant's testimony regarding the exam, we concluded that the arbiter panel's reference to "right" arm constituted a scrivener's error. See Rosario Felix, 45 Van Natta 1179 (1993). We adhere to that conclusion on reconsideration.

The insurer also argues that the imposition of a \$1,000 assessed attorney fee under ORS 656.382(2) is unjustified. The insurer asserts that it successfully obtained a reduction in the award of right arm disability which it appealed.

Although the insurer obtained a reduction in the award of right arm disability through its hearing request, we corrected the Order of Reconsideration to award claimant 2 percent scheduled permanent disability for her left arm rather than her right arm. Thus, we concluded that claimant's permanent disability compensation had not been disallowed or reduced. Since claimant successfully defended against the insurer's hearing request which attempted to reduce or eliminate her permanent disability compensation granted by the Order on Reconsideration, we adhere to our conclusion that claimant is entitled to a carrier-paid attorney fee. See ORS 656.382(2).

The insurer also argues that if it had not sought elimination of the award of the right arm, it might later be precluded from contending that right arm treatment is compensably related to the left arm injury. ORS 656.382(2) merely provides that claimant is entitled to an attorney fee if the carrier seeks a hearing or review and the referee or Board finds that the compensation awarded to claimant "should not be disallowed or reduced." The statutory attorney fee award is not contingent on the reasons the carrier sought a hearing or review or whether those reasons were justified.

We withdraw our March 7, 1995 order. On reconsideration, as supplemented herein, we republish our March 7, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 6, 1995

Cite as 47 Van Natta 628 (1995)

In the Matter of the Compensation of
GARY L. GOODEAGLE, Claimant
 WCB Case No. 94-05157
 ORDER ON REVIEW
 Malagon, Moore, et al., Claimant Attorneys
 Kenneth R. Russell (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Menashe's order that: (1) upheld the SAIF Corporation's denial of claimant's medical services claim regarding a proposed low back surgery; and (2) declined to assess a penalty for SAIF's allegedly unreasonable claims processing. On review, the parties dispute who has jurisdiction over this matter. On review, the issues are jurisdiction, medical services and penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the quotations from the Director's August 18, 1993 order, and with the following supplementation.

In December 1992, claimant requested a hearing regarding SAIF's "de facto" denial of Dr. Lewis' December 8, 1992 request for authorization for a proposed back surgery. On March 25, 1993, after claimant withdrew the hearing request, a prior referee dismissed the request. The dismissal order stated simply that "the matter is dismissed." No one appealed the dismissal order.

In March 1993, the Director initiated review of the propriety of the proposed surgery. At the Director's behest, Dr. Mawk examined claimant and reviewed the medical record. In August 1993, the Director issued an order under ORS 656.327(1), concluding that the proposed surgery was not appropriate. The order further stated that SAIF was not responsible for providing reimbursement for any costs attributable to the surgery.

After receiving claimant's hospital bills, SAIF advised several of claimant's caregivers that, under the Director's August 1993 order, it was not required to reimburse the caregivers.

On April 28, 1994, claimant filed a hearing request regarding SAIF's "de facto" denial of Dr. Lewis' November 1993 surgery request.

In a July 18, 1994 report, Dr. Lewis explained that, since the March 1994 surgery, claimant has been doing "extremely well. He is off all analgesics. He has felt better than he has in years and is becoming more and more functional." (Ex. 29).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that SAIF has requested that we take administrative notice of the prior referee's order dismissing claimant's initial hearing request.¹ We may take administrative

¹ The dismissal order initially was in evidence, but, at the Referee's suggestion, was withdrawn at hearing. (Tr. 6).

notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders. See, e.g., Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Because the dismissal order meets that standard, we take administrative notice of it.

Jurisdiction

The Referee concluded that the Director's August 1993 order was final and, therefore, was law of the case. Accordingly, because there had not been a material change in claimant's condition since the order issued, the Referee concluded that the Director's decision that the surgery was not appropriate controlled. Claimant asserts that, because the Director lacked jurisdiction to issue the August 1993 order, the Referee's decision was in error. We agree.

Claimant initially injured his low back at work in October 1987. He subsequently underwent two laminectomies. He continued to have low back and left leg pain. Thereafter, Dr. Lewis, treating surgeon, determined that claimant needed additional surgery for an absent facet joint and spinal instability. In December 1992, Lewis requested authorization to perform another decompression surgery and a pedicle screw fusion of L4 to S1. SAIF neither accepted nor denied the requested surgery.

In December 1992, claimant requested a hearing regarding SAIF's "de facto" denial of Dr. Lewis' surgery request.² On March 3, 1993, the Director initiated review of the propriety of the proposed surgery. Meanwhile, claimant withdrew his hearing request, which a prior referee dismissed on March 25, 1993. The order did not indicate whether the dismissal was with or without prejudice.

At the Director's request, Dr. Mawk examined claimant and reviewed the medical record. On August 18, 1993, the Director issued an order concerning the proposed surgery, concluding that, at the time, the surgery was not reasonable or necessary because, among other things, more conservative measures had not been tried.

Meanwhile, in October 1993, the Court of Appeals issued its decision in Jefferson v. Sam's Cafe, 123 Or App 464 (1993), rev den 320 Or 453 (1994), which held that the Director lacked jurisdiction to consider the reasonableness or necessity of proposed medical treatment.

On November 11, 1993, after further diagnostic testing, Dr. Lewis sent another letter to SAIF requesting authorization to perform the proposed low back surgery. Dr. Lewis performed the surgery in March 1994. After receiving claimant's hospital bills, SAIF advised claimant's caregivers that, under the Director's August 1993 order, it was not required to reimburse for the services provided. On April 28, 1994, claimant filed a new hearing request, contesting SAIF's "de facto" denial of Dr. Lewis' November 1993 surgery request.

Subsequently, the Supreme Court issued its decisions in Martin v. City of Albany, 320 Or 175 (1994) and Niccum v. Southcoast Lumber Co., 320 Or 189 (1994), which hold that ORS 656.327(1) does not authorize the Director to review disputes over proposed medical treatment

Dr. Lewis' post-operative reports indicate that claimant improved dramatically following surgery. At hearing, claimant testified that the March 1994 surgery had resolved his left leg and low back pain. (Tr. 8-9).

Claimant asserts that, in view of the recent appellate decisions so holding, the Director lacked jurisdiction to issue an order concerning his then-proposed low back surgery. We agree. Martin, supra; Niccum, supra; Jefferson, supra. Therefore, the Director's order is a nullity and we will not consider it in addressing the merits of claimant's medical services claim. Noe Barrera-Ortiz, 46 Van Natta 1483 (1994) (a Director's order regarding a proposed medical procedure was void); see Greeninger v. Cromwell, 127 Or App 435, 440 (1994) (if a judgment is entered by a court lacking subject matter jurisdiction, the judgment is void).

SAIF asserts that, by virtue of claimant's failure to appeal the order dismissing his initial hearing request, the dismissal order has become final. Therefore, SAIF maintains, claimant is barred by claim preclusion from "relitigating" this medical services claim. We disagree.

² We note that this hearing request on a "de facto" denial was premature, because the period within which SAIF had to accept or deny the claim had yet to expire. See ORS 656.262(6).

Claim preclusion requires a valid final judgment. Drews v. EBI Companies, 310 Or 134, 141 (1990). An unappealed order of dismissal that is not "with prejudice" is not a final judgment for purposes of claim preclusion. Hampton Tree Farms, Inc. v. Jewitt, 125 Or App 178 (1993) (citing Drews, Court of Appeals held that a bankruptcy court's order dismissing the bankruptcy proceeding without prejudice is not a final determination on the merits, in the sense required for application of claim preclusion); see Piukkula v. Pillsbury Flouring Co., 150 Or 304, 328 (1935) ("Rulings and decisions in the course of an action which it finally dismissed without prejudice adjudge nothing, because the final judgment by its terms is that nothing has been adjudicated, and this fact is the only *res judicata*.")

Here, the dismissal order states only that "the matter is dismissed." As such, we conclude that it was without prejudice. See Mickey L. Platz, 46 Van Natta 1668 (1994) (a referee's order of dismissal is interpreted by the Board as a dismissal "without prejudice" unless the order otherwise specifies). Accordingly, the dismissal order is not a "final judgment" for claim preclusion purposes. See Nelson Muir, 42 Van Natta 395 (1990) (order of dismissal without prejudice has no preclusive effect on subsequent litigation). Therefore, SAIF's claim preclusion argument fails.

In a related vein, claimant asserts that the Referee erred in concluding that the Director's order was the "law of the case." We agree. The "law of the case" doctrine relates to an adjudication of issues that have become final by operation of law. See R. L. K. and Co. v. Tax Commission, 249 Or 603, 608 (1968) ("law of the case" relates to issues that have culminated in a final decree). ORS 656.327(2) contains no specific time period within which a party must seek a hearing to contest a Director's order under ORS 656.327(1). Benino T. Orn, 46 Van Natta 254, 255 (1994). Therefore, the Director's order had not become "final" when claimant filed his April 1994 hearing request. Accordingly, no basis exists for the application of the "law of the case" doctrine.³

In reaching this conclusion, we acknowledge that claimant did not appeal the dismissal of his initial hearing request regarding the proposed surgery. However, the dismissal order issued before the Director's order issued; therefore, that order could not have been intended to extinguish any rights with respect to the Director's order. Moreover, the dismissal was not "with prejudice." Accordingly, we conclude that claimant's failure to appeal the dismissal order did not render the Director's order "final." See Hampton Tree Farms, Inc. v. Jewitt, *supra*; see also Piukkula v. Pillsbury Flouring Co., *supra*.

SAIF asserts that because, when the Director issued the order in this case, Board case law suggested that the Director had jurisdiction over proposed medical treatment disputes, the Director's order is not a nullity, but is binding on the parties. To the extent that SAIF is arguing that we are precluded from considering recent developments in the case law interpreting applicable statutes, we reject that argument outright. See Walther v. SAIF, 312 Or 147, 149 (1991) (judicial interpretation of statute becomes part of statute as if written into it at the time of its enactment); cf. Betty L. Juneau, 38 Van Natta 553, 556 (1986) (Board approves practice of allowing parties to bring to its attention recent developments in the case law after completion of briefing schedules).⁴

³ Additionally, we are mindful of those cases holding that the "law of the case" doctrine "precludes relitigation or reconsideration of a point of law [or fact] decided at an earlier stage of the same case." Koch v. So. Pac. Transp. Co., 274 Or 499, 512 (1976) (emphasis in original); see State ex rel Orbanco Real Estate Serv. v. Allen, 301 Or 104, 110 (1986) (to invoke the "law of the case" doctrine, the facts and issues in the present proceeding must be the same as in the first). Because the Director's order issued as a result of a proceeding separate from this case, the "law of the case" doctrine, as construed by the above cases, is inapplicable. In reaching this conclusion, we recognize that, in other cases, the "law of the case" doctrine has been loosely interpreted to prohibit the relitigation of issues conclusively decided in earlier, separate proceedings. See, e.g., Kuhn v. SAIF, 73 Or App 768 (1992) (when claimant had, in earlier extent of disability proceeding, established that permanent disability arose out of industrial accident, doctor's opinion in subsequent aggravation proceeding that disability was result of congenital condition was held contrary to law of the case).

⁴ SAIF also asserts that, because a request for reconsideration is pending in Martin v. City of Albany, *supra*, the Director still has jurisdiction to review disputes regarding future medical treatment. Accordingly, SAIF argues, the Director's order in this case precludes claimant from "relitigating" his surgery claim. Because the Court has now issued its appellate judgment in Martin, we need not address SAIF's argument. See Melvin L. Martin, 47 Van Natta 107, on recon 47 Van Natta 268 (1995).

As a corollary to this argument, SAIF asserts that, at the time of the Director's August 1993 order, in view of the then-valid Board law, the parties agreed that the Director had jurisdiction over the dispute. Because subject matter jurisdiction cannot be created by consent, waiver, estoppel or any other conduct of the parties, e.g., Wink v. Marshall, 237 Or 589, 592 (1964); Leanord v. Jackson Co. Rural Fire Dist. No. 3, 92 Or App 242, 247 (1988), the parties' supposed agreement is of no import.⁵

In sum, for the foregoing reasons, we conclude that the Director was without jurisdiction to address the propriety of claimant's proposed low back surgery. Therefore, we will not consider that order in analyzing the merits of this claim.

Before we turn to the medical services issue, we note SAIF's argument that, under Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 563-64 (1989), rev den 309 Or 645 (1990), claimant is entitled to only one opportunity to prove that the proposed surgery was reasonable and necessary. Therefore, the argument goes, because claimant withdrew his first request for hearing, he is now precluded from relitigating that claim. We disagree.

Bird holds that an uncontested denial bars future litigation of the denied condition unless the condition has changed and the claimant presents new evidence to support the claim that could not have been presented earlier. We find Bird distinguishable from the instant case. As we stated above, both its lack of a jurisdictional foundation and finality render the Director's order without preclusive effect. Moreover, Bird applies to cases in which a claimant seeks to litigate a second request for medical services after the denial of an earlier request for medical services has become final by operation of law. Here, although Dr. Lewis twice requested authorization to perform the same proposed surgery, SAIF did not officially accept or deny either request. As such, the requests were denied "de facto." Because there is no limitation period for filing a request for hearing on a "de facto" denial, e.g., Joseph Sweet, 41 Van Natta 1953 (1989), and because claimant's initial hearing request was dismissed without prejudice, SAIF's "de facto" denial of the first surgery request has yet to become final. Accordingly, there is no final denial to serve as a bar to claimant's pursuit of his hearing request regarding SAIF's second "de facto" denial. For these reasons, we reject SAIF's reliance on Bird.

Medical Services

Claimant asserts that the medical evidence is sufficient to establish the reasonableness and necessity of his proposed low back surgery. We agree. In reaching this decision, we consider the entire record, including the surgical findings and Dr. Lewis' post-surgical findings. See Val C. McBride, 42 Van Natta 372, on recon 42 Van Natta 462 (1990) (Board remanded case concerning reasonableness and necessity of proposed surgery for consideration of post-hearing surgical findings that revealed the cause of the claimant's pain).

Dr. Lewis' surgical findings revealed an absent L4-5 facet joint and "a lot of scar tissue" bilaterally in the lumbar surgical site. (Ex. 10-1). Lewis performed a L4 to S1 fusion with L4-5 pedicle screw fixation. (Id.). In a May 1994 report, Dr. Lewis stated that claimant "has had a dramatic improvement in his status post operatively." (Ex. 28). In a July 1994 report, Lewis stated that claimant was doing "extremely well," was off analgesics, felt better than he had in years and continued to improve functionally. (Ex. 29). At hearing, claimant testified that the surgery alleviated his left leg and low back pain. (Tr. 8-9).

SAIF has offered no evidence to controvert this evidence. We conclude that Dr. Lewis' uncontroverted surgical findings and post-operative reports and claimant's uncontested testimony are sufficient evidence of the reasonableness and necessity of the proposed surgery. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988) (physician who performs a claimant's surgery is in best position to provide an opinion regarding the cause of the claimant's current condition). Accordingly, we reverse the Referee's decision upholding SAIF's "de facto" denial of that surgery.

⁵ SAIF also argues that the Hearings Division lacks jurisdiction over this matter because claimant is precluded from relitigating the compensability of his low back surgery by virtue of his previously filed and withdrawn request for hearing. That argument is based on a non-sequitur, in that the jurisdictional issue does not depend on the preclusion issue.

Penalties

Claimant asserts that the Referee erred in failing to award a penalty for SAIF's allegedly unreasonable claims processing, both before and after claimant's surgery, and after the appellate courts issued their decisions in Martin, Niccum and Jefferson. We disagree.

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to the payment of compensation is whether the carrier had a legitimate doubt about its liability. E.g., International Paper Co. v. Huntley, 106 Or App 107 (1991).

In view of the unusual posture of this case, as well as the divergence of pre-operative medical opinion, we conclude that, both before and after surgery, and after the appellate decisions issued in Martin, Niccum and Jefferson, SAIF had a legitimate doubt about its liability for claimant's proposed surgery. Accordingly, we conclude that SAIF's claims processing was not unreasonable, and we affirm the Referee's decision declining to assess a penalty.

Claimant's counsel is entitled to an attorney fee for services at hearing and on review. ORS 656.386(1). After considering the factors 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 concerning the jurisdiction and medical services issues is \$4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record, claimant's appellate briefs, and claimant's counsel's statement of services), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for his counsel's unsuccessful efforts on review concerning the penalty issue.

ORDER

The Referee's order dated August 24, 1994 is affirmed in part and reversed in part. That portion of the order upholding the SAIF Corporation's "de facto" denial of claimant's proposed low back surgery is reversed. SAIF's "de facto" denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded \$4,500, to be paid by SAIF. The remainder of the Referee's order is affirmed.

 April 6, 1995

Cite as 47 Van Natta 632 (1995)

In the Matter of the Compensation of
DARLA J. HOWELL, Claimant
 WCB Case No. 94-02945
 ORDER ON REVIEW
 James L. Edmunson, Claimant Attorney
 Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Black's order that dismissed¹ claimant's hearing request regarding the SAIF Corporation's "de facto" denial of claimant's right shoulder surgery, on the ground that the Hearings Division lacked jurisdiction over the matter. On review, the issue is jurisdiction and, alternatively, compensability.

We adopt and affirm the Referee's order, with the exception of the analysis concerning Jerry L. Conover, 46 Van Natta 456 (1994), and with the following supplementation.

¹ The Referee actually "denied" claimant's hearing request. (Opinion and Order at 5). We treat the "denial" as a dismissal.

Relying on Drews v. EBI Companies, 310 Or 134 (1990) and Jerry L. Conover, supra, the Referee found that claimant was precluded by an unappealed Director's order from relitigating the reasonableness and necessity of her right shoulder surgery. On review, claimant argues that, because Meyers v. Darigold, Inc., 123 Or App 217 (1993), rev den 320 Or 453 (1994), holds that ORS 656.327 is not an exclusive procedure, and that parties may choose whether to litigate under ORS 656.327 or ORS 656.283, the Board should construe ORS 656.327 to allow an independent de novo proceeding under ORS 656.283 unless the same party had previously elected the Director review procedure. We disagree.

In construing ORS 656.327, the Meyers court noted that the statute does not require the parties to invoke the Director review process. 123 Or App at 221. However, the court held that the Board has jurisdiction to consider medical services disputes only if no party has requested that the Director resolve the dispute. Id. at 222. In other words, when any party requests Director review, the Director acquires exclusive jurisdiction over the medical services dispute. Id.

SAIF requested Director review under ORS 656.327 of the propriety of claimant's right shoulder surgery. Consequently, the Director acquired exclusive jurisdiction over this medical services dispute. Therefore, we adopt the Referee's conclusion that the Hearings Division lacked jurisdiction to address this matter.

SAIF asserts, alternatively, that under Jerry L. Conover, supra, claimant is barred by claim preclusion from relitigating the reasonableness and necessity of her right shoulder surgery. We disagree.

In Conover, the issue concerned the effect of a final litigation order under ORS 656.327(2). While the claimant's appeal from a referee's decision dismissing his hearing request concerning a medical treatment dispute was pending, a Director's order had become final by virtue of a final, unappealed subsequent referee's order affirming the Director's order concerning the reasonableness and necessity of the disputed medical services. We held that, by virtue of the final Director's order, issue preclusion barred the claimant from relitigating the medical services issue. Id. at 457.

Conover is distinguishable from this case. ORS 656.327(2) contains no specific time period within which a party must seek a hearing to contest a Director's order under ORS 656.327(1). Benino T. Orn, 46 Van Natta 254, 255 (1994). Therefore, because no one has requested review of the Director's order in this case, that order has yet to become final.² Accordingly, there exists no basis for the application of issue (or claim) preclusion. For these reasons, we reject SAIF's reliance on Conover, and do not adopt the Referee's analysis concerning that case.

Last, we note that claimant's hearing request is based on an alleged "de facto" denial. In our view, no such denial exists. On January 20, 1993, claimant, through her attorney, requested approval for a right shoulder surgery that was performed on January 6, 1993. On March 2, 1993, SAIF sought Director review regarding the reasonableness and necessity of the surgery. Because SAIF sought Director review of this medical services dispute before the expiration of the 90-day period for accepting or denying the claim, see ORS 656.262(6), and because a carrier is prohibited under ORS 656.327(1)(c) from denying a claim after the Director acquires jurisdiction over a medical services dispute, we conclude that SAIF did not "de facto" deny the surgery. Under the circumstances, we find that there is no factual basis for claimant's hearing request. Cf. Michael A. Dipolito, 44 Van Natta 981 (1992) (claimant's hearing request held premature when no written or "de facto" had issued).

Consequently, for this additional reason, we adopt the Referee's ultimate conclusion that the Hearings Division was without authority to grant claimant the relief she is presently seeking; that is, de novo review concerning the propriety of her right shoulder surgery. Review of such a dispute, subject to "substantial evidence" review standards, would vest with the Hearings Division if and when a party requests a hearing regarding the Director's June 30, 1993 order. See ORS 656.327(2); Benino T. Orn, supra.

ORDER

The Referee's order dated July 1, 1994 is affirmed.

² The propriety of the Director's order is not before us.

In the Matter of the Compensation of
FRED D. JUSTICE, Claimant
WCB Case No. 90-05033
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Herman's order, as supplemented on remand, that: (1) upheld the self-insured employer's denial of his aggravation claim for a low back condition; (2) declined to award permanent total disability benefits; and (3) increased claimant's unscheduled permanent disability award for a low back injury from 51 percent (163.2 degrees), as awarded by Determination Order, to 70 percent (224 degrees). In its brief, the employer seeks a reduction of claimant's unscheduled and scheduled permanent disability awards. On review, the issues are aggravation and extent of scheduled and unscheduled permanent disability, including permanent total disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following exception. We do not adopt the Referee's fourth ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

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

Permanent Total Disability

By Opinion and Order dated December 12, 1991, the Referee concluded that claimant was not entitled to an award of permanent total disability because he was capable of regularly performing part-time work in several sedentary occupations, including a retail gift shop cashier, trailer rental clerk, auto rental clerk, customer service clerk, ticket seller, security guard, and telephone solicitor. Claimant requested review of the Referee's order, arguing that those occupations were not "gainful" within the meaning of ORS 656.206(1)(a) and, therefore, should not preclude permanent total disability benefits.

Subsequent to the Referee's order, the Supreme Court issued Tee v. Albertsons, Inc., 314 Or 633 (1992), in which it held that the term "gainful occupation" in ORS 656.206(1)(a) means "profitable remuneration." Because the record was developed prior to the Court's decision in Tee, the Board determined that the record was incompletely and insufficiently developed regarding the "profitable remuneration" issue. Fred D. Justice, 45 Van Natta 971 (1993). Accordingly, the Board vacated the Referee's order and remanded the case to the Referee with instructions to admit further evidence on the issue of whether the aforementioned part-time jobs constitute employments for "profitable remuneration." Id.

Pursuant to the Board's order, a hearing was reconvened on September 13, 1993. Following that hearing, the Referee issued an Order on Remand, determining that the aforementioned part-time jobs constitute "profitable remuneration" for claimant and, therefore, represent "gainful" employment. On that basis, the Referee continued to find that claimant was not entitled to permanent total disability benefits. On review, claimant argues that the aforementioned part-time jobs do not represent "gainful occupations."

In order to establish entitlement to permanent total disability, claimant must prove either that: (1) he is completely physically disabled and therefore precluded from regularly performing any work at a gainful and suitable occupation; or (2) his physical impairment, combined with a number of social and vocational factors, effectively precludes him from regularly performing any work at a gainful and suitable occupation under the "odd lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

The record contains no medical opinion that claimant is completely physically disabled. Therefore, we conclude that claimant is not permanently and totally disabled from a medical standpoint alone.

Dr. Crocker, claimant's treating physician, opined that claimant was not capable of full-time sedentary work. (Exs. 121, 122-22). However, Dr. Crocker opined that claimant was capable of part-time sedentary work with restrictions and that it would benefit claimant to work within his physical limitations. (Exs. 122-27, -32, -33, -44, -45). We agree with the Referee that the medical record establishes that claimant is able to perform sedentary work with the following restrictions: (1) no lifting in excess of 10 pounds; (2) the ability to frequently change position each half hour; and (3) the opportunity to lie down on occasion. (Exs. 61-4, 64, 66, 68-16, -17, 87A, 96, 121, 122).

The question is whether this physical impairment, combined with social and vocational factors, prohibits gainful and suitable employment under the "odd lot" doctrine. At the time of the reconvened hearing, claimant was 47 years old and had a tenth grade education, without a GED. Claimant's previous work history includes work as a package stacker, utility worker, service station manager, construction worker, pipe fitter, and tile setter. (Ex. 37). These jobs were unskilled or semi-skilled. *Id.*

From February 19, 1990 through June 18, 1990, claimant participated in an Authorized Training Plan (ATP) for training as a car salesperson. Although this was a sedentary position, claimant testified that it involved more than 40 hours of work per week. (#1 Tr. 23-24, 45). As a result of claimant's symptomatic increase in pain, he could not continue the training as a car salesperson. Thus, although claimant participated in a training program, he did not complete the program. There is no evidence that claimant received any specific vocational training.

At the initial hearing, Mr. McNaught, claimant's vocational expert, testified that there were as many as 20,000 sedentary jobs in Oregon that someone with claimant's background and education could perform. (#1 Tr. 69, 71). However, Mr. McNaught concluded that claimant was not employable because, although claimant may be able to obtain employment, he was not able to sustain any type of work. (#1 Tr. 65, 67, 87). Mr. McNaught primarily based his opinion regarding claimant's inability to sustain employment on claimant's testimony that he must lie down 50 to 75 percent of the time. (#1 Tr. 67, 87).

However, we agree with the Referee that a person's ability to sustain activity is a medical question. As discussed above, the medical record establishes that claimant is able to sustain part-time restricted sedentary employment. Claimant presents no medical evidence that supports his argument that he is physically unable to sustain employment. Compare Jean E. Stump, 44 Van Natta 662 (1992) (Board held that the claimant was unable to perform regular work at a gainful and suitable occupation where the medical evidence established that, although the claimant was capable of essentially performing part-time sedentary work for up to 15 hours a week, given her physical constraints and pain, she would be unable to comply with a regular schedule consistently enough to satisfy an employer).

We adopt the Referee's reasoning and conclusion that Mr. McGowan, the employer's vocational expert, provides the more persuasive opinion regarding claimant's employability. Mr. McNaught conditioned his opinion on claimant's inability to sustain employment and conceded that there were sedentary jobs available within claimant's restrictions, if he were able to "sustain" work. (#1 Tr. 69, 70, 71, 75). As discussed above, the medical record establishes that claimant is able to sustain work. Both vocational experts noted that the ATP demonstrated that claimant had a "knack" for salesmanship. (#1 Tr. 81, 113, 114). Furthermore, Mr. McGowan opined that suitable work was available within claimant's restrictions, including work as a retail gift shop cashier, trailer rental clerk, auto rental clerk, customer service clerk, ticket seller, telephone solicitor, and security guard. (#1 Tr. 108-117, 127, 129).

ORS 656.206(1)(a) defines the term "suitable occupation" as "one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation." In Tee v. Albertsons, Inc., *supra* at 314 Or 643, the Court noted that "[t]he definition of 'suitable occupation' concerns work that the worker is capable of performing, irrespective of the remuneration received for the work." See also SAIF v. Terry, 126 Or App 558 (1994) (Court held that the part-time work that the claimant was performing at Burger King was not "suitable" employment that would disqualify him from permanent total disability where the evidence established that he was not capable of competitive employment in a theoretically normal labor market). The jobs identified by Mr. McGowan represent "suitable occupations" in that claimant is capable of performing those jobs and they exist in a theoretically normal labor market. However, claimant argues that those jobs are not "gainful occupations."

In Tee v. Albertsons, Inc., *supra*, the Court addressed the meaning of the term "gainful occupation," as that term is used in ORS 656.206(1). There, the worker was capable of performing part-time work at wages which would give her post-injury earnings of between \$80 per week (20 hours at \$4 per hour) and \$142.50 per week (30 hours at \$4.75 per hour). These post-injury wages were significantly lower than the claimant's pre-injury wages.

The claimant in Tee contended that a "gainful" occupation is one that pays a wage comparable to the worker's pre-injury wage. Specifically, the claimant argued that the definition of "suitable employment" in ORS 656.340(6)(b)(B)(iii) (the definition used to determine eligibility for vocational assistance), which requires employment producing a wage within 20 percent of the wage currently being paid for the claimant's regular employment, should be applied to define the term "gainful occupation" in ORS 656.206(1). The Court rejected that argument, reasoning that the "suitable work" definition in ORS 656.340(6)(b)(B)(iii) was expressly limited to the vocational assistance statute. The Court further reasoned that, because vocational assistance serves a different purpose than that served by permanent disability benefits, there was no sound reason for interpreting the term "gainful" in ORS 656.206(1)(a) as equivalent to the term "suitable" in ORS 656.340(6)(b)(B)(iii).¹ *Id.* at 641. Finally, determining that the

¹ The Court also found that "[r]equiring post-injury employment to produce a wage comparable to a worker's pre-injury wage, in order to be 'gainful,' would judicially overrule, at least in part, the statutory provision for unscheduled PPD [permanent partial disability]." Tee, *supra*, 314 Or at 642. The Court reasoned that, according to the claimant's argument, any worker with a permanent disability who was not able to earn 80 percent of his pre-injury wage would be entitled to permanent total disability (PTD) benefits. Thus, PPD benefits would be limited to workers whose earning capacity was diminished less than 20 percent by an unscheduled permanent disability. The Court found that the PPD statute contained no such limitation, and concluded that:

"[t]he legislature has created a system that compensates unscheduled PPD on the basis of its permanent effect on earning capacity. The decision to compensate injured workers for unscheduled PPD reflects a policy choice that such workers should be required to earn that portion of their income that they are capable of earning in regular employment. PPD benefits are for injured workers who are permanently partially disabled." *Id.* at 642-643 (emphasis in original).

We realize the appeal of an objective, uniform standard for defining what is "gainful" employment in determining a worker's entitlement to PTD. In our search for such an objective, uniform standard, we considered comparing the benefits allowed under ORS 656.206(2)(a) to claimant's at-injury wages (within the wage range set forth in ORS 656.206(2)(a)). Under ORS 656.206(2)(a), a worker who is permanently and totally disabled is entitled to receive compensation equal to:

"66-2/3 percent of wages [at injury] not to exceed 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of \$50, whichever amount is lesser."

In our consideration of ORS 656.206(2)(a) as an objective standard, we considered that a worker would be deemed incapable of performing "gainful" employment and entitled to permanent total disability benefits if he is unable to earn at least 66-2/3 percent of his at-injury wages (within the wage range set forth in ORS 656.206(2)(a)). On the other hand, we considered that if a worker is able to earn at least 66-2/3 percent of wages-at-injury, and he is able to realize a gain over and above the financial expenditures he would incur were he to accept employment, he shall not be entitled to permanent total disability benefits.

However, in the end, we rejected such an approach. As discussed above, one basis for the Court's rejection of the application of the objective standard provided by ORS 656.340(6)(b)(B)(iii) to the term "gainful employment" as used in ORS 656.206(1)(a) was that such an application would effectively judicially overrule the unscheduled PPD statute. The same problem occurs in applying ORS 656.206(2)(a) as an objective standard to define "gainful" occupation.

In other words, such an at-injury wage comparison approach puts a limitation on PPD that is not contained in the statute. Under the Court's analysis using ORS 656.340(6)(b)(B)(iii) as an objective standard, PPD would be limited to those workers with unscheduled permanent disability whose earning capacity was diminished less than 20 percent. Under our consideration of using ORS 656.206(1)(a) as an objective standard, PPD would be limited to those workers with unscheduled permanent disability whose earning capacity was diminished less than 33-1/3 percent. As the Court found, there is no indication in the PPD statute that it is so limited.

Like the Court, we may not undermine the legislature's policy choices in creating separate provisions for PPD and PTD by creating an objective standard for "gainful" employment that overrules or diminishes the statutory provision for PPD. If there is to be an objective standard for determining "gainful" employment under ORS 656.206(1)(a), it must come from the legislature.

term "gainful occupation" related to the earnings that the worker can obtain by working at a "suitable occupation," the Court held that the term "gainful occupation" contained in the definition of permanent total disability means "profitable remuneration." Id. at 643.

While we realize that a dissenting opinion is not controlling, we find that the dissenting opinion in Tee provides some insight into what the majority meant by the term "profitable remuneration." In her dissent, Justice Graber argued that the adjective "profitable" was "unnecessary, ambiguous, and potentially misleading." Id. at 644. She argued that a "gainful occupation" within the meaning of the permanent total disability statute "is simply an occupation for which the worker receives a lawful wage." Id. She contrasted this to unpaid work as a volunteer or homemaker, which would not be "gainful." In addition, she argued that "profit" is irrelevant in that a worker capable of owning a business that is expected to gross \$50,000 per year has a "gainful occupation" even if that business loses money one year, and "a worker who is employable at a suitable minimum-wage job has a 'gainful occupation' even if expenses make it difficult to make ends meet." Id.

The majority rejected the arguments made by Justice Graber's dissenting opinion and incorporated the adjective "profitable" into their definition of "gainful occupation" as meaning "profitable remuneration." "Profitable" means "yielding profit"; "profit" means "a pecuniary gain resulting from the employment of capital in any transaction." Random House Webster's College Dictionary 1077 (Glencoe ed. 1991). "Remuneration" means "reward; recompense; salary; compensation." Black's Law Dictionary 673 (Abr. 5th ed. 1983). If the employment relationship is viewed as a "transaction" of services for pay, it is clear that under these definitions, "gainful" employment requires that, at a minimum, the worker receive pay that exceeds the costs of performing the services necessary to earn that pay.

In other words, there must be a "profit" derived from the worker's efforts, i.e., the wages a worker is capable of earning less the expenses that would be incurred in earning those wages. The expenses deducted are those incurred in that transaction or job, e.g., supplies, transportation expenses, parking costs, meal expenses, etc. Personal expenses such as a mortgage or personal debt would not be included since these are not job-related expenses.

Here, claimant initially argued that, in order to be "gainful" employment, the post-injury jobs he is capable of performing must pay wages that are comparable to the pre-injury wages he earned. In making this argument, claimant relied, in part, on Frame v. Crown Zellerbach, 63 Or App 827, former opinion adhered to, 65 Or App 801 (1983). However, inasmuch as Frame was decided in the vocational assistance context, we reject claimant's argument for the reasons discussed by the Tee Court.² Tee, supra at 314 Or 640 n.7.

Turning to the facts as presented at hearing, claimant is capable of regular, part-time work in the aforementioned jobs. Mr. McGowan testified that part-time work was considered between 20 to 30 hours a week. (#1 Tr. 125). We agree with the Referee that, considering claimant's physical capabilities and limitations, it is probable that claimant's hours would be at the low end of this range. (Ex. 122-40). At the reconvened hearing, Mr. McNaught testified that the aforementioned positions had starting

² We also note that requiring post-injury jobs to produce wages that are comparable to pre-injury wages (or pre-injury standards of living) in order for the post-injury jobs to be "gainful" would result in a multi-tiered system in which injured workers with the same disability, education, and ability to work would not be treated the same. We find no indication that the permanent total disability statute intends such disparate treatment of similarly situated injured workers.

After all, the legislature did not set up such a system for rating permanent partial disability. Instead of rating permanent partial disability based on a workers at-injury wage, the legislature chose to assign a dollar amount for each degree of disability. This amount is currently set at \$305 per degree of scheduled disability and \$100 per degree of unscheduled disability. ORS 656.214(2) and (5). It could be argued that a more highly paid worker sustains a greater permanent loss of use or function (in the case of a scheduled injury) or a greater permanent loss of earning capacity (in the case of an unscheduled injury) due to a work injury than does a lower paid worker. Under such a system, injured workers with identical disabilities could receive widely differing compensation for those disabilities. However, that is not the system the legislature chose. Instead, the legislature chose to treat similarly situated injured workers the same by instituting a standard rate per degree of permanent partial disability. Likewise, there is nothing in the permanent total disability statute that indicates that similarly situated injured workers should be treated differently based on their pre-injury wages or their pre-injury standard of living.

wages from the state minimum wage of \$4.75 per hour to \$5.50 per hour. (#2 Tr. 5, 6, 9, 10, 20). Therefore, claimant's estimated weekly earnings would be from \$95 ($\$4.75 \times 20 = \95) to \$110 ($\$5.50 \times 20 = \110).

The Referee examined claimant's total financial situation, including his wife's earnings and his receipt of food stamps, and determined that the aforementioned jobs provided "profitable remuneration" and were, therefore, "gainful occupations." At hearing and on review, claimant argues that these jobs are not "gainful occupations" because they do not produce a livable wage that would bring him above the poverty line. Claimant also argues that the Referee erred in considering claimant's "collateral sources of income" in determining whether the jobs were gainful.

Claimant argues that there should be a "floor" of earnings and, if the employment he is capable of performing does not produce wages above that "floor," the employment should not be considered gainful. Claimant argues that OAR 436-30-055(1)(c)³ recognizes a "floor of earnings," given its reference to the minimum wage and its case-by-case determination of the gainfulness of commission and piece work.

Claimant also contends that the federal and state "poverty line" should be established as the "floor of earnings." Finally, claimant asserts that Mr. McNaught's testimony establishes that an individual needs wages of at least \$100 per week for employment to reflect wages above the poverty line. (#2 Tr. 11-12). Claimant reasons that his estimated wages of from \$95 to \$110 per week do not put him beyond the poverty line and, therefore, the occupations he is capable of performing are not "gainful."

We reject claimant's arguments. Mr. McNaught's testimony does not establish an objective "poverty line." Mr. McNaught testified that the "poverty line" varies from agency to agency, but that it basically consists of a point below which a person could not provide food and shelter for his or her self. (#2 Tr. 20). Mr. McNaught's estimates of a "poverty line" range from wages less than minimum wage at less than six hours work per day, to less than 100 hours of work per month at minimum wage, to \$9,000 per year for a single person, to between \$150 to \$170 per week. (#2 Tr. 11, 12, 14-16). Given this variation, we do not find Mr. McNaught's testimony persuasive regarding an objective "poverty line." Even if we considered the "poverty line" as defined by Mr. McNaught as the point where a person could not provide food or shelter for his or her self, we are not persuaded that claimant could not provide food and shelter based on the aforementioned jobs' projected income.

³ Subsequent to the Court's decision in Tee, the Department adopted OAR 436-30-055(1)(c), which defined "gainful occupation" in the permanent total disability setting. OAR 436-30-055(1)(c) provides:

"'Gainful occupation' is defined as: those types of general occupations that are either full time or part time in duration and pay wages equivalent to, or greater than, the state and federal mandated minimum hourly wage. Those types of general occupations that pay on a commission or piece-work basis, as opposed to a wage or salary basis, may not be "gainful employment" depending upon the facts of the individual situation." WCD Admin. Order 33-1990.

While claimant contends that OAR 436-30-055(1)(c) supports his argument for a "floor of earnings" below which the employment would not be considered gainful, the employer contends that we should simply apply this rule to determine whether the jobs claimant is capable of performing constitute "gainful employment." As later explained in the body of our order, we reject claimant's argument regarding a "floor of earnings." We also reject the employer's contention for the following reasons.

The Supreme Court has held that "statutory interpretation particularly implicates the rule of stare decisis" and that when the Court "interprets a statute, that interpretation becomes a part of the statute as if written into it at the time of its enactment." Walther v. SAIF, 312 Or 147, 149 (1991); Stephens v. Bohlman, 314 Or 344, 350 n. 6 (1992). Here, it is questionable whether the Department's rule is consistent with the Court's interpretation of the statutory term "gainful occupation." Nevertheless, we need not resolve that question.

As explained in the body of our order, the jobs claimant is capable of performing represent "profitable remuneration" and "gainful occupations." Therefore, we need not determine whether OAR 436-30-055(1)(c) is consistent with the Court's interpretation of "gainful occupation" and applies to this case because, even if it was consistent and applicable, the result would be the same. In other words, under both the Court's interpretation of the statute and the Department's rule, the jobs claimant is capable of performing are gainful occupations.

Claimant also argues that the Referee erred in considering claimant's "collateral sources of income" in determining whether the jobs were gainful. We agree.

ORS 656.206(1)(a) focuses on the worker's incapacity to regularly perform work at a gainful and suitable occupation in defining permanent total disability. Resources available to the worker outside of his or her capacity to perform work are not taken into consideration in ORS 656.206(1)(a).

This interpretation is supported by Allen v. Fireman's Fund Ins. Co., 71 Or App 40 (1984), and Harris v. SAIF, 292 Or 683 (1982). In Allen, the claimant was not disqualified from an award of permanent total disability by his potential to work in collaboration with his wife, who would fill in for him on bad days. The court held that the test was whether the claimant was employable, not whether he and his wife were employable. Allen, supra at 71 Or App 47.

In Harris, the Court of Appeals had affirmed the Board's order that found claimant no longer permanently totally disabled based on his earnings through investments and real estate transactions. The Supreme Court reversed and remanded the case. Harris, supra at 292 Or 697. The Court stated that "[t]he claimant's ability to work, not his or her financial situation is the criterion for disability compensation." Id. at 696. The Court held that a claimant's ability to generate income is relevant only to the extent it tends to establish his or her employability at a gainful and suitable occupation. Id. at 697.

Although both Allen and Harris dealt with a worker's employability rather than the gainfulness of employment, those cases demonstrate that the focus of ORS 656.206(1)(a) is on the worker's ability to work, not on his or her resources outside of his or her ability to work. If the claimant's own investment activities may not be taken into consideration in determining his or her entitlement to permanent total disability benefits, then surely a spouse's financial contribution or a government program, such as food stamps, may not be considered.

In summary, we conclude that an occupation is gainful, i.e., represents "profitable remuneration," if the income a worker is capable of earning through his or her own efforts at that occupation exceeds the expenses incurred in earning that income. Applying that reasoning to the facts of this case, we proceed to determine whether the above enumerated jobs represent gainful occupations.

In our prior order which returned this matter for further development, we indicated that the record was lacking evidence regarding the financial expenditures, if any, that claimant would realize were he to accept such employment. Following the reconvened hearing, the record contains the following evidence. Claimant owns a 1985 Ford Escort, reportedly in good working order, and a 1966 Chevrolet pick-up truck in poor condition. Claimant's vocational provider stated that claimant had reliable transportation for work. (Ex. 37-3, 37-7). Claimant lives in a rural area, suggesting that he will sustain transportation costs to perform these suitable occupations. Nevertheless, despite the insertion of our list in remanding this case for further development, the record does not establish the amount, if any, of these transportation costs.

Claimant argues that it is not appropriate to assume that he has no children at home (for potential consideration as a child / dependent care cost) or to make assumptions regarding his current transportation situation based on a February 1989 vocational report. However, as previously noted, the case was expressly remanded for evidence regarding the issue of whether the aforementioned jobs constituted "profitable remuneration," as well as for development of potential costs attributable to such jobs. Thus, we are not necessarily assuming that claimant has no children at home (assuming for the sake of argument that we would consider such costs as expenses attributable to the job) or that his transportation needs have been satisfied. Rather, on this record, we are merely stating that there is no evidence of such expenses attributable to the identified part-time job. Claimant has the burden of proof and we can only address the record before us. See ORS 656.206(3); ORS 656.266.

The only other expense in accepting employment that is arguably identifiable in the record is clothing costs. The security work job would probably require a uniform. In addition, claimant was allowed a \$310 clothing allowance during his scheduled six-month training program in automotive sales. (Exs. 68-7, -12, -13, 69a).

Thus, only commuting costs and costs for appropriate clothing are arguably identifiable in the record. Notwithstanding this identification, and despite our statements in remanding this case, the record does not establish whether such costs will be incurred if claimant performed the suitable

occupations, and, if so, whether such expenses would exceed the income derived from the occupations. In light of such circumstances, claimant has failed to prove that the costs that he would incur in performing the aforementioned part-time positions would be so great as to render the jobs unprofitable.

Accordingly, on this record, we find that the expenses associated with performing the part-time jobs that claimant is capable of performing do not bring those jobs outside the realm of "profitable remuneration." Therefore, we conclude that the aforementioned jobs represent "gainful occupations." Because claimant is able to regularly perform work at a gainful and suitable occupation, he is not entitled to permanent total disability benefits.⁴

⁴ Dissenting member Hall agrees with our conclusion that we must confine our analysis to income attributable to claimant and not to other family members. Nevertheless, Member Hall would apparently include collateral sources of expenses in evaluating whether a proposed occupation constitutes "profitable remuneration." Such reasoning is not only inconsistent, but it further illustrates the inherent flaw in his analysis.

Member Hall's essential argument is based on the concept that a "profitable" wage is one that will protect the injured worker and his/her dependents from being reduced to resorting to taxpayer supported services or charity. In support of this position, he relies on the objectives of the Workers' Compensation Law found in ORS 656.012(2)(a) and (c). Section (2)(a) sets forth an objective to provide fair, adequate and reasonable income benefits to injured workers and their dependents. Section (2)(c) expresses a goal to restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable.

To the extent that Member Hall's argument infers that our analysis conflicts with the statutory objectives described above, we reject that notion. Our conclusion is not only consistent with the aforementioned goals, but it is also in accordance with the specific statutory requirement for PTD entitlement as interpreted by the Tee Court. The relevant statute (ORS 656.206), as well as the benefits which flow from a PTD award, are all derived from "the permanently incapacitated worker," not his/her dependents or family unit. Likewise, our examination of the gainfulness of a proposed occupation must be confined to the economic viability of that position as it pertains to that particular worker and that particular job.

To do otherwise, would inevitably lead to disparate decisions based solely on the personal lifestyles of the injured worker and his/her family. For example, assume that there are two injured workers with the same physical limitations and educational / vocational abilities, who are presented with the same projected occupation. Assume further that each will incur the same "job-related" expenses which will not offset the income derived from the job. The only difference is that one worker has lived frugally, while the other has extensive financial obligations. Under Member Hall's "worker - dependent / self-sufficiency" analysis, the former worker would likely not be PTD, but the latter would be. Not only would such disparity of judgments be abhorrent to a system designed to achieve substantial justice to all injured workers and employers, but it would be entirely inconsistent with a statutory scheme which is focused on an injured worker and his/her physical/educational/vocational capacity to return to the work force.

Member Hall tries to deflect criticism on this point by noting that our own analysis also considers individual circumstances in determining job-related expenses. We recognize that the individual circumstances of a worker must be considered to some degree in determining what are reasonable expenses of obtaining and holding a particular job. We submit, however, that Member Hall's analysis goes much further. He proposes to consider not only the expenses of obtaining and holding a job, but also whether a worker would receive a sufficient income to keep both the worker and his/her dependents off of taxpayer-supported programs. That requires consideration of more than the expenses of obtaining or holding a job, but also the living expenses of a worker and his/her dependents. Clearly, such living expenses would depend on the worker's and dependents' personal lifestyles and fiscal restraint. It is those personal factors which, under Member Hall's analysis, will separate workers who qualify for PTD benefits from those who do not. In our opinion, such unequal treatment based on personal, non-occupational factors is not substantial justice.

Member Hall also criticizes our reasoning concerning the definition of "profitable remuneration." In doing so, he neither challenges our references to dictionary meanings of the terms nor disputes the fact that "profitable remuneration" was the term created by the Supreme Court to define "gainful occupation" under ORS 656.206(1). Instead, Member Hall would apparently have us transform the phrase "profitable remuneration" to "worker-dependent socio-economic sufficiency remuneration." Had the Court wished to establish such a standard, it had every opportunity to do so. Since it did not, but instead produced the term "profitable remuneration," we remain confident that our decision properly applies the term in a manner entirely consistent with the goals and objectives of the workers' compensation system. By contrast, Member Hall has, under the guise of a contextual-historical discussion, effectively ignored the "profitable remuneration" standard set forth by the Court and has, instead, legislated a new standard based on general policy objectives in ORS 656.012.

Turning to the present record, Member Hall states that the record is not sufficiently developed under the "worker-dependent/self-sufficiency" standard, and he proposes to remand this matter for further evidence taking under that standard. Yet,

Extent of Permanent Partial Disability

Unscheduled Permanent Partial Disability

The Referee increased claimant's unscheduled permanent disability award for his low back injury from 51 percent, as awarded by the May 16, 1991 Determination Order, to 70 percent. The parties do not dispute the following values: age (1), formal education (1), training (0), skills (3), impairment (30). However, the employer questions the Referee's assignment of an adaptability value of 10. Although agreeing with the Referee's adaptability value, claimant argues that the Referee made an error in calculating the total award and that the total unscheduled permanent disability award should be 80 percent. We agree with claimant.

We adopt the Referee's reasoning and conclusions regarding the adaptability value (10).

Former OAR 436-35-300(6) provides that the values for formal education, training, and skills shall be added to arrive at a value for the education factor. (WCD Admin. Order 7-1988). Adding these values (1 + 0 + 3) produces an education factor of 4.

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value (1) is added to his education value (4), the sum is 5. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value (10), the product is 50. Former OAR 436-35-280(6). When that value is added to claimant's impairment value (30), the result is 80 percent unscheduled permanent disability. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 80 percent.

Scheduled Permanent Partial Disability

The Referee awarded claimant 10 percent scheduled permanent disability for the loss of use or function of his left leg. The employer challenges only the Referee's award of 5 percent for a chronic condition limiting repetitive use of claimant's left leg.

The employer argues that the Referee based the award for a chronic condition solely on the basis of a finding of positive straight leg raising on the left. Furthermore, the employer argues that a positive straight leg raising test does not signify pathology in the leg, but, instead, in the low back. Therefore, the employer argues, because claimant has been fully compensated for his low back impairment, he is not entitled to a chronic condition award for the leg.

he offers the Referee and the parties no practical guidance in the application of his standard. It is curious, for example, that he has not identified a single taxpayer-supported program. Is he referring to state, local and/or federal programs? How is his standard to be applied to workers and/or dependents who were already dependent on taxpayer-supported programs at the time of the compensable injury? With such questions, among others, left unanswered, we are skeptical of the practicability of his standard.

Finally, dissenting member Gunn contends that we have neglected to define job-related expenses which will be considered in determining whether a proposed occupation constitutes "profitable remuneration." Admittedly, our discussion of the expenses derived from the proposed occupation in this case was limited. Nevertheless, the reason for the lack of analysis on this point is the minimal record developed regarding such expenses (even after this case was remanded for the express purpose of further development concerning such matters).

As with many of our "fact intensive" decisions, expenses which shall be considered in the "profitable remuneration" calculus will be identified as we address such issues in future cases. Thus, our failure to discuss other potential job-related expenses should not be interpreted as a conclusion that such expenses are only those confined to this particular case. Likewise, today's decision does not render the Tea holding "meaningless" as Member Gunn asserts. For the reasons discussed above, we believe that our decision properly applies the term "profitable remuneration," and is consistent with the statutory scheme. Furthermore, it is not difficult to envision future cases in which the minimal income available to a significantly impaired worker from a proposed occupation is offset by the expenses (e.g., travel, parking, lunch, supplies) derived from that job. In such a case, the proposed occupation would not constitute "profitable remuneration" and, thus, would not represent a gainful occupation.

We disagree with the employer that the Referee based the chronic condition award solely on a finding of positive straight leg raising on the left. The medical record establishes that claimant has referred pain from his low back into his left leg that limits repetitive use of that leg. (Exs. 81a, 87, 90, 92a, 114).

Furthermore, Foster v. SAIF, 259 Or 86 (1971), holds that a claimant can receive separate scheduled and unscheduled awards in cases such as this where an unscheduled injury results in referred disability in a scheduled body part. See Frances C. Johnson, 46 Van Natta 206 (1994).

For these reasons, we agree with the Referee that claimant is entitled to: (1) a chronic condition award for the left leg; and (2) a total scheduled permanent disability for the loss of use or function of his left leg of 10 percent.

Attorney Fees

The employer requested a reduction of the permanent disability award and we have not disallowed or reduced that award. ORS 656.382(2) authorizes the assessment of an attorney fee under such circumstances. See Kordon v. Mercer Industries, 308 Or 290 (1989).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the issue of extent of unscheduled and scheduled permanent disability benefits 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.

Claimant's attorney is also entitled to an attorney fee award payable from the increased compensation created by this order. See OAR 438-15-055. Consequently, claimant's attorney is awarded 25 percent of the increase in compensation created by this order. However, the total "out-of-compensation" fee granted by this order and the Referee's order shall not exceed \$3,800.

ORDER

The Referee's order dated December 12, 1991, as supplemented on remand on October 7, 1993, is modified in part and affirmed in part. In addition to the Referee's and the Determination Order awards of 70 percent (224 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) for a total award to date of 80 percent (256 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total "out-of-compensation" attorney fee granted by the Referee's order and this order shall not exceed \$3,800. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed attorney fee of \$1,000 for defending claimant's award of permanent disability compensation on review, payable by the self-insured employer.

Board Member Turner-Christian specially concurring.

I agree with the majority's conclusion that, under the statute and the Tee case, claimant has not established that he is permanently and totally disabled. However, I offer this concurring opinion in order to express my concern with the outcome of this case and future permanent total disability cases.

Prior to the Tee case, claimants had a difficult burden of proof in establishing entitlement to permanent total disability. Because of the significance of such an award, and the cost to the system of that award, I agree that the burden of proof should be rigorous. However, the Tee case effectively places yet another hurdle in the path of the seriously injured worker, by requiring that worker to come forth with even more evidence which now must take the form of "expenses" and/or additional doctor and expert opinions. The result of such a requirement, I am afraid, is that depending on the individual circumstances (e.g., a worker with a less serious injury, but higher expenses), workers will be awarded or denied permanent total disability in a disparate manner.

In the present case, I find it difficult to believe that the worker can be restored without an award of permanent total disability, due to his condition and the nominal wage being provided. However, I believe that the Board is bound to follow the "profitable remuneration" precedent set forth by the Court, and I therefore am compelled to reach the same conclusion as the majority. I do not, however, believe that this should be the end of this issue. Other forums have found acceptable methods of restoring workers to their prior positions in society, and I am convinced that our legislature could do the same. Because the proper remedy can be provided by legislative intervention, and because this matter concerns the most seriously injured workers in our system (and also involves some of the greatest costs to the system), all sides would benefit from the legislature revisiting the statute, in light of the Tee decision.

Board Member Hall dissenting.

As a preliminary matter, I join the majority in concluding that collateral sources of income may not be considered in determining whether the worker is entitled to permanent total disability. I would further note that we are judging this individual claimant as he appears in this record, without regard to yet unrealized or future developments, without regard to the benevolence of others, and without regard to claimant's own superhuman efforts. Harris v. SAIF, 292 Or 683, 695 (1982); Gettman v. SAIF, 289 Or 609 (1980). In short, we are to determine whether claimant, based on this record, can realistically obtain and hold gainful and suitable employment, i.e., sell his services on a regular basis in a hypothetically normal labor market. Harris v. SAIF, *supra*; Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). We must not forget these basic principles of workers' compensation law, because it is within this larger context that we are applying the term "gainful."

As I participate in this effort to determine whether claimant is permanently and totally disabled, I am obviously mindful of the Supreme Court's analysis and ultimate conclusion that "[t]he term 'gainful occupation' contained in the definition of PTD in ORS 656.206(1)(a) means profitable remuneration". Tee v. Albertsons, Inc., 314 Or 633, 643 (1992). However, whether defined as "gainful" or "profitable," we must still be able to identify and apply that which constitutes "gainful" or "profitable" on a case-by-case basis. Indeed, that is why Tee was remanded to the Board.¹ Specifically, the Court stated that "[b]ecause this is the first decision of this court interpreting the meaning of 'gainful occupation,' and because the Board is the appropriate body to apply the meaning of 'gainful occupation' under the facts of this case in performing its fact-finding function, it is appropriate to remand this case to the Board for further consideration in light of this opinion." Tee, *supra* at 643 (footnote omitted).

In some respects, analyzing the statutory phrase "suitable and gainful employment" is not unlike analyzing the statutory phrase "arising out of and in the course of employment." The latter phrase having been analyzed and applied as a two-part test, a seven-part test, and a unitary test, but in the final analysis being interpreted and applied in such a way as to fulfill the statutory purpose "in light of the policy for which the determination is to be made." Rogers v. SAIF, 289 Or 633, 642 (1980). In defining the statutory phrase "arising out of and in the course of employment," the Court quoted with approval the Court of Appeals' reasoning that the terms "must be applied in each case so as to best effectuate the socio-economic purpose of the Workers' Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer." Rogers v. SAIF, *supra* at 643, quoting Allen v. SAIF, 29 Or App 631, 633-634 (1977). It is no less important to apply "profitable remuneration" with that objective in mind: does our application of "profitable remuneration" "best effectuate the socio-economic purpose of the Workers' Compensation Act" by protecting the worker and his/her family from poverty due to a work related injury? Id.; Leo Polehn Orchards v. Hernandez, 122 Or App 241 (1993).

The various attempts to methodically and objectively calculate "course and scope" of employment are, in the end, only tools to assist in the ultimate inquiry of whether there is a sufficient work connection to make the injury or disease compensable as a matter of public policy. Rogers v. SAIF, *supra* at 642. Likewise, in our effort to identify and apply "profitable remuneration," any objective calculus we develop will only be a tool to assist in the ultimate inquiry of whether the socio-economic purpose of the Act is being fulfilled. If we are assuming we must produce some single (or even seven-part) objective calculus against which all potentially "gainful" employment will be measured, I submit that neither the statute nor the Supreme Court holding in Tee require us to do so. On this

¹ The Board is interpreting the Court's definition of "gainful occupation" in the present case, rather than in the Tee case, because I must recuse myself from the Tee case.

point there should be no confusion, utilization of a fixed formula (e.g., wage minus costs associated with earning that wage, state or federal minimum wage, or state or federal poverty level) is not dictated by either statute or case law. If we choose to create a fixed formula, we do so voluntarily.

Oregon's first Workers' Compensation Law was enacted in 1913. At that time, permanent and total disability was defined in terms of a worker's permanent incapacity to perform work at "any gainful occupation." Oregon Laws 1913, chapter 112, section 21, paragraph 4(b). Although the legislature has amended the statute several times over the years, including adding the term "suitable occupation" in defining permanent total disability, it has not defined the term "gainful occupation." The Supreme Court first considered the meaning of "gainful occupation" in 1992, 79 years after enactment of the statute. Tee, supra at 643. However, once the Supreme Court has interpreted a statute, that interpretation "becomes a part of the statute as if written into it at the time of its enactment." Walther v. SAIF, 312 Or 147, 149 (1991); Stephens v. Bohlman, 314 Or 344, 350 n.6 (1992). Therefore, it is appropriate to review what the Court did and did not say in Tee. After all, fulfilling the socio-economic purposes of the Act was addressed in Tee, but it was done so specifically in the context of certain arguments.

In Tee, the claimant argued that the definition of "suitable employment" contained in ORS 656.340(6)(b)(B)(iii), a vocational assistance statute, should apply in the determination of whether a potential occupation represented "gainful employment." ORS 656.340(6)(b)(B)(iii) defines "suitable employment," in part, as "[e]mployment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment." The claimant argued that not requiring comparability of wages violated the purposes for which the Workers' Compensation Law was enacted. Tee, supra at 640. Specifically, the claimant argued that denying permanent total disability because she is capable of regular part-time, low-paying employment is inconsistent with the objective of the Workers' Compensation Law of returning the worker to self-sufficient status. Id.

The Court rejected the claimant's arguments. Id. First, it found that claimant's arguments ignored the difference between the specific goal of vocational assistance to "return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of injury," ORS 656.340(5), and the general goal of the Workers' Compensation Law to "restore the injured worker physically and economically to a self-sufficient status." ORS 656.012(2)(c). Second, it found that claimant's arguments ignored the role of the statute providing for permanent partial disability. Tee, supra at 640. The Court reasoned that "[r]equiring post-injury employment to produce a wage comparable to a worker's pre-injury wage, in order to be 'gainful,' would judicially overrule, at least in part, the statutory provision for unscheduled PPD." Id. at 642.

The Court acknowledged that there is no legislative history regarding the meaning of "gainful" as used in ORS 656.206(2). Id. at 638 n. 3. In the end, the Court defined the statutory term "gainful occupation" as meaning "profitable remuneration." The Court did not set forth an objective formula or calculus for determining when remuneration is "profitable" and when it is not. Rather, the Court remanded the case to the Board with the instruction to "apply the meaning of 'gainful occupation' under the facts of this case. . . ." Tee, supra at 643.

We are bound by the Court's decision. Thus, there is no question that "gainful occupation" means "profitable remuneration." Walther v. SAIF, supra. However, what does "profitable remuneration" mean? By defining a statutorily undefined term with another statutorily undefined term, and stating that the term is to be applied on a case-by-case basis, the Court has left room for interpretation.

It is important to note that the Tee Court did not say the socio-economic purposes of the Act were to be ignored and did not say "gainful occupation" or "profitable remuneration" should be defined or applied in such a way as to contravene the socio-economic purposes of the Act. Rather, what the Court rejected was claimant's use of either a vocational assistance criteria (80 percent of wage at-injury rule) or a comparison to wage at-injury criteria. Furthermore, the Court's rejection of those proposed criteria did not contravene the overriding purposes of the Act. The Board is still free to identify and apply "profitable remuneration" in a way that will ultimately fulfill the socio-economic purposes of the Act (albeit without use of either wages at-injury or vocational assistance criteria).

In the final analysis, "profitable remuneration" must be examined in its statutory context. The findings and policy, the articulation of purpose and mission, for the Workers' Compensation Law is set forth in ORS 656.012. The legislature found that the performance of industrial enterprises would inevitably result in injury to some of the workers involved in those enterprises and that the method provided by common law for compensating injured workers "often requires the taxpayer to provide expensive care and support for the injured workers and their dependents." ORS 656.012(1)(a) and (b). As a result of those findings, the legislature declared the objectives of the Workers' Compensation Law, in pertinent part, 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;

"* * *

"(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable. . . ." ORS 656.012(2)(a) and (b). (Emphasis added).

Therefore, if "profitable remuneration" is applied in a way that forces a compensably injured worker to depend on taxpayer supported services in order to survive, we are violating one of the most fundamental premises of Oregon's Workers' Compensation Law, which is to avoid requiring taxpayers to absorb the cost of supporting injured workers and their dependents. ORS 656.012(1)(b). In other words, such an application would not implement the socio-economic purpose of the Workers' Compensation Law to financially protect the injured worker and his or her family from poverty due to a work injury. Rogers v. SAIF, *supra* at 643; Leo Polehn Orchards v. Hernandez, *supra*.

In addition, if we so narrowly apply "profitable remuneration," that we force an injured worker to seek assistance from taxpayer supported services or charity, we are violating a second fundamental premise of Oregon's Workers' Compensation Law, to provide "fair, adequate and reasonable income benefits to workers and their dependents" and restore the injured worker to economic self-sufficiency to the greatest extent practicable. ORS 656.012(2)(a) and (b). It is in this context that the courts have long recognized that a claimant's permanent and total disability status is not to be judged with consideration of the benevolence of others. Harris v. SAIF, *supra* at 695.

We must give effect to all provisions of a statute. ORS 174.010. Surely, we cannot ignore the very policy underpinnings of the Workers' Compensation Law, which provide that the overriding goal is to restore injured workers to economic self-sufficiency. While the purpose of the Workers' Compensation Law may not require application of the vocational assistance statute or the at-injury wage in defining "gainful occupation," we must nevertheless identify and apply this term consistently with ORS 656.012(2)(c).

Review of the purpose and mission of the Oregon Workers' Compensation Law, as defined by the Act itself and as consistently interpreted by the courts over several decades, as well as a review of the Court's decision in Tee, leads to the following conclusion: in simplest terms, a "profitable" wage is one that will protect the injured worker and his or her dependents from being reduced to resorting to taxpayer supported services or charity. If the only "suitable" employment is that which produces a wage insufficient to protect an injured worker and his or her dependents from a need to resort to taxpayer supported services or charity, then it is not "profitable."

To those looking for an objective criteria, or wanting to know what the proposed self-sufficiency standard looks like, they will no doubt turn to the federal or state poverty level as the standard. That is appealing and such consideration may be helpful; however, it may only be used as a "tool" or guide to assist in the ultimate determination of entitlement to PTSD. A rigid formula is not required.

The majority creates a specific formula by defining "profitable remuneration" as: The identified wage a worker may potentially earn less the identified, potential "costs" of earning that potential wage. Applying this formula, the majority determines that, if any funds remain at the end of the equation, the potential wage constitutes "profitable remuneration." However, if the definition of "gainful occupation" in the permanent total disability context is applied by the majority's narrow formula, a worker's ability to return to self-sufficient status will be unduly restricted and the purpose of the Workers' Compensation Law will be defeated.

In the instant case, claimant is currently capable of working approximately 20 hours per week at restricted, sedentary jobs for which potential wages range from \$4.75 per hour to \$5.50 per hour. Therefore, his estimated weekly wages would be from \$95 (\$4.75 x 20 hours) to \$110 (\$5.50 x 20 hours), for an estimated annual wage of from \$4,940 to \$5,720. Whether this potential wage constitutes "profitable remuneration" for this particular claimant depends upon a factual analysis and determination of whether this wage would keep claimant and his dependents (if any) from having to resort to taxpayer supported services or charity.² Given the present state of the evidentiary record, and given the fact that the case was not previously developed with this criteria in mind, I would remand this case to the Hearings Division for further development of the record.

The majority offers criticisms of my analysis of the Tee Court's "profitable remuneration" definition. I do not find these criticisms persuasive.

First, the majority contends that, although I agree that collateral sources of income may not be considered in evaluating whether a proposed occupation constitutes "profitable remuneration," I impermissibly consider collateral sources of expenses by considering the worker's dependents or "family unit." However, as fully explained in my dissent, one of the statutory purposes of the Workers' Compensation Law is to provide "fair, adequate and reasonable income benefits to injured workers and their dependents. . . ." ORS 656.012(2)(a) (emphasis added). Thus, contrary to the majority's opinion, the legislature has mandated consideration of a worker's dependents in determining a "fair, adequate and reasonable income," something the majority's formula approach neglects to do.

Furthermore, my analysis considers only the worker's dependents, it does not take into account the worker's "family unit." Like the prohibition on considering collateral income, I would not consider the earners of that collateral income as dependents. In other words, a person may be a member of the worker's family unit and not be financially dependent upon the worker. In fact, in the instant case, there is no evidence that claimant's wife is financially dependent upon claimant. On this record, claimant's wife is the earner of the collateral income that is maintaining claimant and herself. Therefore, based on the record as developed, I do not consider claimant's wife to be his dependent.

In addition, although criticizing consideration of a worker's dependents in determining whether a proposed wage constitutes "profitable remuneration," the majority, too, considers the worker's individual circumstances in determining whether the proposed wage is "profitable remuneration." It does so by considering the expenses the individual worker would incur in holding down a particular job. Indeed, when this case was first remanded for evidence of expenses associated with earning wages, child - dependent care costs were identified as an example of such expenses. Fred D. Justice, 45 Van Natta 971, n. 1 (1993). It is ironic to consider dependent care costs incurred during the hours a worker performs a job, but not consider the number of dependents in analyzing whether the proposed wage is sufficient to keep claimant and those dependents from needing to resort to taxpayer supported services or charity.

The majority would also, apparently, subtract the cost of transportation to and from the potential work site as one of the costs of earning the potential wage. This "cost" will vary depending on where claimant resides in proximity to the potential work site. Thus, the same potential wage may be profitable for an injured worker who lives near a potential work site but not profitable for one who must commute a long distance.

² The record establishes that claimant is potentially able to perform only part-time, restricted work. The claimant in Tee did not assert that her inability to work full-time entitled her to a PTD award. Tee, supra at 635 n 1. However, prior to the Court's decision in Tee, case law had held that regular part-time work can constitute "gainful" employment. Georgia-Pacific Corp. v. Perry, 92 Or App 56, rev den 307 Or 77 (1988); Poumelle v. SAIF, 70 Or App 56, 60 (1984); Hill v. SAIF, 25 Or App 697, 701 (1976). See also, John K. Huffman, 42 Van Natta 319 (1990), aff'd mem 105 Or App 635 (1991) (regular part-time work, 25 to 30 hours per week, at \$5.00 per hour is "gainful and suitable" employment within the meaning of ORS 656.206); Vivian F. Foltz, 43 Van Natta 119 (1991) (regular part-time work, 20 hours per week, at minimum wage is "gainful" employment). Compare Peggy S. Charpiloz, 42 Van Natta 125 (1990) (part-time entry level work for one to two hours per week is not "gainful employment").

While I recognize those prior decisions, I note that they were decided neither in light of the Tee Court's standard of "profitable remuneration" nor in light of my reasoning that the Tee standard must result in economic self-sufficiency to defeat a finding of PTD. Therefore, while some regular part-time work might satisfy this standard, any such determination would depend upon a case-by-case factual analysis applying this standard.

The majority's second criticism of my analysis is that it will result in treating similarly situated injured workers differently. However, by its very nature, a determination of PTD under the "odd-lot" doctrine is subject to an individual injured worker's circumstances. In such cases, an individual's nonmedical factors (e.g., age, education, and vocational history) are considered. Under my analysis, to the extent injured workers are truly similar, they will be treated the same. In other words, if two injured workers are the same age, have the same education, the same degree of impairment, and the same vocational factors, then they will be treated the same. Under such circumstances, a difference in treatment would arise only if the injured workers had a different number of dependents. However, a different number of dependents would necessarily mean that the injured workers are not "similarly situated." Again, the majority, too, would treat similar injured workers differently in that they would consider the varying costs that similarly injured workers would incur while doing the same type of work, e.g., commuting costs and dependent care costs.

Contrary to the majority's assertion, similarly impaired workers will not be treated differently based upon varying standards of living, i.e., the cost of maintaining extensive financial obligations versus those associated with a frugal lifestyle. My analysis is not based upon a worker's preinjury lifestyle; but, rather, is based upon identifying a subsistence level of income sufficient to keep the injured worker and his or her dependents off of taxpayer-supported programs or charity (i.e., economic self-sufficiency). In other words, my intent is not to return the injured worker to the (preinjury) lifestyle to which he or she has become accustomed. Although, depending on the facts of a particular case, an "economic self-sufficiency" standard may provide that result.

Moreover, the majority is raising this different treatment of "similarly situated" injured workers criticism as a rationale for standardizing PTD. However, the legislature has not yet seen the need to standardize PTD. This is in contrast to the legislature's standardization of PPD. ORS 656.214(2) and (5). I find that the majority's attempt to standardize PTD oversteps the Board's authority.

Finally, the majority criticizes my proposal for lacking "practical guidance in the application of [this] standard." Page 30 - 31, n. 4. Here, the case was previously remanded with instructions directed at establishing the expenses that would be incurred if claimant were to perform the identified potential jobs. The current record is not adequately developed for my application of the Court's definition of "profitable remuneration." Consequently, this case should be remanded to the Referee with instructions to determine whether the proposed jobs would permit claimant to avoid resorting to taxpayer supported services or charity. Such analysis must be based on the particular facts of each case. As previously noted, determination of permanent total disability is not standardized like that for permanent partial disability. Indeed, the majority looks for a "standard" in my proposal even though I have specifically cautioned against using state or federal poverty levels (or any other strict formula or calculus) as anything more than a tool to assist in the analysis.

Board Member Gunn dissenting:

I disagree with the majority's reasoning regarding the application of the term "profitable remuneration" in determining whether the proposed part-time employment constitutes "gainful employment" under ORS 656.206(1)(a). Consequently, based on the following reasoning, I respectfully dissent.

When I first read the majority opinion in Tee v. Albertsons, Inc., 314 Or 633 (1992), I was struck with horrible flashbacks to my college accounting and economics classes. I was afraid, and the majority opinion seems to imply, that Board members and the parties' attorneys would be turned into economists and accountants. This conversion would take place without the benefit of formal training and experience.

For example, I note that the majority reasons that profit is simply whatever remains after expenses have been deducted. Apparently, a fact-finder is simply to look at the wage ascribed to a particular occupation and subtract the expenses of performing that occupation. Anything remaining is profit. I submit under that analysis all occupations are profitable, and, thereby, the majority's decision renders the Tee Court's holding meaningless. I reach such a conclusion because the sole cost component in hypothetical employments for light / sedentary workers will be their labor (rather than any "phantom" expenses attributable to the hypothetical employment).

The first question would be what constitutes a worker's expenses. The majority's analysis provides little enlightenment regarding what expenses should be considered (other than those associated with employment). Is it clothing, transportation, tools, dependent care, housing, food? I submit that these expenses exist independent of any occupation, and are required by all in society. As such, they are not properly an "expense" of an occupation.

The second question is the extent and level of these expenses. For example, would a proper expense for transportation be an automobile if cheaper public transportation were available? Would the purchase of top of the line tools be appropriate if cheaper generic substitutes were available? Should occupation expenses be amortized over the expected lifetime of employment. If that's the case, given a long enough employment, all expenses would eventually be surpassed leaving nothing but profit.

The problem with the majority's analysis is that it fails to recognize that profit has different meanings and applications, depending upon the context. The worker brings to an occupation his/her labor, whether cerebral, physical or both. There are no "expenses" in an occupation. The application of a simple dictionary definition may be sufficient for legal interpretation, but it is inadequate for commercial application, or the factual analysis required here.

A major failing in the majority's analysis is that we are not comparing anything to actual occupations or jobs. That is, we are trying to determine if a worker's employment will be gainful or profitable when the employment is merely "proposed" not "actual." We are dealing with a market abstraction. The evidence we receive is market surveys of potential employment that may exist. There does not exist an actual employer with a real job upon which we can determine actual expenses.

Here, the evidence in this PTD case is no different than any other PTD case. We are faced with assuming certain expenses because no real employment exists upon which to determine actual expenses. Claimant must show expenses exist for a job that does not exist in fact. A job that only exists in the report and testimony of a vocational expert. Ultimately, we pile one abstraction on another and then characterize our decision as "fact finding."

I read the majority's decision to say that, if any suitable job exists, then it must be gainful or profitable remuneration. Since the worker's labor is always the major component of employment, extrinsic expenses (no matter how broad a definition of "expenses" is used) will not exceed the component. If not on the first day of employment, the amortization of any extrinsic expenses will eventually yield a profit. In effect, the majority's position would eliminate any meaning to the statutory term "gainful employment," as well as the Court's rather oblique definition of "profitable remuneration." (Why didn't they use "lucrative" remuneration?).

In conclusion, I have struggled to find some way to apply the statute and the Court's definition that employment must be suitable and gainful ("profitable remuneration"). Having explained why I cannot adopt the majority's facile answer, I must at least have my own. I do.

My analysis requires applying the Court's definition within the context of the entire Act. In particular, I would rely on a primary objective of the Act to restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable. See ORS 656.012(2)(c). The Workers' Compensation Act is a tool of society; one being supported by the society. Thus, in accordance with the objectives of the workers' compensation system, I would consider employment "gainful" and "profitable" if it returned, to the greatest extent practicable, a worker to the self sufficiency that existed before the injury.

To apply this analysis, I would have to be able to make this determination based on an objective standard. I believe the most appropriate and readily determinable method is to multiply the "pre-injury" wage by the number of hours or days claimant could work. In the event that such a wage would enable the worker to remain ineligible for welfare, food stamps or any other form of public assistance, the proposed employment would be "gainful" or "profitable" to both the worker and society. If the claimant's "pre-injury" wage was insufficient to avoid public assistance, then the "gainful" and "profitable" standard should be based on the worker's rate of temporary disability under ORS 656.210.

In the Matter of the Compensation of
WARREN KEMERY, Claimant
WCB Case No. 92-13322
ORDER ON REVIEW
Ralph M. Yenne, Claimant Attorney
Saif Legal Dept., Defense Attorney

Reviewed by Board Members Haynes, Turner-Christian and Hall.

Claimant requests review of Referee Howell's order that upheld the SAIF Corporation's denial (on behalf of the Department of General Services/Insurance Fund for inmate injuries) of claimant's injury claim because it was not timely filed with the Department of General Services. On review, the issue is timeliness.

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

In the next to last paragraph of the Referee's Findings of Fact, we make the following corrections. On January 10, 1992 (not June) claimant completed a report of injury. On January 21, 1992, claimant's Department of Corrections supervisor signed that form. On July 8, 1992, the Department of General Services received claimant's injury report. (Ex. 1).

On remand from our previous decision (Warren E. Kemery, 46 Van Natta 1221 (1994)), the Referee held that the Department of General Services did not abuse its discretion in refusing to waive the requirement that an inmate injury claim must be filed within 90 days of the injury. We agree.

ORS 655.520(3) provides that the timely filing requirement may be waived by the Department [of General Services] "on the ground that, for good and sufficient reason, the claim could not be filed on time." The Department's policy provides that "only physical and mental incapacity will be recognized as good and sufficient reason for failing to file a claim in a timely manner." (See Ex. 4-4).

On review, claimant contends that he did satisfy the grounds for waiving the timely filing requirement because he was "physically incapacitated" by virtue of being imprisoned. We are not persuaded by claimant's argument that he was "physically incapacitated" because he was incarcerated. Accepting claimant's interpretation would lead to the absurd result that all inmates would automatically have grounds for waiving the timely filing requirement. Such an interpretation would make both the timely filing requirement and the waiver criteria ("good and sufficient reason") of ORS 655.520(3) meaningless. We decline to interpret the statute and the Department's rule in such a way as to render them both meaningless. Consequently, we concur with the Referee's reasoning that the Department did not abuse its discretion in declining to waive the 90 day filing requirement.

ORDER

The Referee's order dated July 27, 1994 is affirmed.

Board Member Hall dissenting.

Because I find that claimant timely filed his Inmate Injury Fund claim, I would conclude that his claim is not barred and should be found compensable on the merits. Therefore, I dissent.

ORS 655.520(3) requires that an Inmate Injury Fund claim be filed with the Department of General Services ("General Services") within 90 days after the injury. However, General Services has discretion to waive the filing requirement "on the ground that, for good and sufficient reason, the claim could not be filed on time." Id. Further, ORS 655.520(1) provides that Inmate Injury Fund claims shall be filed "in the manner provided for workers' claims in ORS chapter 656, to the extent not inconsistent with ORS 655.505 to 655.550."

Under ORS chapter 656, an employer receiving a worker's claim is required to assist in the processing of the claim. ORS 656.262(1). Among other assistance, the employer is required to forward the worker's claim promptly to its insurer for processing.

ORS chapter 655 is silent about how a claim is actually filed with General Services; it merely requires that the filing be done in a timely manner. Because inmates are in the physical custody of the Department of Corrections ("Corrections"), as a practical matter, claims by injured inmates are filed with Corrections, which then forwards the claims to General Services for processing. Hence, for claim processing purposes, Corrections and General Services stand in the shoes of the "employer" and the "insurer," respectively. For this reason, it is not inconsistent with ORS chapter 655 to require Corrections to forward claims promptly for processing, as employers are required to do under ORS chapter 656. See ORS 655.520(1).

Here, it is undisputed that a Department of Corrections employee, the kitchen steward, was aware of claimant's amputation injury when it occurred on November 4, 1991. Claimant verbally reported his injury to a supervisor or supervisors on more than one occasion. On January 10, 1992, claimant completed a report of injury, which his Department of Corrections supervisor signed on January 21, 1992. However, the Department of General Services did not receive claimant's injury report until July 8, 1992, eight months after the injury.¹

These facts are distinguishable from those in Dept. of Justice v. Bryant, 101 Or App 226 (1990), where the injured inmate did not timely file a claim with either Corrections or the Department of Justice (the agency then responsible for administering the Inmate Injury Fund). Rather, the inmate in Bryant informed his supervisor of the injury but was told not to file an accident report or a claim for benefits. The facts of this case are also distinguishable from those in William A. Stevenson, 44 Van Natta 96 (1992), where the injured inmate submitted infirmary notes and reports to Corrections, but did not timely file a claim with either Corrections or the Department of Justice. Because the facts of Bryant and Stevenson are distinguishable, I would not expand their holdings to apply here. Inasmuch as claimant in this case timely filed his claim with Corrections, and, through no fault of his own, the claim was not forwarded to General Services, I would conclude that the claim was timely filed in accordance with ORS 655.520(3).

Additionally, even if I were to find that the claim was not timely filed under ORS 655.520(3), I would conclude that General Services abused its discretion in declining to waive the filing requirement in this case. Our authority to review General Services' action for abuse of discretion is grounded in ORS 655.525, which provides that "[a]n inmate . . . may obtain review of action taken on the claim as provided in ORS 656.283 to 656.304."

Here, claimant did all that he could to file his claim in a timely manner. It was only because of error by Corrections that the claim was not timely filed. Under these circumstances, I would find that, "for good and sufficient reason, the claim could not be filed on time," and that General Services abused its discretion in not waiving the filing requirement. Further, inasmuch as there is no dispute that claimant would be entitled to benefits if the claim was not barred on the timeliness grounds, I would conclude that the claim is compensable. For these reasons, I must respectfully dissent.

¹ At the original hearing in this matter, Mr. Stuhr, coordinator of safety and sanitation for the Department of Corrections, testified that some 5-6 inmate injury reports had gotten "lost" in the paperwork in his office. They were forwarded together to General Services with an explanatory note, indicating that late filing of those reports was not the fault of the inmates. However, Mr. Stuhr was unable to state whether claimant's injury report was among those submitted late by the Department of Corrections.

In the Matter of the Compensation of
TERESA MARCHBANK, Claimant
WCB Case No. C5-00448
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Brownstein, Rask, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On February 22, 1995, 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.

The CDA involves a third party recovery and provides the following information. A third party settlement has been achieved in the amount of \$29,000; out of this amount, \$11,818.09 will be distributed to claimant (representing the balance of the insurer's lien), and the insurer will recover \$2,549.04. Furthermore, claimant agrees to reimburse her attorney for costs in the amount of \$199.31 and pay an attorney fee of \$7,250, such sum to be paid out of the third party settlement proceeds. The summary sheet of the CDA provides that the "Total Due Claimant" is \$19,010.65 and the "Total Due Attorney" is \$7,250.

On March 9, 1995, the Board requested the parties to provide an addendum, expressing concerns regarding the specific amount of consideration to claimant under the CDA; the amount of the attorney fee; and the reimbursement of costs. The insurer's attorney responded that the amount of consideration to claimant pursuant to the CDA was \$11,818.09 and indicated that the attorney fee and costs were to be paid from the third party settlement proceeds. Claimant's attorney has expressed full agreement with the representations contained in the insurer's letter.

Based on the parties' responses, we find that the agreement, particularly the summary page, does not accurately set forth the amount of consideration to be paid claimant in exchange for releasing certain rights pursuant to the CDA. Rather, the amount of \$19,010.65 (set forth in the summary page) appears to combine amounts that will be paid to claimant from the third party settlement, and the consideration for releasing certain rights under the CDA.

Moreover, we understand the reference on the summary page to represent the attorney fee to be paid from the proceeds from the third party settlement rather than by the insurer for claimant's counsel's efforts concerning the CDA. We have the same understanding regarding the sum of \$199.31 for costs that is described in the CDA.

Accordingly, reading the summary page in conjunction with the CDA, we find that the intent of the parties to be as follows:

(1) Total consideration due claimant pursuant to the CDA: \$11,818.09 (the amount the insurer agrees to reduce its statutory third party lien);

(2) Total amount due claimant's attorney pursuant to the CDA: \$0. However, as discussed above, an attorney fee and an amount of \$199.31 for costs will be paid from the proceeds of the third party settlement.

Based on this interpretation, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236 (1). Consequently, the CDA 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.

In the Matter of the Compensation of
BRADLEY S. PARKER, Claimant
WCB Case No. 93-12192
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Peterson's order which set aside its "back-up" denial of claimant's left elbow injury claim. On review, the issues are "back-up" denial and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

"Back-up" Denial

On July 31, 1992, claimant was struck on the left elbow by a falling rock while working for the employer. The incident was witnessed by at least one co-worker, and claimant reported the injury to his employer on the day it occurred.

On October 29, 1992, claimant first sought treatment for his left elbow from Dr. Swanson, orthopedic surgeon. On January 29, 1993, the insurer accepted claimant's claim for left elbow epicondylitis. (Ex. 35).

On August 23, 1993, the insurer issued a "back-up" denial of claimant's left elbow injury, on the basis that there had been a "material misrepresentation" of claimant's past medical history. (Ex. 53). At hearing, the insurer stated that the basis for the "back-up" denial was fraud. (Tr. 5).

The Referee concluded that, pursuant to ORS 656.262(6), the insurer had not proven, by clear and convincing evidence, that claimant's claim was not compensable. We agree with the Referee's ultimate conclusion, but offer the following reasoning.

We have previously held that ORS 656.262(6) does not apply to "back-up" denials based on fraud, misrepresentation or illegal activity. See Randy G. Harbo, 45 Van Natta 1676 (1993); Tony N. Bard, 45 Van Natta 1225 (1993). Therefore, the carrier is not required to prove by clear and convincing evidence that the claim is not compensable. Rather, the carrier has the burden of proving fraud or misrepresentation in order for the "back-up" denial to be effective. See Bauman v. SAIF, 295 Or 788 (1983). In order to justify a "back-up" denial, the misrepresentation must have been sufficiently material that the carrier's decision to accept the claim could reasonably have been affected. Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987); SAIF v. Abbott, 103 Or App 49, 52-53 (1990).

Here, the insurer contends that its acceptance was induced by fraud and misrepresentation. We disagree.

The insurer argues that claimant failed to advise the insurer, at the time of his July 1992 injury, that he had previous problems with his elbows. Specifically, the insurer states that claimant denied that he had any previous problems with either elbow. However, when asked whether she had ever called claimant to inquire about prior injuries, the insurer's claims examiner stated that she had no documentation of asking claimant about a prior injury. (Tr. 273). Furthermore, an 801 form was prepared by the insurer, so any lack of reference on the form to prior injuries cannot be attributed to claimant. (Ex. 31). Finally, the only evidence in the record at the time of claim acceptance, other than the 801 form, included medical reports from claimant's treating physician diagnosing left lateral epicondylitis secondary to acute trauma. (Exs. 29, 30, 32, 34).

Accordingly, because we find that, at the time the insurer accepted claimant's left elbow claim, the record contained no evidence of fraud or misrepresentation, we conclude that the insurer's decision to accept the claim could not reasonably have been affected. Ebbtide Enterprises v. Tucker, *supra*.

We find that the insurer has not met the burden of establishing that its fraud-based "back-up" denial was permissible. Accordingly, claimant is not required to establish that the claim is, in fact, compensable. Parker v. North Pacific Ins. Co., 73 Or App 790 (1985).

Clear and Convincing Evidence

The insurer advances the alternative argument that, if ORS 656.262(6) were applicable, then a proper "back-up" denial can be premised on any probative evidence that is new, or "later obtained," since its acceptance decision. Moreover, the insurer asserts that, once it establishes that the denial is based on "later obtained" evidence, it can rely on the entire record (regardless of whether "old" or "new" evidence) to establish by clear and convincing evidence that the claim is not compensable. (App. Br. 3).

Essentially, the insurer disagrees with the Referee's opinion that: "the burden of proving non-compensability is shifted to the insurer and the burden of proof is that of clear and convincing evidence, which is later obtained after acceptance." (Emphasis in original) (Opinion and Order at 3). We need not resolve the issue posed by the insurer's alternative argument because, even if the entire record is considered, we are not persuaded that the insurer has established by clear and convincing evidence that the claim is not compensable.

To satisfy the "clear and convincing" legal standard, the insurer would have to prove that it is "highly probable" that claimant's left elbow condition is not compensable. See Drews v. SAIF, 318 Or 1 (1993); Darwin G. Widmar, 46 Van Natta 1018 (1994). Based on the following reasoning, we are not persuaded that the entire record supports such a conclusion.

The insurer does not dispute that claimant's left elbow was struck by a falling rock while he was working for its insured in 1992. (App. Br. at 9). Moreover, the medical evidence indicates that claimant left elbow condition was due to that traumatic injury.

Dr. Duff (orthopedic surgeon) and Dr. Brooks (neurologist) examined claimant on behalf of the insurer. It was their opinion that claimant had "left lateral epicondylitis" related to his 1992 injury. (Ex. 37-3). Drs. Duff and Brooks explained that claimant was able to forestall seeking medical treatment immediately after the injury because: "his job was mainly supervisory in nature and he did not have to use the left arm." (Ex. 37-4). Claimant's attending physician, Dr. Swanson, concurred with their opinion. (Ex. 40). There is no contradictory medical evidence.

Furthermore, even if we found that neither Drs. Duff, Brooks nor Swanson offered persuasive medical opinions, we would still be unable to discern any extrinsic evidence that would prove that it was "highly probable" that claimant's left elbow condition was not due to his 1992 injury. See Darwin G. Widmar, *supra*. Accordingly, even if ORS 656.262(6) were applicable, and even if we considered "pre" and "post" acceptance evidence, we would find that the insurer had failed to prove by clear and convincing evidence that claimant's injury claim for a left elbow condition is not compensable.

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

ORDER

The Referee's order dated June 7, 1994 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$800, payable by the insurer.

In the Matter of the Compensation of
JAMES H. SKINNER, Claimant
WCB Case No. 94-00620
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn, Neidig and Turner-Christian.

Claimant requests review of Referee Menashe's order that set aside a Director's vocational assistance order authorizing payment of travel costs to claimant incurred while participating in an authorized training program (ATP). On review, the issue is claimant's entitlement to reimbursement for travel expenses during an ATP. We affirm.

FINDINGS OF FACT

In December 1989, claimant sustained a compensable disabling injury. His weekly net income on the date of injury was \$410.56. Following the injury, claimant received a net income of \$370 a week in temporary total disability benefits.

In April 1993, claimant entered into an authorized training program (ATP). The insurer's plan for that program included reimbursement up to \$819 to claimant for his expenses incurred in traveling to the ATP. At the time that the plan was approved, claimant's net income was \$423.91 per week (higher than his income at the time of his compensable injury). After the plan was approved, the insurer determined that claimant's actual travel costs were \$2,247. When the insurer refused to pay more than \$819, claimant requested Director review.

Applying OAR 436-120-087, the Director's order instructed the insurer to fully reimburse claimant for his travel expenses. The insurer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the Director's order, finding that OAR 436-120-087 did not require the insurer to pay for such costs. That rule requires the insurer to provide "direct worker purchases" that are necessary, in part, for a worker's participation in employment or training services. Direct worker purchases include "travel expenses for transportation" required for participation in vocational assistance. OAR 436-120-087(2)(b). Determination of the necessity of such purchases is based on a comparison of "the worker's pre-injury net income" with "the worker's post-injury income." OAR 436-120-087(1). To find a purchase necessary, "the worker's pre-injury net income must be found greater than the worker's post-injury net income." Id.

The Director's order found that claimant's weekly "pre-injury net income" was \$410 and that the "post-injury net income" was his temporary disability benefits of \$370 per week. Alternatively, the order found that, based on 1993 wages of the job-at-injury, claimant's "pre-injury net income" would be \$490.50 per week. Because both the \$410 and \$490.50 figures exceeded the weekly wage of \$370 per week, the Director found that claimant was entitled to reimbursement for the entire amount of his travel costs.

The Referee disagreed, deciding that "the purpose of the administrative rule is to determine if direct purchase will be authorized for the worker during the time of the authorized training program" and that the "only rational connection of post-injury net income is to determine if a subsidy is reasonably financially required." Thus, the Referee found that the rule required a comparison with the pre-injury net income with the "net income at the time the worker enters the program." Because the Director based the "post-injury net income" on claimant's temporary disability benefits he received immediately following the injury, the Referee concluded that the Director violated OAR 436-120-087 and set aside the order.

The decision of the Director may be modified only if it violates a statute or rule; exceeds the agency's statutory authority; was made upon unlawful procedure; or is characterized by abuse of discretion or clearly unwarranted exercise of discretion. ORS 656.283(2). Moreover, in interpreting and applying rules promulgated by the Director, the Director's interpretation is generally entitled to

deference. Mershon v. Liberty Northwest Ins. Corp., 96 Or App 223, rev den 308 Or 315 (1989). Claimant asserts that, because the rule does not define "post-injury net income," the Director did not violate the rule by using the amount of temporary disability benefits immediately following the compensable injury.

We agree that the rule does not define "post-injury net income" and that the term is ambiguous. However, the rule also requires a comparison of claimant's net income before and after the injury to determine the necessity of the "direct purchase" during participation in vocational assistance. Thus, we interpret "post-injury net income" in the context that the rule requires reimbursement of travel expenses only when the claimant has less income than before the injury.

We first note that the rate of temporary total disability is always less than the wage at the time of injury. See ORS 656.210(1). Thus, if "post-injury net income" was based on such benefits, every worker participating in employment or training services would qualify for reimbursement of travel expenses. By providing a contingency for receiving travel expenses (i.e., less "post-injury net income" than "pre-injury net income"), the rule obviously is not intended to apply in such a global manner. Consequently, because the Director considered temporary disability benefits as "post-injury net income," we conclude that the Director violated OAR 436-120-087(1).¹

Furthermore, travel expenses qualify as a "purchase" only when the worker participates in vocational assistance. Thus, we agree with the Referee that "post-injury net income" is most reasonably construed as also being limited to the period of time when the worker is participating in vocational assistance. We find further support for our interpretation in OAR 436-120-087(2)(b)(A), which limits reimbursement for transportation costs to those in excess of what the worker paid at the time of injury if the worker is receiving temporary total disability. Accordingly, we interpret "post-injury net income" in OAR 436-120-087(1) as referring to claimant's wages at the time of participation in the ATP.

Based on this reasoning, the Director's finding that claimant's temporary total disability benefits of \$370 per week he received following the injury qualified as "post-injury net income" under OAR 436-120-087(1) is unsupported and not entitled to any deference.² Consequently, we agree with the Referee that the Director's order violated a Department rule and should be set aside. See ORS 656.283(2)(a).

ORDER

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

¹ According to the dissent, the Director's interpretation of an administrative rule must be irrational before the Board may determine that there has been a violation of the rule by the Director under ORS 656.283(2). We find nothing in the statute indicating such a high standard for modification of the Director's order. Rather, a finding that the Director's application of a rule is "unsupported," as in this case, constitutes a violation of the rule and, thus, allows for modification of the Director's order. See ORS 656.283(2)(a).

² We also find unsupported the Director's alternative finding that pre-injury net income should be based on the current wage of the job-at-injury. The rule unambiguously refers to the worker's pre-injury net income, clearly indicating that the claimant's income at the time of injury is to be considered.

Board Member Gunn dissenting.

The majority exceeds its legal authority under ORS 656.283(2). It imposes its interpretation of a rule over that of the Director of the Director's rule. Its action shows no deference to the Agency, instead ignoring the interpretation of the very entity that formulated the rule. The majority does all this so it can provide itself with a device to argue that the Director has violated this rule. I believe that such circular reasoning is inappropriate and exceeds the Board's review function and authority under ORS 656.283(2).

The Board's review of a Director's order is limited by clear statutory instructions. We can only **modify** the Director's order under four discrete circumstances. In the instant case, the referee and the majority have held the Director violated OAR 436-120-087. They reach this conclusion by substituting

their own interpretation of this rule, a rule promulgated and produced by the Director. Their interpretation is contrary to that of the Director. The majority forgets that this is why the Director's interpretation is entitled to deference.

In this case, the Referee and the majority claim that their interpretation is the only rational construction of OAR 436-120-087. I disagree. Even the Referee notes that the application of the rule by the Director is "understandable." The majority must show that the Director's interpretation **violates** the rule before modifying that decision. That standard is not met absent a facially clear violation of the rule. Because the Director's interpretation of the rule was not irrational, I believe that the majority's attempt to modify the Director's order exceeds the statutory authority and infringes on the Director's jurisdiction.¹

For these reasons, I must respectfully dissent.

¹ Contrary to the majority, the dissent does not require rationality from any rule, whether issued from the Director or the Board. The dissent does find it both irrational and illegal for the Board to modify a Director's order because the Board's interpretation of a rule is merely contrary to a rational interpretation offered by the maker of the rule.

April 6, 1995

Cite as 47 Van Natta 656 (1995)

In the Matter of the Compensation of
WILLIAM J. SIPPEL, Claimant
WCB Case No. 94-02755
ORDER ON REVIEW
Schneider, Hooten, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Garaventa's order that upheld the insurer's denial of claimant's injury claim for a cervical and lumbar strain/sprain. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with one modification. We change the last sentence to read as follows: As a result of these injuries, claimant told Dr. Kayser that he had received 170 to 200 chiropractic treatments.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the causation issue required expert medical opinion because claimant had prior low back problems and because his low back and neck symptoms did not arise immediately after the July 19, 1993 injury. Claimant contends that the Referee erred in finding that the case presented a complicated medical question requiring expert medical opinion.

In Barnett v. SAIF, 122 Or App 279 (1993), the court listed five factors for determining whether expert evidence of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a supervisor; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any contrary expert evidence. In Barnett, the court concluded that expert testimony was not required where the claimant suffered immediate low back pain, promptly reported the injury and sought medical treatment within 24 hours. The claimant had never before experienced low back problems.

In the present case, claimant was injured on July 19, 1993 when he fell off a cat walk at the employer. According to claimant, his injury is the kind that would reasonably be expected to cause back and neck pain. We disagree. Unlike Barnett, there is no evidence that claimant sought immediate medical treatment for a low back or cervical condition, although he did seek immediate treatment for the rib injury. This case is also distinguishable from Barnett in that claimant had prior low back and cervical complaints or symptoms.

Approximately one week after claimant's injury, he was examined by Dr. Teal, who diagnosed a minimally displaced rib fracture, left sixth, but did not diagnose a back or cervical condition. (Ex. 2). In the section of the report discussing claimant's prior medical history, Dr. Teal reported that claimant had had chronic back problems and "since he fell, he has some increasing pain in his low back radiating up between his shoulders and into his head and he has some numbness in some of the toes of his right foot but he didn't specify which ones and he only mentioned it coincidentally while he was seen after his x-rays." (Ex. 2; emphasis added).

At hearing, claimant testified that when he went to see Dr. Teal he was only having pain in his chest. Claimant said that his back started bothering him after the pain started subsiding from his ribs, probably within a month or so after his injury. (Tr. 13-14).

Claimant does not dispute that he had prior back and cervical complaints and symptoms. Claimant testified that since the 1986 compensable back injury, his back bothered him "once in awhile." (Tr. 19). Dr. Kayser reported that claimant had "never fully recovered" from his 1986 back injury. (Ex. 4). Because there is no evidence that claimant sought treatment for his low back and cervical conditions immediately following the injury and in light of his previous back and cervical complaints/symptoms, we consider the causation issue to be 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).

Two physicians reported on whether claimant's current conditions were related to his July 19, 1993 injury. Claimant relies on the report of Dr. Lusby, a chiropractor. On February 11, 1994, almost seven months after the injury, Dr. Lusby reported that claimant said he had had pain in his low back and neck since his fall on July 19, 1993. (Ex. 11). Dr. Lusby's history of the onset of claimant's symptoms differs from claimant's testimony at hearing. Furthermore, Dr. Lusby's opinion is conclusory regarding causation. Although Dr. Lusby reported that the "impact of the fall strained his low back and neck," the report did not indicate whether she was aware of claimant's previous back and neck complaints/symptoms. For these reasons, we afford Dr. Lusby's opinion little probative weight.

Claimant was examined by Dr. Kayser approximately one month after the injury. On August 31, 1993, Dr. Kayser said that claimant had some mild cervical pain that was not much of a problem at that time and had "chronic lower lumbar back pain that has dated back to the 1986 injury that has been aggravated by this fall." (Ex. 4). In a later report, however, Dr. Kayser apparently changed his mind about the causation of claimant's back condition. On March 25, 1994, Dr. Kayser reported:

"I think it would be most appropriate to have Dr. Teal comment on whether there was any injury to [claimant's] back at the time. Certainly, from my standpoint, I can only go on what the patient tells me and that is that he had had previous back problems, he still has ongoing back problems, and the injury to himself when he broke his rib also injured his back. I am sure you are aware that is a very difficult question about which to be specific." (Ex. 12).

In light of Dr. Kayser's March 25, 1994 report, we attach little probative value to his earlier report describing claimant's July 19, 1993 injury as "aggravating" his back pain. There are no other opinions discussing the causation of claimant's low back and cervical conditions. Consequently, we conclude that claimant has failed to establish the compensability of his low back and cervical conditions.¹

ORDER

The Referee's order dated June 22, 1994 is affirmed.

¹ Because we have concluded that claimant has not established that his condition is compensable, we do not address his argument that the insurer cannot raise the question of a new injury vs. an aggravation because the insurer never issued a disclaimer of responsibility under ORS 656.308(2). See Joyce A. Crump, 47 Van Natta 466 (1995) (application of ORS 656.308(2) is contingent on finding a claim compensable). Board Member Hall directs the parties' attention to the dissenting opinion in Crump, in which he and Member Gunn concluded that the employer's failure to comply with ORS 656.308(2) precluded the employer from asserting as a defense that actual responsibility lies with another employer or insurer.

In the Matter of the Compensation of
FLOYD R. WILSON, Claimant
WCB Case No. 93-11321
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's medical services claim for a hospitalization in June 1993. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last two findings, and with the following supplementation.

Claimant injured his left knee at work in April 1986. In September 1986, he underwent arthroscopic surgery. A week later, he developed left leg deep vein thrombosis (DVT). In December 1986, claimant was hospitalized for syncope, which claimant's then-treating physician related to the DVT. SAIF accepted claimant's left knee injury and DVT; it initially denied as a current condition, then rescinded its denial of, claimant's syncopal episode .

During the ensuing years, claimant was hospitalized several times for DVT and syncope, among other conditions. SAIF reopened the claim as a result of these hospitalizations, and paid claimant time loss and medical benefits.

Dr. Swena, family practitioner, became claimant's treating physician in 1992. (See Ex. 46). Between September 1992 and June 1993, claimant underwent many left leg venous ultrasounds. Dr. Randol, radiologist, performed and interpreted each of these ultrasounds. The September 30, 1992 ultrasound revealed popliteal vein DVT; further ultrasounds revealed improvement and eventually became negative. (Exs. 45, 48, 53, 57, 58).

On June 28, 1993, claimant was again hospitalized for complaints of left leg pain and near syncope. (Ex. 61). Dr. Randol performed another left leg ultrasound, which revealed an abnormality in the adductor canal region. (Ex. 60). Based on that finding, Randol diagnosed "[i]nterval development of apparent clot in the left superficial femoral vein in the region of the adductor canal, when compared to the prior study on 11 June 1993." (*Id.*) Dr. Swena treated claimant for DVT. (Exs. 61, 63).

On July 6, 1993, an ultrasound revealed little interval changes. (Ex. 64). A July 13, 1993 ultrasound, performed by Dr. Hanson, radiologist, revealed changes consistent with the post-thrombophlebitic process. (Ex. 66).

In August 1993, claimant requested that his claim be reopened. (Ex. 70). In September 1993, Dr. Taylor, professor of vascular surgery at Oregon Health Sciences University, examined claimant on SAIF's behalf. Based on his review of the ultrasound reports and claimant's history, Taylor concluded that claimant did not have recurrent DVT. (Exs. 74-1, 77). Consequently, he concluded that the major contributing cause of claimant's current hospitalization was unknown. (Ex. 74-1). On September 20, 1993, SAIF denied claimant's medical services claim for a hospitalization for DVT. (Ex. 75).

Thereafter, Drs. Swena and Randol reaffirmed their opinions that claimant had had DVT in June 1993. (Exs. 76, 79, 82, 85, 86-24). After reviewing "the actual films that were taken from the venous ultrasound," Dr. Taylor adhered to his opinion. (Tr. 59; see Tr. 62).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, based on the reports and testimony of Dr. Taylor, claimant failed to establish that his hospitalization on June 28, 1993 was related to any of his accepted conditions. We disagree.

Medical services for conditions resulting from an injury are compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245(1); Beck v. James River Corp., 124 Or App 484, 487 (1993). Accordingly, claimant's current hospitalization is compensable if his need for treatment bore a material relationship to any of his accepted conditions.

The evidence establishes that claimant's current hospitalization bore at least a material relationship to his accepted DVT. SAIF asserts that claimant's current hospitalization was not for DVT, while claimant asserts that it was. The medical evidence regarding this issue is divided. Under such circumstances, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

SAIF urges us to rely on Dr. Taylor's status as a vascular surgeon to conclude that his opinions are entitled to the greatest weight. We decline the invitation. We do not doubt that Dr. Taylor is a well-respected expert in vascular surgery. Nevertheless, we find persuasive reasons not to give probative weight to his opinions. Most of Dr. Taylor's analysis is based on his review of the reports of claimant's venous ultrasounds, (see Exs. 74, 77, Tr. 38, 42), not the ultrasound films themselves. Although Taylor reviewed the films of one of the ultrasounds (the record is not clear which), his analysis consists mainly of a critique of the written ultrasound reports. Under the circumstances, we find that reasoning insufficient to establish that claimant's current hospitalization was not related to his accepted DVT.¹

Rather, we rely on the opinions of Drs. Swena and Randol, both of whom diagnosed DVT in June 1993. Although Dr. Swena is not a vascular surgeon, he had the opportunity to observe and treat claimant over a prolonged period of time. Furthermore, in diagnosing claimant's DVT in June 1993, Dr. Swena relied on the expertise of Dr. Randol, who, as the radiologist who performed all but one of claimant's left leg ultrasounds, was in the best position to provide an opinion regarding whether claimant had DVT. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). In turn, Dr. Randol's conclusions are supported by the July 13, 1993 ultrasound performed by Dr. Hanson, radiologist, which revealed post- thrombophlebitic changes.

Under the circumstances, we find Dr. Swena's and Randol's reports sufficient to establish that claimant had DVT in June 1993. Consequently, we conclude that claimant has established that his need for treatment in June 1993 bore at least a material relationship to his accepted DVT. ORS 656.245(1); Beck v. James River Corp., supra. For these reasons, we reverse the Referee's decision upholding SAIF's denial of the June 1993 hospitalization.

Claimant raises several other issues on review in support of his claim. In view of our conclusions set forth above, we need not address those issues.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is \$3,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by 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 June 29, 1994 is reversed. The SAIF Corporation's denial of claimant's medical services claim is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded a reasonable assessed attorney fee of \$3,500, to be paid by SAIF.

¹ Dr. Collins, who performed a records review on SAIF's behalf, qualifiedly concurred with Dr. Taylor's conclusions. (Ex. 81-2). Because we have discounted Dr. Taylor's testimony and reports, and because Collins' review was limited to the record, we afford the latter's opinion no weight.

In the Matter of the Compensation of
NORMAN P. BREWER, Claimant
WCB Case No. 94-05182
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Livesley's order that upheld the self-insured employer's denial of his occupational disease claim for a bilateral knee condition. On review, the issue is compensability.

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

The Referee appeared to analyze claimant's right knee claim as a "resultant condition" claim under ORS 656.005(7)(a)(B). However, we find that claimant's bilateral knee conditions were gradual in onset and that such conditions (osteoarthritis, or degenerative joint disease) are recognized as an inherent hazard of exposure to weightbearing activities at work. Therefore, we conclude that claimant's bilateral knee conditions must be analyzed under an occupational disease theory under ORS 656.802. See James v. SAIF, 290 Or 343, 348 (1981). Although the Referee analyzed the right knee claim under ORS 656.005(7)(a)(B), inasmuch as the standard of causation under that provision (major contributing cause) is the same as that applied under ORS 656.802, we adopt the Referee's opinion and conclusions regarding the application of that standard.

Next, claimant challenges the Referee's finding that he had longstanding osteoarthritis in the left knee. We find some evidence in the record to indicate that claimant has longstanding osteoarthritis in the left knee. (See Ex. 1-1). However, it is unclear whether the left knee osteoarthritis actually preexisted claimant's employment with the employer. Assuming arguendo that claimant's left knee osteoarthritis did not preexist his employment, we nevertheless would conclude, based on our evaluation of the medical evidence, that claimant has not carried his burden of proving that his work activities were the major contributing cause of the onset of left knee osteoarthritis.

Finally, in lieu of the Referee's finding that claimant's off-work activities were not contributory, we find that claimant's off-work activities did contribute both to the worsening of the preexisting right knee osteoarthritis and to the onset of left knee osteoarthritis. However, the contribution by off-work activities did not rise to the level of major contributing cause.

ORDER

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

Member Hall, specially concurring.

While I readily agree that claimant has not carried his burden of proving the compensability of the right knee condition, I believe the left knee condition presents a closer question. I write separately to address this question.

It is undisputed that claimant has worked as a welder for the employer for more than 14 years. It is also undisputed that his job required extensive crawling, squatting, walking, climbing and carrying welding equipment. Dr. Lantz, claimant's treating orthopedic surgeon, described work as "a significant factor" in the development of left knee osteoarthritis. (Ex. 8-20). He could not identify any other causative factor which was more significant than claimant's work history. (Id.) He explained that the left knee osteoarthritis was a "wear and tear" type of phenomenon resulting from repetitive stress on the knee over a period of time. (Ex. 8-21). He stated that claimant's work has been the most significant factor regarding activities and stressors on the left knee. (Ex. 8-38).

These statements, when read as a whole, support a finding that work activities were the major contributing cause of the onset of left knee osteoarthritis. However, when pressed for an opinion directly addressing the "major contributing cause" standard, Dr. Lantz was equivocal. He stated that there was a "good chance" that work was over 50 percent of a factor in the left knee condition. (Ex. 8-20).

Hence, on one hand, Dr. Lantz believes that work was the most significant stressor on the left knee. Yet, on the other hand, he cannot state, with a reasonable degree of medical certainty, that work was the "major contributing cause" of the left knee condition. Ultimately, I am left unpersuaded that Dr. Lantz's opinion is sufficient to carry claimant's burden of proof. I therefore concur in upholding the denial.

April 7, 1995

Cite as 47 Van Natta 661 (1995)

In the Matter of the Compensation of
KENNETH M. HUGHES, Claimant
WCB Case No. 94-03053
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Davis' order that affirmed an Order on Reconsideration award of 13 percent (19.5 degrees) scheduled permanent disability for loss of use or function of the left knee. 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, the Referee admitted into evidence, over claimant's objection, a "post-arbiter" medical report from Dr. Fuller (orthopedic surgeon), a non-attending physician. (Ex. 20). Reasoning that the report addressed the causal relationship between claimant's compensable injury and his impairment, the Referee concluded that the report was admissible. The Referee relied on Frank H. Knott, 46 Van Natta 364 (1994).

Subsequent to the Referee's order, we addressed a related evidentiary issue in David B. Weirich, 47 Van Natta 478 (1995). In Weirich, we disavowed our holding in Knott. Specifically, we held that a post-medical arbiter report, even if it solely concerns causation, falls within the "no subsequent medical evidence" limitation set forth in ORS 656.268(7). We reasoned that this approach is consistent with the intent of the legislature to avoid "dueling doctors" and provide a "bright-line" for parties litigating extent of permanent disability issues. See ORS 656.268(7); see also, Daniel L. Bourgo, 46 Van Natta 2505 (1994) (holding that "supplemental" medical arbiter reports are not admissible except where the Department or the arbiter indicate that the initial report was incomplete).

Here, the medical arbiter's report was authored by Dr. Dinneen (orthopedist) on January 13, 1994. (Ex. 14). Dr. Fuller's report was generated on May 18, 1994. Inasmuch as Dr. Fuller's medical report was submitted after the reconsideration process was complete, it is subject to the "no subsequent medical evidence" limitation set forth in ORS 656.268(7). David B. Weirich, *supra*. Accordingly, we reverse the Referee's evidentiary ruling to admit Exhibit 20 and we exclude that exhibit from the record.

Extent of Scheduled Permanent Disability

For the reasons set forth below, we affirm the Referee's order that affirmed the January 28, 1994 Order on Reconsideration, which awarded 13 percent (19.5 degrees) scheduled permanent disability for loss of flexion in his left knee.

Claimant contends that he is entitled to an increased award of scheduled permanent disability due to an inability to repetitively use his left knee and a chondromalacia condition. Based on the admissible medical evidence, we are not persuaded that either of these claimed conditions is attributable to claimant's compensable injury. See ORS 656.266; Jean M. Graham, 45 Van Natta 1114 (1993).

Claimant's attending physician, Dr. Blatt, opined that claimant experienced no permanent impairment as a result of his June 14, 1993 compensable injury. (Ex. 6). Dr. Blatt explained that claimant suffered from preexisting osteoarthritis and that his compensable injury had resolved over a period of two weeks. (Exs. 10, 13).

Dr. Dinneen, the medical arbiter, found that claimant was limited in his ability to repetitively use his left knee and quantified that chronic condition as "moderate to marked." (Ex. 14-3). However, Dr. Dinneen opined that "overall" impairment was attributable to claimant's preexisting degenerative arthritis and post-surgical changes. *Id.*

Claimant argues that he is entitled to an award of 5 percent scheduled permanent disability because his compensable injury is partially responsible for his lost range of motion. *See David E. Lowry*, 45 Van Natta 749 (1994). In support of his argument, claimant relies on Dr. Dinneen's statement that he had "mild inability to repetitively use the left knee" as a result of the compensable injury in June 1993. (Ex. 14-3).

We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993); *Raymond L. Owen*, 45 Van Natta 1528 (1993); *Timothy W. Reintzell*, 44 Van Natta 1534 (1992). Rather, we rely on the most thorough, complete and well-reasoned medical evidence to evaluate claimant's permanent impairment. *See Somers v. SAIF*, 77 Or App 259 (1986). Furthermore, absent persuasive reasons to do otherwise, we give greater weight to the conclusions of a claimant's attending physician. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find no reasons not to defer to Dr. Blatt's opinion. In particular, Dr. Blatt's conclusion that claimant suffered no permanent impairment as a result of his June 1993 injury is corroborated by Dr. Dinneen's conclusion that claimant's "overall" impairment is due to noncompensable degenerative changes. (Ex. 14-3).

To the extent that Dr. Dinneen found that claimant had a "mild" inability to repetitively use his left knee due to the June 1993 injury, we do not rely on that opinion. Specifically, Dr. Dinneen does not explain the causal connection between that "mild" inability and claimant's compensable injury. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980). Rather, we are persuaded by Dr. Blatt's opinion that claimant's accepted left knee injury resolved over a two week period without any permanent impairment. *See Weiland v. SAIF, supra.*

Lastly, Dr. Dinneen found "mild to moderate" chondromalacia of claimant's left knee. (Ex. 14-3). However, there is no further discussion by Dr. Dinneen and no other physician diagnosed a chondromalacia condition affecting claimant's left knee. Consequently, the evidence is insufficient to establish a causal connection between that chondromalacia condition and claimant's accepted June 1993 injury. *See ORS 656.266; Moe v. Ceiling Systems, supra.*

Inasmuch as SAIF does not seek to modify claimant's award of 13 percent (19.5 degrees) scheduled permanent disability, the January 28, 1994 Order on Reconsideration is affirmed in its entirety.

ORDER

The Referee's order dated June 24, 1994, is affirmed.

In the Matter of the Compensation of
WILLIAM C. PETERSON, Claimant
WCB Case No. 94-03734
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Referee Myzak's order which set aside its partial denial of claimant's consequential condition claims for blood-clot conditions and a mental disorder (depression). On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

In September 1990, claimant, a bus driver, compensably injured his head and neck. SAIF accepted the claim as a cranial contusion. Claimant returned to work and the claim was closed on February 28, 1991 by a Notice of Closure which did not award any permanent disability.

Claimant continued to experience neck pain, along with headaches, after claim closure. On December 31, 1991, Dr. Knox, claimant's attending neurologist, declared claimant temporarily and totally disabled and removed him from work. In July 1992, while hospitalized with pneumonia, claimant developed right leg pain and discomfort. Dr. Knox diagnosed probable deep vein thrombophlebitis, which he related to claimant's protracted bed rest for pneumonia. (Ex. 18-9). Claimant was discharged by Dr. Gallant, an internist, with the diagnoses of atypical pneumonia and thrombophlebitis involving right deep venous thrombosis. (Ex. 23-1).

In December 1992, claimant developed left knee discomfort and left quadrant pain, for which he was again hospitalized. Claimant was examined by a number of physicians. Dr. Thomas, a kidney specialist, diagnosed left renal vein thrombosis "secondary to hypercoagulable state." (Ex. 18-12). Dr. Thomas suspected that the "clotting disorder" was responsible for claimant's renal vein thrombosis. Anticoagulants were prescribed, as they had been after claimant's first hospitalization.

On January 25, 1993, Dr. Gallant authored a medical report entitled "comprehensive history and physical exam." (Ex. 39). Acknowledging claimant's acute and chronic medical problems, Dr. Gallant wrote that claimant appeared to have a "hypercoagulable state," which was worsened by smoking. Dr. Gallant further opined that "this has resulted in thrombosis in the leg, in the kidney, and possibly the lung."

In the meantime, claimant continued to experience chronic neck pain for which Dr. Knox recommended cervical-disc surgery that was postponed pending stabilization of claimant's vascular problems. In December 1993, Dr. Gallant diagnosed "depression" for which he planned a psychiatric referral. Apparently, Dr. Gallant was unable to find a psychiatrist for claimant. He instead prescribed medication to treat the depression. (Ex. 42).

On December 18, 1993, Dr. Gallant wrote that claimant's cervical disc claim had resulted in a need for medication and bed rest. According to Dr. Gallant, the bed rest and sedentary lifestyle "has resulted in a hypercoagulable state with the risk and eventual conditions of phlebitis, pulmonary emboli, renal vein thrombosis, and, in turn, increased risk of hypoventilation, resulting in pneumonia." (Ex. 42-A).

SAIF subsequently arranged for the review of medical records by a vascular surgeon, Dr. Porter. Dr. Porter, who did not have a complete packet of medical records, concluded that there was no relationship between claimant's injury and his thrombi or pulmonary embolism. (Ex. 44). Dr. Barker, a pulmonary specialist, also conducted a records review and found no evidence of a pulmonary embolism. Concluding that it was "possible" that claimant had deep venous thrombosis and left renal thrombosis, Dr. Barker opined that the "genesis" of the thrombotic states was "unclear." Dr. Barker recommended further diagnostic studies.

As part of a panel of orthopedic consultants evaluating claimant's cervical condition, Dr. Parvaresh, a psychiatrist, performed a psychiatric interview and mental status examination on March 8, 1994, including an MMPI-II and Beck Depression Inventory. (Ex. 45). Dr. Parvaresh diagnosed psychological factors affecting claimant's physical condition, but conceded that claimant may well have experienced depression within the past year. Reasoning that claimant had "a lot of other medical problems" that were more serious than his neck pain, Dr. Parvaresh concluded that these unspecified conditions would be the major contributing cause of any depression claimant might have suffered, rather than the compensable 1990 injury or its sequelae.

On March 17, 1994, SAIF denied the compensability of numerous conditions mentioned in claimant's medical records: deep vein thrombosis, venous thrombosis, renal vein thrombosis, pulmonary embolism, pneumonia, psychological depression, hypercoagulable state, splenomeglia and hepatomeglia.

On March 24, 1994, in response to an inquiry from SAIF, Dr. Knox wrote that claimant's vascular problems were not related to the compensable head and neck injury. (Ex. 49). Dr. Knox subsequently opined, without explanation, that claimant's depression was related to the compensable injury. (Ex. 50A).

On March 31, 1994, Dr. Gallant reiterated that claimant's sedentary life and bed rest, which he described as "sequelae" of the compensable injury, were the major contributing factors to claimant's "hypercoagulable state, resulting in deep vein thrombosis, renal vein thrombosis and pulmonary embolism." (Ex. 50). Dr. Gallant further opined that claimant's depression was a "direct result" of the compensable injury and its sequelae.

Dr. Gallant testified during a deposition that, while there was no proof of a pulmonary embolism, the 1990 injury and sequelae were the major contributing cause of claimant's deep venous thrombosis, venous thrombosis and renal vein thrombosis. (Ex. 52-10). Specifically, Dr. Gallant attributed the thrombi to claimant's sedentary lifestyle resulting from his compensable injury. (*Id.*). Dr. Gallant, however, testified that he could not relate claimant's hypercoagulable state to the compensable injury. (Ex. 52-13).

With respect to claimant's depression, Dr. Gallant conceded that he was not a psychiatrist. However, he explained that he treats depression frequently in his practice and that he would not necessarily defer to the opinion of a psychiatrist. (Ex. 52-22). Dr. Gallant also testified that claimant's depression was due to chronic pain and reduced quality of life from the cumulative effect of all claimant's medical problems, including the vascular conditions. However, Dr. Gallant stated that neck pain was the "predominant feature." (Ex. 52-23).

CONCLUSIONS OF LAW AND OPINION

During closing argument, claimant conceded that the denied pulmonary embolism, hypercoagulable state, splenomeglia, and hepatomeglia were not compensable. Reasoning that the other denied conditions should be analyzed as consequential conditions resulting from the compensable 1990 injury, the Referee determined that claimant had the burden of proving that the compensable injury was the "major contributing cause" of those conditions. See ORS 656.005(7)(a)(A).

The Referee concluded that claimant's pneumonia was not compensable, finding that there was no medical evidence relating this condition to the compensable injury. However, the Referee found that claimant's blood clot conditions were compensable, concluding that Dr. Gallant's medical opinion was the most persuasive. Relying on medical evidence from Drs. Gallant and Knox, as well as what she considered corroborating medical evidence from Dr. Parvaresh, the Referee also found that claimant's psychological condition was a compensable consequence of the 1990 injury.

On review, SAIF contends that the Referee erred in finding claimant's vascular conditions and psychological condition compensable consequences of the 1990 injury. We agree with respect to claimant's vascular conditions, but disagree with respect to claimant's diagnosed depression.

Vascular Conditions

Inasmuch as claimant alleges that his vascular conditions are indirect consequences of his head and neck injury, claimant must prove that his injury is the "major contributing cause" of those conditions. Albany General Hospital v. Gasperino, 113 Or App 670 (1992). SAIF contends that the

Referee erred in relying on Dr. Gallant's medical opinion in finding that claimant satisfied his burden of proving major causation. We agree.

In resolving complex medical causation issues, such as those presented here, we rely on 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). In this case, we find persuasive reasons not to rely on the medical opinion of claimant's attending physician for his vascular conditions, Dr. Gallant.

At the outset, we note Dr. Gallant's testimony that claimant's "hypercoagulable state," which he agreed was a "propensity" for developing blood clots, is not related to the compensable 1990 injury. (Trs. 52-13,19). Based on this testimony, claimant conceded during closing argument that this condition is not compensable.

We agree with SAIF's contention that Dr. Gallant's "pre-deposition" medical reports attributed claimant's thrombosis conditions in part to the noncompensable "hypercoagulable state." Although Dr. Gallant testified that claimant's blood clot disorder was a result of his "sedentary life" caused by his compensable injury, Dr. Gallant did not specifically address the contribution of claimant's noncompensable hypercoagulable state in his testimony. Inasmuch as Dr. Gallant did not weigh the relative contributions of the noncompensable clotting disorder and claimant's compensable injury, we do not find his testimony that claimant's injury is the major contributing cause of the vascular conditions to be well-reasoned. Therefore, we do not find his opinion persuasive. Somers v. SAIF, supra.

We find additional support for our conclusion that claimant has not proved a major causal connection between his thrombi and his compensable injury in Dr. Thomas' report, in which he opined that claimant's renal vein thrombosis was "secondary to" the noncompensable hypercoagulable state. We also note Dr. Knox's opinion that claimant's deep vein thrombophlebitis was related to protracted bed rest necessitated by claimant's bout with pneumonia. Claimant does not contest the Referee's determination that his pneumonia is not compensable.

Since Dr. Gallant's medical opinion is the only one that attributes claimant's vascular conditions to the compensable injury, and we have determined that it is not persuasive, it follows that claimant has failed to sustain his burden of proof. Accordingly, we reverse the Referee's decision on this issue and reinstate SAIF's denial of those conditions.

Psychological Claim

We also analyze claimant's psychological condition as an indirect consequence of his compensable injury. Thus, claimant must prove that his compensable injury is the major contributing cause of his mental disorder diagnosed as depression. Albany General Hospital v. Gasperino, supra.

There are three physicians who address the compensability of claimant's psychological condition: Drs. Gallant, Knox and Parvaresh. SAIF contends that, if we find that claimant's vascular conditions are not compensable, we should find the psychological claim not compensable based on Dr. Parvaresh's medical opinion. While we have determined that claimant's thrombosis conditions are not compensable, we, nevertheless, conclude that claimant has sustained his burden of proving that he suffers from compensable depression.

Dr. Knox opined that claimant's compensable injury was the major contributing cause of claimant's depression. However, Dr. Knox provided no explanation for his conclusion. This is an especially significant weakness given claimant's numerous medical problems, some of which are compensable and others which are not. Because we cannot determine whether Dr. Knox was basing his opinion on compensable or noncompensable medical conditions, we do not consider Dr. Knox's unexplained medical opinion to be persuasive. See Frances C. Johnson, 46 Van Natta 206, 208 (1994) (unexplained medical opinion regarding etiology of psychological condition found unpersuasive), aff'd Legacy Health Systems v. Johnson, 132 Or App 369 (1995). It, therefore, follows that resolution of the causation issue depends on an evaluation of Dr. Gallant's and Dr. Parvaresh's medical opinions.

Dr. Gallant testified that the compensable 1990 injury was the major contributing cause of claimant's depression. (Tr. 52-13). SAIF asserts that Dr. Gallant's opinion is not persuasive because he is not a psychiatrist and because he did not differentiate between compensable and noncompensable conditions in concluding that claimant's injury and sequelae were the major contributing factors in claimant's depression. We disagree with SAIF's assertions.

We do not discount Dr. Gallant's medical opinion for lack of expertise. Although Dr. Gallant is not a psychiatrist, this does not, by itself, mean that his opinion is not entitled to weight. See Barrett v. Coast Range Plywood, 264 Or 641, 649 (1987); Keith J. Prondzinski, 46 Van Natta 290, 291 (1994). Moreover, Dr. Gallant testified that he frequently treats depression in his practice, sometimes in conjunction with a psychiatrist or neurologist, and sometimes on his own. (Tr. 52-22). Dr. Gallant further testified that, because of this, he does not necessarily defer to the opinion of a psychiatrist. (Id.)

We also find that Dr. Gallant's opinion establishes that compensable stressors are the major contributing cause of his mental disorder. While Dr. Gallant admitted that noncompensable factors such as claimant's thrombosis conditions played a role in claimant's depression, he testified that claimant's neck pain was the "predominant feature" in claimant's condition. (Tr. 52-23). Inasmuch as claimant's neck pain is a compensable component of the claim, we conclude that the compensable injury and its compensable sequelae (neck pain and diminished quality of life because of the neck pain) are the major contributing cause of claimant's psychological condition. See Albert H. Olson, 46 Van Natta 1848, 1850 (1994) (impact of disabling injury, including emotional response to physical inability to work, determined major cause of depressed condition).¹

We do not find Dr. Parvaresh's opinion to be more persuasive. Although he is a psychiatrist, Dr. Parvaresh examined claimant only one time when claimant did not display evidence of depression. Dr. Parvaresh also wrote that claimant was difficult to interview and not very informative. (Ex. 45-6). Given his greater familiarity with claimant through extensive treatment of claimant's psychological condition, we find Dr. Gallant's assessment of the etiology of claimant's mental disorder to be more persuasive. See Diane C. Marquardt, 46 Van Natta 980, 982 (1994) (opinions of treating internist and psychologist given greater weight than one-time examination of psychiatrist).²

Therefore, we agree with the Referee that claimant sustained his burden of proving that he suffers from a compensable mental disorder. Accordingly, we affirm the Referee's decision setting aside SAIF's denial of claimant's psychological condition.

Attorney Fees

The Referee awarded claimant's counsel an assessed attorney fee of \$3,000 for services rendered in reversing SAIF's denial of both the vascular and psychological conditions. Inasmuch as we have reinstated SAIF's denial of claimant's vascular conditions, we must reduce the Referee's combined attorney fee. In determining the proper assessed attorney fee under ORS 656.386(1), we, therefore, consider only the compensable psychological condition.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find a reasonable assessed attorney fee for claimant's counsel's services at hearing regarding the psychological claim is \$2,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompenstated.

¹ We recognize that we have previously found Dr. Gallant's opinion unpersuasive with respect to the etiology of claimant's vascular condition. However, in contrast to that medical opinion, Dr. Gallant properly weighed both compensable and noncompensable factors in arriving at his conclusion regarding the causation of claimant's depression. (Ex.52-22, 23). Thus, we are persuaded by Dr. Gallant's evaluation of the etiology of that condition.

² SAIF also contends that Dr. Gallant's opinion is not persuasive because, unlike Dr. Parvaresh, he did not take a detailed history regarding a number of off-the-job stressors in claimant's life. We do not find SAIF's argument persuasive. Inasmuch as Dr. Parvaresh did not attribute claimant's psychological problems to these factors, we do not find Dr. Gallant's failure to consider these stressors to be significant.

Claimant's counsel is entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the psychological condition is \$600, 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 and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated is affirmed in part and reversed in part. That portion which set aside SAIF's denial of claimant's vascular conditions is reversed. The portion of SAIF's denial concerning claimant's vascular conditions is reinstated and upheld. The Referee's attorney fee award of \$3,000 for services at hearing is reduced to \$2,500. The remainder of the Referee's order is affirmed. Claimant's counsel is awarded an assessed attorney fee of \$600 for services on review, to be paid by SAIF.

April 7, 1995

Cite as 47 Van Natta 667 (1995)

In the Matter of the Compensation of
DONALD A. RAINES, Claimant
WCB Case No. 94-03865
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Steven D. Hallock, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Referee Crumme's order that: (1) increased claimant's unscheduled permanent disability award for low back injury from 12 percent (38.4 degrees), as granted by an Order on Reconsideration, to 19 percent (60.80 degrees); and (2) assessed an attorney fee pursuant to ORS 656.382(2). Claimant cross-requests review, arguing that the Referee erred by offsetting a prior permanent disability award of 10 percent. On review, the issues are extent of unscheduled permanent disability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for findings 13 and 14.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The insurer contends that the Referee erred by increasing claimant's adaptability factor from one to five and by increasing claimant's skills factor from one to two. 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 October 27, 1993 Determination Order (those contained in WCD Admin. Order 6-1992) apply to claimant's claim. See Marlin D. Rossback, 46 Van Natta 2371 (1994); Cornell D. Garrett, supra.

Stipulated Values

At hearing, the parties stipulated to the value of 9 percent for impairment, 1 percent for age, 1 percent for formal education and zero for training. (Tr. 3). Although the Referee found that the parties stipulated as to these values under the former temporary rules, we do not interpret the parties' stipulation as an attempt to specify which standards apply. See Dana W. Wood, 44 Van Natta 2241 (1992). Therefore, we adopt the parties' stipulations and apply them under the applicable standards.

Skills

The Referee found that the DOT code that most accurately described claimant's job duties with the employer was "welder, arc," DOT 810.384-014. The insurer argues that claimant's job description is "welding supervisor," DOT 819.131-014. The job duties of a "welding supervisor," DOT 819.131-014, include supervising and coordinating activities, analyzing work orders, requisitioning supplies, inspecting work and training workers. Contrary to the insurer's argument, the record does not establish that claimant's job duties consisted primarily of supervising and training workers and coordinating activities. Rather, we agree with the Referee that claimant performed mostly nonsupervisory duties. Therefore, we agree that the DOT code that most accurately described claimant's job duties with the employer was "welder, arc," DOT 810.384-014.

The insurer argues that the Referee erroneously increased the "skills" factor from one to two, because he used an SVP rating of five, instead of eight. The occupation of "welder, arc," DOT 810.384-014 is assigned an SVP of 5, entitling claimant to a skills value of 2. See former OAR 436-35-300(4)(e).

Adaptability

Claimant's adaptability value is based on the strength demands of his job at the time of injury compared with his maximum residual functional 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 in the DOT for the worker's job at injury. Former OAR 436-35-270(3)(g).

The insurer contends that the Referee erred in changing the adaptability factor from one to five because he mistakenly rated claimant's job as "heavy" when the evidence indicated that it was actually "light." The insurer contends that the 20-pound lifting restriction imposed by claimant's attending physician in 1984 was permanent and demonstrates that claimant's prior strength was light.

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 436-35-270(3)(g); Marlin D. Rossback, supra; Cornell D. Garrett, supra.

Although the insurer relies on the "permanent" 20-pound lifting restriction imposed in 1984, the evidence establishes that the restriction was not permanent. On October 11, 1984, Dr. Heusch, claimant's attending physician, restricted claimant's lifting to not more than 20 pounds. (Ex. 10). Dr. Heusch's subsequent reports, however, indicate that the lifting restriction was not permanent. In October 1991, Dr. Heusch reported that claimant is "required to do heavy lifting as a welder." (Ex. 17). In March 1992, Dr. Heusch reported that claimant "continues to work as a welder which is doing heavy work with a lot of pushing and especially pulling motor heads." (Ex. 18).

Although claimant testified that he changed the way he worked after the 1984 back surgery, he continued to do heavy work at his employer's insistence. At hearing, the insurer asked claimant whether he had stopped pushing the heavy stuff around on the carts after the 1984 surgery. Claimant testified:

"I had to do it. It was my job, part of my job. I quit pulling on them. I found that when I got back to work that I could not pull anymore on the casting bench, and I did ask the company for lighter work, and they definitely said no. So I had to continue on as far as I could go with it." (Tr. 13-14).

Claimant testified that he had difficulty doing his regular work but he continued to do it anyway. (Tr. 17-18).

Although the insurer contends that claimant's job should be classified as "welding supervisor," we previously concluded that claimant's job was "welder, arc," DOT 810.384-014. The DOT describes this job as a heavy-strength job. Based on the record, we conclude that the DOT description that most accurately describes claimant's job establishes his strength category as heavy.

At the time of reconsideration, claimant had the physical capacity to do "light/medium" work with the restrictions that he avoid frequent stooping, crouching, crawling, and twisting. (Ex. 25-4). Thus, claimant's RFC was light/medium work. Former OAR 436-35-270(3)(d) and (e). Thus, the comparison of strength demands at the time of injury and the RFC establishes an adaptability value of 5. Former OAR 436-35-310(3) and (4).

Computation of Unscheduled Disability

Having determined each of the values necessary under the standards, we calculate claimant's unscheduled permanent disability. When claimant's age value of 1 is added to the formal education value of 1 and the skills value of 2, the sum is 4. When that value is multiplied by claimant's adaptability value of 5, the product is 20. When that value is added to claimant's impairment value of 9, the result is 29 percent unscheduled permanent disability award. See OAR 436-35-280.

Consideration of Prior Award

Claimant cross-requests review, contesting the Referee's conclusion that claimant was entitled to a 19 percent unscheduled permanent disability award. Specifically, claimant argues that the Referee erred by "offsetting" claimant's award by 10 percent due to his 1984 permanent disability award.

In September 1978, claimant strained his low back at work. The employer's workers' compensation insurer at that time, the SAIF Corporation, accepted the claim. Claimant's 1978 injury claim was reopened in January 1984 due to a worsening that required a decompressive laminectomy in March 1984. On November 30, 1984, claimant's SAIF claim was closed with an award of 10 percent unscheduled permanent disability for his low back. (Ex. 11). In early April 1991, claimant suffered increased low back and left leg symptoms at work. Cigna, the insurer in this case, was eventually found responsible for the "new injury" claim. (Ex. 19).

A claimant is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, 42 Van Natta 2846, 2850 (1990). Because claimant previously was awarded 10 percent unscheduled permanent disability for his low back, we consider such award in arriving at the appropriate permanent disability for the current injury. See ORS 656.214(5); OAR 436-35-007(3)(b); Patrick D. Whitney, 45 Van Natta 1670, 1671 (1993). This determination requires a comparison of the current extent of disability under the standards with the prior permanent disability award to decide if the current award reflects any preexisting disability for which the claimant received benefits. OAR 436-35-007(3)(b); Patrick D. Whitney, supra. If the preexisting disability is included in the current award, the award is reduced by an amount that represents the previously compensated loss of earning capacity. Id.

Claimant argues that it was the new injury in 1991 that diminished his earning capacity. We disagree. After claimant's 1984 back surgery, Dr. Heusch reported that claimant had range of motion forward flexion of 70 degrees, hyperextension 30 degrees and right and left lateral bending 30 degrees. (Ex. 10). Based on the surgery and these limitations, claimant was granted 10 percent permanent partial disability in November 1984. In December 1993, following his 1991 compensable "new injury," claimant had the physical capacity to do "light/medium" work with the restrictions that he avoid frequent stooping, crouching, crawling, and twisting. (Ex. 25-4). These restrictions exceeded those which had been previously established following the 1984 surgery.

Claimant also contends that he had returned to his duties and was not exhibiting impairment from the prior condition. We agree that claimant returned to his previous work duties. However, claimant testified that after the 1984 surgery, his back hurt quite often and he continued to get worse.

We conclude that claimant continued to suffer some impairment resulting from his prior compensable injury and surgery. On the other hand, although claimant changed the way he worked after the 1984 surgery, he did return to his former work duties. Under these circumstances, we conclude

that 24 percent of the current award represents permanent disability which was not present prior to the 1991 "new injury." Therefore, claimant is entitled to an award of 24 percent unscheduled permanent disability as "due to" the 1991 injury. Accordingly, claimant's award shall be increased from 19 percent to 24 percent.

Assessed Attorney Fee

Finally, the insurer argues that the Referee erroneously awarded claimant an assessed attorney fee under ORS 656.382(2) for prevailing against the insurer's request for hearing. The insurer contends that claimant is not entitled to an assessed fee because his compensation was reduced when the Referee allowed the insurer's request to apply a 10 percent offset. We disagree.

Claimant's attorney is entitled to an assessed fee under ORS 656.382(2). The insurer requested a hearing on the Order on Reconsideration which had awarded 12 percent unscheduled permanent disability, and the Referee concluded that claimant's permanent disability compensation should not be disallowed or reduced. In fact, the Referee increased claimant's award to 19 percent. On review, we have further increased claimant's award to 24 percent (76.80 degrees) permanent disability, a net increase of 12 percent from the Order on Reconsideration award of 12 percent (38.40 degrees).

Thus, due to application of the "offset" from claimant's prior award, his total award under this claim is less than he would otherwise be granted. Nonetheless, claimant not only successfully defended against the insurer's hearing request which attempted to reduce or eliminate claimant's 12 percent permanent disability award granted by the Order on Reconsideration, but he has also prevailed over the insurer's attempt to reduce or eliminate the Referee's 19 percent permanent disability award. Accordingly, claimant is entitled to a carrier-paid attorney fee for services rendered at both the hearing level and 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 concerning the insurer's request for review regarding the permanent disability issue is \$ 1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services related to the attorney fee issue. Finally, we affirm the Referee's \$800 attorney fee award under ORS 656.382(2).

ORDER

The Referee's order dated August 5, 1994 is modified in part and affirmed in part. In addition to the Referee's and Order on Reconsideration's awards of 19 percent (60.80 degrees), claimant is awarded an additional 5 percent (16 degrees) unscheduled permanent disability, giving him a total award to date of 24 percent (76.80 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total "out-of-compensation" attorney fees granted by the Referee's and Board orders shall not exceed \$3,800. For services on review, claimant's counsel is awarded an assessed fee of \$1,000, to be paid by the insurer. The remainder of the Referee's order is affirmed.

April 7, 1995

Cite as 47 Van Natta 670 (1995)

In the Matter of the Compensation of
GLORIA A. VANEEKHOVEN, Claimant
 WCB Case Nos. 94-06256 & 94-05118
 ORDER ON REVIEW
 Bischoff & Strooband, Claimant Attorneys
 Meyers, Radler, et al., Defense Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Spangler's order which: (1) upheld Scott Wetzell's compensability and responsibility denial on behalf of the self-insured employer (Albertson's,

Inc.) of claimant's current low back condition; and (2) upheld Liberty Northwest's compensability and responsibility denial on behalf of Family Resources, Inc., of the same condition. On review, the issue is compensability and, potentially, responsibility.

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

Claimant sustained a compensable low back injury on June 1, 1991, while employed by the self-insured employer, Albertson's. Claimant received no permanent disability as a result of a November 1992 Determination Order and subsequent March 1993 Order on Reconsideration. Claimant and Albertson's entered into a Claim Disposition Agreement in August 1993.

In the meantime, claimant began working for Liberty's insured in June 1992. Claimant alleges that, on February 16, 1994, she was sitting on the floor with a co-worker (Smith-Tracy), rose quickly to answer a telephone, and then felt a sharp jabbing pain in her low back. Claimant testified that she discussed her injury with Smith-Tracy and reported her injury to her supervisor (Hallgrimson) on February 21, 1994. Claimant did not seek medical treatment until March 2, 1994, when she filed her form 801 alleging that she had injured herself.

At hearing, Hallgrimson disputed several aspects of claimant's testimony, including the mechanism of injury and the date she was informed of the alleged injury. The Referee reasoned that, in light of the inconsistencies in the testimony of claimant and Hallgrimson, as well the existence of medical records that contradicted claimant's testimony regarding the history of her low back symptoms, claimant was not a credible witness. Accordingly, the Referee concluded that claimant had failed to sustain her burden of proving that her current low back condition was compensable.

On review, claimant contends that the Referee's credibility determination is not entitled to deference inasmuch as it was not based on demeanor, but rather on objective evaluation of the substance of her testimony. Claimant is correct. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Davies v. Hanel Lumber Co., 67 Or App 35 (1984); Christopher C. Ciongoli, 46 Van Natta 1906 (1994). However, based on our de novo review of the record, we agree for the reasons stated in the Referee's order that claimant is not a credible witness.

Claimant also directs our attention to the fact that Liberty failed to call Smith-Tracy, whom she asserts was present at the hearing at the employer's "behest," to testify regarding the circumstances of the alleged injury. Citing ORS 10.095, claimant contends that, because Liberty did not call Smith-Tracy to testify, we should view Hallgrimson's testimony with distrust.¹ We disagree.

In Roberts v. SAIF, 18 Or App 590, 593 (1974), the court stated that former ORS 17.250(7) (now ORS 10.095(8)) "ha[d] application in this type case as well." Specifically, the court held that the claimant failed to prove that he sustained a compensable injury in the course of his employment when he failed to produce his fellow worker whom he claimed witnessed his injury, or placed any reason in the record why the co-worker was not called.

The circumstances of this claim are similar to those in Roberts. Here, claimant also has the burden of proof. Like the claimant in Roberts, she, too, failed to produce a co-worker who could corroborate her testimony regarding the circumstances of her injury, or placed any reason in the record why Smith-Tracy was not called.² Therefore, were we to apply any significance to the lack of

¹ ORS 10.095 provides, in pertinent part:

"(7) That evidence is to be estimated, not only by its own intrinsic weight, but also according to the evidence which it is in the power of one side to produce and of the other to contradict; and, therefore,

"(8) That if weaker and less satisfactory evidence is offered when it appears that stronger and more satisfactory was within the power of the party, the evidence offered should be viewed with distrust."

² Claimant asserts that Smith-Tracy was present at the hearing at the employer's "behest." The cited portion of the hearing transcript appears to indicate that Smith-Tracy was outside the hearing room, but does not verify claimant's assertion that she was present at the employer's "behest." (Tr. 45).

testimony from co-worker Smith-Tracy, we would construe the failure to call Smith-Tracy against claimant. See Kirk Meyers, 42 Van Natta 2757 (1990) (where the claimant did not produce witnesses at hearing who could allegedly verify that he was injured at his job, the claimant failed to sustain his burden of proving that he injured his knee in the course and scope of his employment). Consequently, in addition to the reasoning expressed by the Referee, we conclude that claimant failed to sustain her burden of proof.

Finally, claimant cites medical evidence in support of her contention that she sustained a "new injury." (Exs. 38, 47, 48). However, this medical evidence was based on claimant's history of an injury on February 16, 1994. Inasmuch as this history is "subject to the infirmities of claimant's credibility," we do not find it persuasive evidence that claimant injured herself in the course and scope of her employment. Roberts, supra, at 593.

ORDER

The Referee's order dated September 23, 1994 is affirmed.

April 7, 1995

Cite as 47 Van Natta 672 (1995)

In the Matter of the Compensation of
DARLENE L. VANOVER, Claimant
 WCB Case No. 94-03565
 ORDER ON REVIEW
 Malagon, Moore, et al., Claimant Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The insurer requests review of those portions of Referee Livesley's order that: (1) awarded claimant interim compensation; and (2) reserved for later hearing the reclassification issue. On review, the issues are interim compensation and jurisdiction. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction, replacement, and supplementation. Claimant returned to light duty work on May 10, 1993.

We replace the findings of ultimate fact with the following. Claimant is not entitled to interim compensation for the three day period beginning May 5, 1993 and ending May 7, 1993. Claimant is entitled to interim compensation in the form of: (1) temporary partial disability (TPD) from May 10, 1993 through May 20, 1993; (2) temporary total disability (TTD) from May 24, 1993 through June 3, 1993; and (3) TPD from June 4, 1993 through August 4, 1993, the date of claim acceptance.

In addition, we offer the following supplementation and summary of the pertinent facts. Claimant injured her left shoulder at work on Tuesday, May 4, 1993. The employer first knew of this injury on May 6, 1993. (Ex. 2).

Claimant's normal work schedule was from 8:00 a.m. to 4:00 p.m., Monday through Friday, with the weekends off. (Ex. 2). Claimant finished her shift on Tuesday, May 4, 1993, the date of injury. She was off work due to the injury for the next three work days (from May 5, 1993, through May 7, 1993). She returned to light duty work on the following work day, Monday, May 10, 1993. She continued working light duty through May 20, 1993, and returned to regular work on Friday, May 21, 1993. (Exs. 1, 2, 2A, 3, 3A, 4).

On Monday, May 24, 1993, Dr. Nolan took claimant off work for 48 hours and referred her to Dr. Jany, orthopedist, who became claimant's attending physician. (Ex. 3, 4A, 5, 6). On May 25, 1993, Dr. Jany took claimant off work for six weeks. (Ex. 6-2). On June 1, 1993, Dr. Jany approved a written offer of a light duty job submitted by the employer. (Ex. 7). This job consisted of hanging clothes at a store and paid claimant's regular wage. (Exs. 2, 7-2; Tr. 24-26).

On June 4, 1993, claimant accepted this modified job offer, worked one day, and quit. (Ex. 7-3, Tr. 24-25). When claimant quit the modified job, it remained available to her. (Tr. 26-27). Claimant has not worked since. (Tr. 24).

On August 4, 1993, within 90 days from the employer's notice of the injury, the insurer accepted left shoulder impingement syndrome as nondisabling. (Ex. 10). The insurer paid no interim compensation on the claim.

On August 19, 1993, claimant requested that Dr. Jany take her completely off work. (Ex. 11). Dr. Jany refused to do so, found claimant continued to be released for light duty work, and left unchanged the release to the light duty modified job he had made on June 1, 1993. Id.

On March 23, 1994, the Hearings Division received claimant's request for hearing. Claimant identified "any and all" denials, compensability, temporary partial disability, temporary total disability, and failure to pay temporary total disability as those issues to be litigated at hearing.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that her claim should be reclassified as disabling either directly by the Referee or, in the alternative, under an aggravation theory pursuant to ORS 656.273. (Tr. 2-4, 18). In that regard, claimant raised the issue of a "de facto" denial of an aggravation claim. The insurer claimed surprise and the Referee allowed the insurer's motion to reserve the aggravation issue for a subsequent hearing. (Tr. 1-20). The insurer also argued that the Referee lacked jurisdiction over the reclassification issue. (Tr. 2, 5). The Referee went forward on the issue of claimant's entitlement to "time loss on the claim at the present time in its nondisabling status." (Tr. 20).

Jurisdiction

In his order, the Referee reasoned that it was impossible to proceed on the issue of reclassification where "claimant's arguments appear to rely on interpretations of all of the statutes involved in reclassification, including ORS 656.273," and where the aggravation theory was claimed as surprise by the insurer and postponed for a subsequent hearing. Therefore, the Referee reserved the reclassification issue for later hearing. In addition, the Referee declined to address the jurisdiction issue, noting that the insurer raised the issue of jurisdiction only in regard to the reclassification issue.

On review, the insurer renews its argument that claimant's request for reclassification must be dismissed for lack of jurisdiction. We agree.

If within a year after the injury, a worker claims that a nondisabling injury is disabling, the request for reclassification must be presented to the Director for determination pursuant to ORS 656.268. ORS 656.277(1). Such a claim made more than a year after the date of injury must be made pursuant to ORS 656.273 as a claim for aggravation. ORS 656.277(2).

We find our decision in Charles B. Tyler, 45 Van Natta 972 (1993), directly on point. In Tyler, the claimant's injury claim had been accepted and classified as nondisabling almost eight months after the date of injury. More than a year after the date of injury, the claimant requested reclassification of the claim as disabling. Relying on Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993), we concluded that the claimant had sufficient time to challenge his claim classification within one year from the date of injury. We held that the claimant's reclassification request was untimely and, therefore, he must make the claim as an aggravation claim pursuant to ORS 656.273. See ORS 656.277(1), (2). Compare Donald R. Dodgin, 45 Van Natta 1642 (1993) (applying Degrauw, supra, and determining that where the claim was first accepted as nondisabling more than a year after the date of injury, thereby precluding the claimant, through no fault of his own, from seeking reclassification by the Director of the nondisabling classification, the claimant may object to the initial claim classification by requesting a hearing).

Here, the insurer accepted the claim as nondisabling on August 4, 1993, three months after the date of the May 4, 1993 injury. (Ex. 10). The notice of acceptance included a statement of claimant's right to request reclassification as required by ORS 656.262(6). Thus, claimant had nine months within which to request the Director to reclassify her claim. There is no evidence that claimant requested reclassification of her claim until she raised the issue of reclassification at the July 19, 1994 hearing. This request for reclassification occurred more than a year after the date of injury.

In addition, the exception developed in Degrauw and Dodgin which allowed those claimants to request reclassification more than a year after the date of injury by means of a hearing does not apply here. This is not a situation where the insurer accepted the claim as nondisabling more than a year after the date of injury and thereby precluded claimant, through no fault of her own, from seeking reclassification from the Director. Instead, here, claimant's claim was accepted well within a year from the date of injury and she had ample time within which to request reclassification from the Director.

Accordingly, we conclude that, because claimant requested reclassification of her claim more than a year after the date of injury, neither the Director, the Hearings Division, nor the Board has jurisdiction over the request. Instead, claimant must make her claim as one for an aggravation. Charles B. Tyler, supra; Dennis Hutchison, 46 Van Natta 539 (1994). Because the aggravation issue was reserved for a subsequent hearing, we do not address that issue on review.

Interim Compensation

The Referee found claimant entitled to interim compensation in the form of TTD for six days (May 24, 25, 26, 27, 28, and 31) and TPD thereafter through the date of acceptance.¹ For the reasons discussed below, we modify the Referee's award.

As a preliminary matter, we note that the insurer argues that, because claimant failed to request reclassification of her claim to disabling status within a year from the date of injury, she is barred by claim preclusion from denying that her claim is nondisabling. Furthermore, the insurer argues, because nondisabling claims do not have time loss, the Board should find that claimant is not entitled to time loss. As discussed above, by statute, claimant is not precluded from establishing that her nondisabling claim became disabling. However, because she raised this issue more than a year after the date of injury, she must make the claim pursuant to ORS 656.273 as an aggravation claim. ORS 656.277(2).

To the extent that the insurer's arguments may be read to contend that we do not have jurisdiction over the issue of entitlement to interim compensation on a claim accepted as nondisabling, we disagree with that contention. In Ralph E. Fritz, 44 Van Natta 1168 (1992), we held that we had jurisdiction to address claimant's entitlement to interim compensation benefits in a claim that had been accepted as nondisabling. There, the claim was closed by a Notice of Closure and the claimant subsequently requested a hearing raising, inter alia, the issues of TTD and TPD. On review, we found that claimant's specification of issues could reasonably be interpreted as raising the issue of interim compensation. Relying on Steven V. Bischof, 44 Van Natta 225, on recon 44 Van Natta 433 (1992), we found that the actual issue presented was the claimant's procedural entitlement to temporary disability benefits rather than the disabling/nondisabling issue which was within the Director's jurisdiction.

In the present case, claimant's claim has been accepted, albeit as nondisabling. Therefore, claimant's "interim compensation" takes the form of TTD and TPD. See Sandra L. Berkey, 41 Van Natta 944, 945 (1989). We find no material distinction between Fritz and the present case. Fritz holds that the Board and Hearings Division have jurisdiction to address a claimant's entitlement to interim compensation benefits because that issue concerns the claimant's procedural entitlement to temporary disability rather than whether or not the claim is disabling or nondisabling. Accordingly, based on Fritz, we conclude that we have jurisdiction to address claimant's "procedural" entitlement to interim compensation (TTD or TPD).

"Interim compensation" is temporary disability payments made between the employer's notice of injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n. 1 (1984). A claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim. See ORS 656.262(4)(a); Stone v. SAIF, 57 Or App 808, 812 (1982). Medical verification of an inability to work is not required in order to receive interim compensation for an initial injury. ORS 656.262; Shirley A. Bush, 43 Van Natta 59 (1991).

¹ The Referee identified the date of acceptance as August 27, 1993. However, the claim was accepted on August 4, 1993. (Ex. 10).

Although a claimant is entitled to interim compensation whether or not the claim is proved compensable, there is no duty to pay such compensation if the worker has not "left work" as a result of the injury pursuant to ORS 656.210(3). See Bono v. SAIF, *supra*, 298 Or at 408, 410. A worker may "leave work" by either being absent from work or having sustained diminished earning power due to the work injury. Bono v. SAIF, *supra*; Randel G. Jensen, 45 Van Natta 898 (1993), *affirmed* RSG Forest Products v. Jensen, 127 Or App 247 (1994). However, a claimant who is absent from work for reasons unrelated to the injury is not entitled to interim compensation. Nix v. SAIF, 80 Or App 656 (1986).

Claimant completed her shift on May 4, 1993, and was off work due to the injury for the next three work days (from May 5, 1993, through May 7, 1993). She returned to light duty work on the following work day, Monday, May 10, 1993. She continued working light duty through May 20, 1993, and returned to regular work on Friday, May 21, 1993. (Exs. 1, 2, 2A, 3, 3A, 4). Thus, claimant was absent from work due to the injury during this time period for a total of three days. However, no disability payment is recoverable for TTD suffered during the first three calendar days after the worker leaves work as a result of the injury unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital. ORS 656.210(3). Therefore, claimant is not entitled to interim compensation for the period from May 5, 1993 through May 7, 1993.

On Monday, May 24, 1993, Dr. Nolan took claimant off work for 48 hours and referred her to Dr. Jany, orthopedist, who became claimant's attending physician. (Ex. 3, 4A, 5, 6). On May 25, 1993, Dr. Jany took claimant off work for six weeks. (Ex. 6-2). However, on June 1, 1993, Dr. Jany approved a written offer of a light duty job submitted by the employer. (Ex. 7). This job consisted of hanging clothes at a store and paid claimant's regular wage. (Exs. 2, 7-2; Tr. 24-26).

On June 4, 1993, claimant accepted this modified job offer, worked one day, and quit for reasons unrelated to her injury. (Ex. 7-3, Tr. 24-25). Because claimant accepted this job on June 4, 1993, and testified that she only worked one day before quitting, we conclude that she returned to modified work on June 4, 1993. Thus, claimant was absent from work due to the injury from May 24, 1993 through June 3, 1993, a total of nine work days. Accordingly, claimant is entitled to interim compensation in the form of temporary total disability for these nine days.

However, a question is presented as to whether claimant is entitled to interim compensation in the form of temporary partial disability during the following periods: (1) the period from May 10, 1993 through May 20, 1993, while claimant performed modified (light duty) work; and (2) the period from June 4, 1993 through August 4, 1993, the date the insurer accepted the claim, during which time claimant was released only to modified (light duty) work. Based on the following reasoning, we conclude that claimant is so entitled.

During the periods in question, claimant was not released to regular work. In addition, she remained released to only modified work at the time she left the modified job.

When a claimant is released to modified work at or above his or her regular wages, the claimant is entitled to TPD, even though the actual rate of TPD may be computed to be zero. Sharman R. Crowell, 46 Van Natta 1728, 1729 (1994) (citing Kenneth W. Metzker, 45 Van Natta 1631, 1632 (1993) and Valorie L. Leslie, 45 Van Natta 929 (1993), *rev'd on other grounds* Leslie v. U.S. Bancorp, 129 Or App 1 (1994)). Here, because claimant was released to modified work for the periods in question, although the modified job provided paid her regular at-injury wage, she is entitled to interim compensation in the form of TPD, albeit perhaps at the rate of zero once her TPD is calculated. Sharman R. Crowell, *supra*; Joseph M. Lewis, 47 Van Natta 381 (1995).

In reaching this conclusion, we note that the Bono Court recognized that a worker's entitlement to interim compensation is not contingent on total disability. Bono, *supra* at 298 Or 410. In addition, we apply the court's holding 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 TPD because she had been discharged from her modified job for reasons unrelated to her compensable injury. Computing the claimant's TPD under former 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 former 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 may be of great, little, or no importance in determining whether the worker has a diminution in "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.

Here, from May 10, 1993 through May 20, 1993, claimant performed modified (light duty) work. The fact that she was unable to perform her regular job establishes a diminished earning capacity during that period. Therefore, claimant is entitled to interim compensation in the form of TPD during that period. The same reasoning applies to establish that claimant is entitled to TPD during her return to modified work on June 4, 1993.

On June 5, 1993, claimant left a modified job for reasons unrelated to the compensable injury. At the time claimant left the modified job, it remained available to her. In addition, the medical evidence establishes that the modified job was within claimant's physical capacity. Specifically, Dr. Jany refused to release claimant from work and continued to find that claimant was capable of performing the modified job. (Ex. 11).

However, because claimant remained released only to modified work at the time she left the modified job, we find that she has established that her earning power was diminished by that limitation. Bono v. SAIF, supra at 298 Or 410. Accordingly, claimant is entitled to interim compensation in the form of TPD for the period from June 4, 1993 through August 4, 1993, the date of claim acceptance.

Because claimant is entitled to interim compensation in the form of TPD for the periods from May 10, 1993 through May 20, 1993 and from June 4, 1993 through August 4, 1993, she is now entitled to a calculation of the TPD rate for these periods by the insurer based on her proportionate loss of earning power at any kind of work. OAR 436-60-030; Stone v. Whittier Wood Products, supra.

Accordingly, we modify the Referee's decision regarding the interim compensation in the form of TPD, and direct the insurer to calculate claimant's TPD under the court's guidance in Stone. See OAR 436-60-030. In addition, claimant is entitled to interim compensation in the form of TTD for a total of nine work days (from May 24, 1993 through June 3, 1993).

Inasmuch as claimant did not submit an 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).

ORDER

The Referee's order dated August 15, 1994 is modified in part, reversed in part, and affirmed in part. That portion of the order that declined to address jurisdiction of the reclassification issue is reversed. Insofar as claimant's hearing request pertains to a request for reclassification, the request is dismissed for lack of jurisdiction. In lieu of the interim compensation awarded by the Referee, claimant is awarded interim compensation in the form of: (1) temporary total disability for a total of nine days, from May 24, 1993 through June 3, 1993; and (2) temporary partial disability (TPD) for the periods from May 10, 1993 through May 20, 1993 and from June 4, 1993 through August 4, 1993. The insurer is directed to calculate claimant's TPD as previously set forth in this order. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, payable directly by the insurer to claimant's attorney. However, the total "out-of-compensation" attorney fee payable by the Referee's order and this order shall not exceed \$1,050. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JESSE G. AYALA, Claimant
WCB Case No. 93-10025
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Referee Holtan's order that: (1) affirmed a Director's order finding claimant not eligible for vocational assistance; and (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable resistance to providing vocational assistance. On review, the issues are vocational assistance and penalties.

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

We briefly summarize the facts. SAIF sent, and claimant received, a total of three requests for information regarding his education and work history, which was material to his eligibility for vocational assistance. Claimant did not respond to the first two requests.¹ The third request, which was denominated "WARNING LETTER," advised claimant that his failure to respond within 10 days would result in a finding of ineligibility for vocational assistance. SAIF allowed claimant 10 days from his receipt of the warning letter to respond. Claimant responded approximately 12 days after his receipt of the letter. Several days after SAIF received claimant's untimely response, it issued a Notice of Ineligibility for Vocational Assistance. Claimant requested Director review of SAIF's decision. The Director found claimant ineligible for vocational assistance on the basis of claimant's failure to cooperate with SAIF's requests for information.

The Director's order may be modified only if it violates a statute or rule, exceeds statutory authority, was made on unlawful procedures, or was characterized by an abuse of discretion or clearly unwarranted exercise of discretion. ORS 656.283(2). Claimant asserts that the Director violated former OAR 436-120-045(6) (since renumbered OAR 436-120-350(7) (WCD Admin. Order 94-058 (October 31, 1994))) in finding him ineligible for vocational assistance.² Claimant argues that, because SAIF received his eventual, albeit late, response to the warning letter before it sent him the ineligibility notice, he fully cooperated with SAIF's requests. We disagree.

As a preliminary matter, we find that the hearing before the Referee satisfied the procedures required in a contested case. Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993).

Former OAR 436-120-045(6) provides that eligibility for vocational assistance ends if "[t]he worker has failed, after written warning, to fully participate in an evaluation of eligibility or a vocational evaluation as required by the insurer, or to provide requested information which is material to such evaluations." (Emphasis added). This rule predicates a worker's eligibility for vocational assistance on his or her "full" participation with evaluations and requests for information "as required by" the carrier. The rule gives a carrier considerable leeway in determining what information it needs, and how to obtain it. This includes establishing reasonable time limits within which a claimant must respond to a written warning. See Earnest E. Lasley, 43 Van Natta 386 (1991), aff'd Lasley v. Ontario Rendering, 114 Or App 543 (1992) (Board unable to conclude that Director abused discretion in finding the claimant ineligible for vocational assistance when the claimant failed to cooperate with carrier's request for information within a certain time frame).

Here, SAIF's "warning letter," which was its third request for information, advised claimant that he had 10 days to respond or risk a finding of ineligibility for vocational assistance. Under former OAR 436-120-045(6), SAIF was authorized to impose that time limit; moreover, under the circumstances of

¹ Claimant admitted that he did not respond to the first two requests because he "kept putting it off." (Ex. 38-2).

² At hearing, claimant asserted that the Director had abused his discretion. Although claimant does not press that argument on review, for the reasons set forth in this order, we would reject an abuse of discretion argument.

this case, we find the 10-day limit reasonable.³ Because claimant did not respond within the time limit, and because he totally ignored SAIF's first two requests for information, we agree with the Director that claimant failed to participate fully with SAIF's requests for information. Our conclusion is not altered by the fact that claimant eventually responded to SAIF's requests for information, or that SAIF received the information before it issued the ineligibility notice.

Under the circumstances, we hold that the Director did not violate former OAR 436-120-045(6) by finding that claimant was ineligible for vocational assistance. Accordingly, the Referee's order affirming the Director's order is affirmed.

ORDER

The Referee's order dated June 16, 1994, and reconsidered July 14, 1994, is affirmed.

³ Claimant asserts that SAIF's imposition of the 10-day deadline violates the policy underlying ORS 656.012, which states that one of the purposes of workers' compensation law is to restore workers to self-sufficient status. That argument is without merit.

April 11, 1995

Cite as 47 Van Natta 678 (1995)

In the Matter of the Compensation of
JACK R. COOPER, Claimant
WCB Case No. 94-01253
ORDER ON REVIEW (REMANDING)
Pozzi, Wilson, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Gunn, Turner-Christian, and Haynes.

Claimant requests review of Referee Hoguet's order which: (1) denied his renewed motion for continuance of the hearing; and (2) upheld the insurer's denial of claimant's occupational disease claim for a bilateral carpal tunnel condition. Contending that the Referee erred in denying the continuance motion, claimant seeks remand. On review, the issues are evidence, remand, and, potentially, compensability. We vacate and remand.

Prior to the April 28, 1994 hearing, claimant moved for a continuance of the scheduled hearing. Specifically, claimant sought a continuance so that he could obtain a litigation report from Dr. Grimm, a physician who had not previously examined claimant, regarding the causation of his bilateral carpal tunnel syndrome.

In addition, claimant requested the opportunity to cross-examine Drs. Kappes and Grewe, treating physicians who had authored medical reports which the insurer had submitted for admission at the upcoming hearing. Recognizing claimant's right to cross-examine those physicians, the insurer did not object to claimant's "cross-examination" request. However, the insurer did object to claimant's request to continue the hearing to obtain a report from Dr. Grimm.

After telephone conference calls with the parties' counsels on April 22nd and April 25th, Assistant Presiding Referee Schultz denied the continuance motion on April 25, 1994 by written interim order. In so doing, the Referee's order expressly stated that:

"Claimant requests an opportunity to cross-examine the authors of these reports, treating Drs. Kappes and Grewe. Employer does not object to claimant's request and recognized claimant has the right to cross-examine those doctors given the timing of the submission of their reports. OAR 438-06-081; 438-06-091."

The Referee's order concluded with the reasoning that, "but for the fact that claimant has chosen to exercise his right to depose the authors of exhibits 10A and 12 [Drs. Kappes and Grewe], this record would close on Thursday, April 28, 1994 at the time of hearing."

At the hearing, the insurer withdrew submission of the reports from Drs. Kappes and Grewe. Thereafter, claimant renewed his motion for continuance. Referee Hoguet, however, denied claimant's motion, reasoning that all information presented at hearing regarding the motion for continuance was either presented or could have been presented at the time the Assistant Presiding Referee rendered his decision. Conceding that he probably had the discretion to rule on the merits of claimant's renewed motion, the Referee nevertheless declined to do so as a matter of policy. Proceeding to the merits of the claim, the Referee upheld the insurer's denial.

On review, claimant requests remand so that he may obtain a medical report from Dr. Grimm, asserting that Referee Hoguet abused his discretion in denying claimant's renewed motion for continuance. We disagree.

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

Claimant's primary argument on review is that he exercised due diligence in attempting to obtain medical evidence from Dr. Grimm prior to the hearing. Therefore, claimant asserts that he is entitled to a continuance pursuant to OAR 438-06-091(2)&(3). In order to evaluate the merits of claimant's contention, it is necessary to review the circumstances surrounding claimant's efforts to secure medical evidence from Dr. Grimm.

Claimant filed his claim for bilateral carpal tunnel syndrome on November 15, 1993. The claim was denied on December 27, 1993. On March 9, 1994, claimant's counsel met with a consulting neurosurgeon, Dr. Grewe, who opined that he could not state that claimant's occupation was the major contributing cause of his carpal tunnel condition. (Ex. 10A). According to claimant, Dr. Grewe recommended that he seek the opinion of Dr. Grimm. (Tr. 40). Claimant's counsel promptly informed claimant that he should make an appointment with Dr. Grimm. Apparently, because of financial difficulties, claimant was not able to schedule an appointment with Dr. Grimm until claimant's counsel agreed to guarantee payment of the office visit.

The record indicates that, at least by April 4, 1994, the appointment with Dr. Grimm had been scheduled for May 3, 1994, several days after the scheduled April 28, 1994 hearing. (Ex. 11). Claimant testified that it was impossible to schedule the appointment with Dr. Grimm prior to the hearing. (Tr. 39). However, claimant conceded on cross-examination that his wife made all the attempts to schedule the appointment and that he could not say whether she made one or several phone calls. (Tr. 42).

In support of his contention that he was entitled to a continuance, claimant asserts that this was not an example of "doctor shopping" and that he had no idea what kind of opinion Dr. Grimm would render. However, claimant offered no explanation as to why he did not attempt to schedule an appointment with another qualified physician when it became apparent that it would be impossible to obtain a report from Dr. Grimm prior to the hearing. Moreover, there is no evidence that Dr. Grimm was made aware of the urgency of obtaining his medical opinion prior to the hearing.

Claimant also points to the insurer's delay in providing claim documents as hindering his efforts to develop his case. However, we are not persuaded that this provides a sufficient justification for claimant's failure to obtain medical evidence to support his claim prior to hearing. Although it appears that the insurer did not timely comply with claimant's requests for claim documents on December 27, 1993 and January 28, 1994, claimant had all relevant claim documents by February 25, 1994, some two months prior to the April 28, 1994 hearing. (Ex. 10H).

Considering the circumstances surrounding claimant's attempt to obtain Dr. Grimm's medical opinion, we are unable to conclude that Referee Hoguet abused his discretion in denying claimant's renewed motion for continuance on that basis. Consequently, we do not disturb the Referee's ruling insofar as it pertains to Dr. Grimm.

Claimant also asserts that Referee Schultz's interim order acknowledged the insurer's "pre-hearing" lack of objection to claimant's right to cross-examine both Dr. Grewe and Dr. Kappes, claimant's treating rheumatologist, who also opined that he was unable to determine the cause of claimant's carpal tunnel condition. (Ex. 12). In light of the insurer's subsequent withdrawal at hearing of the aforementioned physicians' reports, claimant contends that Referee Hoguet erred in denying his request for a continuance to depose Dr. Grewe and Dr. Kappes.

As previously noted, Referee Schultz's interim order acknowledges claimant's right to depose the aforementioned physicians. It also recognized that, as the party with the burden of proof, claimant has the right to offer final rebuttal evidence. Finally, the interim order noted that the insurer did not object to claimant's right to cross-examine Drs. Kappes and Grewe.

Notwithstanding its previous acknowledgments, at the hearing, the insurer's counsel withdrew the medical reports of Drs. Grewe and Kappes. Thereafter, claimant then submitted the medical evidence withdrawn by the insurer's counsel, but his request to cross-examine Drs. Grewe and Kappes was denied. The Referee based his decision on the premise that claimant had become the sponsor of the physicians' reports. Under the particular circumstances of this case, we hold that the Referee's ruling was improper.

During the proceedings before Assistant Presiding Referee Schultz, the insurer's counsel neither objected to claimant's request to cross-examine Drs. Grewe and Kappes at the forthcoming hearing nor, in any way, preserved its option to withdraw sponsorship of those reports at the upcoming hearing. In fact, the insurer explicitly recognized claimant's right to depose the doctors. Inasmuch as the reports from Drs. Grewe and Kappes were solicited by the insurer, and since the insurer never suggested that it would not be presenting those reports at the upcoming hearing, we conclude that the reports offered at hearing should be considered to have been sponsored by the insurer. To do otherwise would permit the insurer to take a position at hearing that was incongruent with its clear and unqualified position at the pre-hearing motion conference.¹

Thus, we treat the insurer as the proponent of the medical reports submitted by Drs. Kappes and Grewe. Inasmuch as the Referee did not have the opportunity to rule on claimant's request for cross-examination of those physicians based on the assumption that the insurer was the proponent of their medical reports, we remand this case to the Referee for reconsideration of claimant's request for cross-examination. ORS 656.295(5).

Accordingly, the Referee's order dated May 18, 1994, as amended June 1, 1994, is vacated. This matter is remanded to Referee Hoguet for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. At those proceedings, the Referee shall reconsider claimant's request to cross-examine Drs. Grewe and Kappes. If the Referee denies claimant's motion to cross-examine Drs. Grewe and Kappes, the Referee shall issue a final, appealable order. If the Referee grants claimant's request, the hearing record shall be reopened and the case continued until completion of the record. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

¹ In reaching this conclusion, we recognize that it is not uncommon for a party to withdraw an exhibit at hearing and for another party to present that exhibit for admittance into evidence. Under most circumstances, the party presenting the exhibit (the sponsoring party) will not be permitted to cross-examine its own witness. Today's decision should not be interpreted as altering this common practice.

However, we consider the particular circumstances represented in this case to be appreciably different from those situations which generally arise at the hearings level. Here, a "postponement"/"continuance" motion was lodged prior to the hearing, at which time the insurer raised no objection to claimant's request for cross-examination of the physicians who had authored the reports the insurer was sponsoring. In fact, the Assistant Presiding Referee's interim order expressly provides (and the insurer does not challenge such a provision) that the insurer recognizes claimant's cross-examination rights via deposition, which will preclude closure of the record following the forthcoming hearing.

In light of the insurer's unqualified position during the "pre-hearing" proceeding regarding its sponsorship of the reports and claimant's right to cross-examine (including continuance of the hearing for "post-hearing" depositions), we consider the insurer's subsequent withdrawal of those reports at hearing to be inconsistent with the goals of substantial justice. In other words, had the insurer clarified that it was reserving the right to alter its position at the upcoming hearing regarding the medical reports and claimant's cross-examination rights, our decision today may well have been very different. Had the insurer taken such a position, claimant would have been on notice that it could not necessarily assume that the insurer would not contest at hearing his rights to cross-examination of the authors of the insurer-sponsored reports. In the event of such a "reservation" from the insurer, claimant would then have been on notice that his cross-examination rights were not entirely secure and that he may wish to further increase his efforts to secure additional medical evidence. (Albeit an arduous, if not infeasible, task in light of the short time between the denial of his postponement motion and the hearing).

Board Member Haynes dissenting in part.

While I agree that claimant should not be granted a continuance to obtain medical evidence from Dr. Grimm, I strongly disagree with the majority's decision to remand this case for yet another ruling on whether claimant can have a continuance to cross-examine Drs. Grewe and Kappes. For this reason, I am compelled to dissent from that part of the order.

Unlike the majority, I perceive no "incongruity" between the position the insurer took at the pre-hearing conference before Assistant Presiding Referee Schultz and its subsequent withdrawal of exhibits at the hearing. When the insurer acknowledged claimant's right to cross-examine Drs. Kappes and Grewe before the Assistant Presiding Referee, it was sponsoring the medical reports from those physicians. Although the majority avers that the insurer never suggested that it would not present the reports at the upcoming hearing, it is unrealistic to expect insurer's counsel to anticipate events at the hearing.

The majority cites no statute or rule that required the insurer to maintain sponsorship of exhibits at the hearing. Clearly, there was nothing in the interim order which compelled the insurer to submit exhibits that were no longer in the insurer's best interests to present. The majority cites only some vague notion of "substantial justice" as support for its conclusion that the insurer's conduct was improper. This may be sufficient justification for the majority, but it is not enough for me.

Insurer's counsel is being paid to make strategic decisions such as the one made at the hearing. As long as counsel's conduct does not violate any statute or administrative rule and is within the acceptable range of lawyering, then neither a referee nor the Board should substitute its notion of "substantial justice" for the legitimate actions of counsel. The majority too readily forgets that claimant was in a disadvantageous position at hearing because of his lack of diligence in obtaining medical evidence to support his claim. The majority's decision to remand the claim gives claimant an undeserved opportunity to buttress his case at the expense of the insurer.

Inasmuch as I believe that the majority's decision unfairly interferes with acceptable lawyering by insurer's counsel and does not achieve "substantial justice," I must respectfully dissent from that portion of the majority's order which remands this case to the Referee.

April 11, 1995

Cite as 47 Van Natta 681 (1995)

In the Matter of the Compensation of
MARK R. ENGLISH, Claimant
WCB Case No. 93-11679
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The insurer requests review of Referee Black's order that set aside its denial of claimant's "current condition" claim for depression. In its brief, the insurer contends that claimant is barred by res judicata from making a claim for depression. On review, the issues are res judicata and compensability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the first sentence.

CONCLUSIONS OF LAW AND OPINION

Claimant is a truck driver who sustained two vehicular accidents in April and May 1991. In the second accident, claimant inadvertently ran over and killed a young skateboarder who had, unbeknownst to claimant, hitched a ride on his truck. Claimant returned to driving until July 1991, when his mental condition began to deteriorate. In September 1991, he sought emergency room care for mental instability and suicidal ideation. Dr. Friedrich, his treating psychiatrist, diagnosed major depression and post-traumatic stress syndrome.

Claimant filed a claim for "occupational disease." On March 9, 1992, the insurer accepted "temporary post traumatic stress syndrome 3/19/91 through 12/31/91." It issued a Notice of Closure the next day, awarding temporary disability, but no permanent disability. Claimant did not appeal the Notice of Closure.

Claimant, who had returned to truck driving, continued to treat with Dr. Friedrich through June 1992 for increased stress related to driving. In November 1992, claimant sought treatment for a recurrence of depression after discontinuing his medication.

On August 8, 1993, claimant again sought treatment for a recurrence of depression. The insurer issued a denial of claimant's depression on the basis that claimant's current depression condition was caused by his preexisting condition and, therefore, was no longer related to the accepted injury. At hearing, the parties agreed that the issues were whether claimant's depression was compensable as a consequential condition, or, alternatively, whether the depression was independently compensable as an occupational disease. (Tr. 4,5). Claimant also raised a claim for aggravation. (Tr. 3).

The Referee concluded that claimant's current depression and need for further psychiatric treatment remained related to his compensable psychological condition, diagnosed as major depression, in addition to the accepted condition of post traumatic stress disorder (PTSD). Finding claimant's aggravation claim compensable, the Referee set aside the insurer's denial. We affirm the Referee's opinion that claimant's current depression and need for treatment are compensable, but we do so based on an "occupational disease" theory.

Res Judicata

Citing Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995), which issued subsequent to the Referee's order, the insurer argues that, because claimant failed to challenge the Notice of Closure, he is precluded from asserting that his accepted claim encompasses major depression. Claimant does not assert that the insurer's acceptance of a claim for PTSD was an acceptance of depression. Instead, claimant agrees that the insurer did not accept depression as a component of the PTSD claim. Moreover, claimant contends that he is not barred by res judicata from establishing the compensability of his claim for depression, as he had not expressly waived that claim in any manner.

We agree with claimant. First, because the PTSD and depression are separable conditions, claimant may establish compensability of his depression independently from the PTSD. See, e.g., Leslie C. Muto, 46 Van Natta 1685 (1994). In addition, there is no evidence in the record that claimant intentionally relinquished his right to seek compensation for his depression condition. See Drews v. EBI Companies, 310 Or 134, 151 (1990) (a waiver is "the intentional relinquishment of a known right," citing Brown v. Portland School Dist. #1, 291 Or 77, 84 (1981)).

Moreover, we find the insurer's citation of Messmer inapposite. In Messmer, the court held that, by virtue of the carrier's failure to appeal a Determination Order that awarded permanent disability compensation based in part on the underlying fact that the claimant experienced impairment from the effects of a surgery for the claimant's apparently noncompensable degenerative condition, the carrier was barred by claim preclusion from denying that the degenerative condition was part of the claimant's compensable claim.

Here, unlike the circumstances in Messmer, the Notice of Closure awarded no permanent disability. Consequently, there are no underlying facts presented by the Notice of Closure relating to the compensability of claimant's unaccepted depression. Thus, we conclude that that condition was not a basis for the order. Consequently, claim preclusion does not bar claimant from proving that the denied condition is compensable.

The insurer next argues that, because the persuasive medical evidence establishes that claimant's depression did not arise directly from his working conditions and that claimant's current need for treatment was caused, in major part, by his preexisting chronic depression, claimant's current occupational disease claim fails. We disagree.

In September 1991, when claimant initially sought care for mental instability and suicidal ideation, Dr. Freidrich diagnosed claimant with both major depression and PTSD. Although the insurer accepted only the PTSD, it had notice of a claim for compensation regarding the diagnosed depression. See Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992) (a physician's report requesting medical services for a specified condition constitutes a claim). Because the statutory period within which the claim may be accepted or denied has expired, we conclude that claimant's occupational disease claim has been "de facto" denied. ORS 656.262(6); SAIF v. Allen, 320 Or 192, 212, 214 (1994); Barr v. EBI Companies, 88 Or App 132 (1987); Syphers v. K-W Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981). Consequently, we analyze claimant's depression claim as one for a new occupational disease.

To establish the compensability of a mental condition, a claimant must prove that the employment conditions are the major contributing cause of his disease and must establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d). Claimant has the burden of proof. ORS 656.266.

There is no dispute that claimant suffers from a mental disorder generally recognized in the medical community; that his mental disorder was caused by conditions other than those generally inherent in every working situation; and that his mental disorder was not the result of reasonable disciplinary, corrective or performance evaluation actions. Rather, the parties' dispute centers on whether the claimant has proved, by clear and convincing evidence, that his mental disorder arose out of and in the course of employment. ORS 656.802(3)(d). To be clear and convincing, the truth of the facts asserted must be "highly probable;" that is, the evidence must be free from confusion, fully intelligible and distinct. See Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987).

Here, opinions were offered concerning the cause of claimant's depression at the time of onset by Dr. Freidrich, claimant's attending physician, and Dr. Turco, a psychiatrist who examined claimant for the insurer. Dr. Goranson, psychiatrist, provided an opinion for the insurer after a records review.

Dr. Turco opined that an accumulation of stressors, including a vehicular accident in 1986, when claimant's log truck was run into, work-related back surgery, economic difficulties related to his ownership of a truck, and the two accidents were the cause of claimant's depressive episode. Dr. Turco was unable to apportion the contribution of each stressor to claimant's eventual breakdown and opined that, to a certain extent, the logging truck accident, back surgery and the first 1991 accident preexisted the culminating accident when the child was killed. (Ex. 7A). Nevertheless, he opined in 1992 that claimant's treatment, as provided by Dr. Friedrich, was directly related to claimant's mental condition claim. (Ex. 17). In 1993, after reviewing later treatment reports, Dr. Turco changed his mind, concluding that the major contributing cause of any need for treatment was personal issues and not the "event of August 19, 1991." (Ex. 27).

Dr. Goranson opined that the major contributing causes of claimant's condition were the result of claimant's previous non-work experiences. In support of his conclusion, Dr. Goranson theorized that claimant's experiences in Korea and his early history of physical abuse and abandonment primed his nervous system to be over-responsive to subsequent events, and his nervous system was stimulated by the "imagined" trauma of killing the child. (Ex. 28-14 and -15).

Dr. Freidrich agreed with Dr. Turco that claimant experienced a major depressive episode caused by the accumulation of multiple stressors involving several vehicle accidents, particularly the most recent with the loss of the child's life, as well as financial difficulties related to the operation of the truck. He opined that all these stressors were employment related and were, together, the major contributing cause of claimant's depressive episode. (Ex. 12). Dr. Freidrich also opined that claimant's traumatic combat experiences in Korea and subsequent psychiatric hospitalizations did not have an effect on his depressive episode, with the exception of the death of the young boy, which evoked an earlier experience in Korea, noting that claimant had not been psychiatrically impaired for 35 years prior to the current depressive episode. (Id.).

We are more persuaded by Dr. Friedrich's opinion than those of Dr. Goranson or Dr. Turco. Dr. Friedrich, as claimant's treating physician, was in the best position to evaluate the overall contribution of events. Moreover, his opinion is more complete and is based on a complete history and a clear understanding of the factors present at the onset of claimant's depression. Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF, 77 Or App 259 (1986).¹ In addition, Dr. Turco's change of opinion from that at the time of the onset of claimant's condition to that two years later is inadequately explained.

Consequently, we conclude that claimant has established, by clear and convincing evidence, that his depression arose directly from his employment conditions. Therefore, his new occupational disease claim for depression is compensable.² ORS 656.802.

Because we conclude that claimant has established an occupational disease claim for depression for which the insurer is responsible, we modify those portions of the Referee's order which directed the insurer to process the depression claim under the PTSD claim.

The Referee set aside the insurer's September 27, 1993, partial denial of claimant's "current condition" depression as no longer related to claimant's "injury" (that is, the accepted PTSD condition), and remanded the claim to the insurer for processing according to law. Inasmuch as we have found that claimant's depression is compensable as a new occupational disease claim, it follows that the insurer's partial denial of claimant's current condition as related to the PTSD claim is upheld. Likewise, it follows that the insurer must process claimant's depression claim under a "new occupational disease" claim.

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

ORDER

The Referee's order dated August 10, 1994 is modified. The insurer's partial denial of claimant's current condition as related to the PTSD claim is reinstated and upheld. The insurer's "de facto" denial of claimant's occupational disease claim for depression is set aside. The Referee's order is modified to direct the insurer to process claimant's August 19, 1991 occupational disease claim for depression as a new claim. The insurer is also responsible for the Referee's \$2,800 attorney fee award under the new claim. For services on review, claimant's attorney is awarded \$2,000, payable by the insurer.

¹ Moreover, even if claimant had a preexisting, but nonsymptomatic, depressive condition, the record indicates that working conditions were the cause of the worsening of that condition.

² Because claimant's claim for depression has not yet been processed to closure, it would be premature for us to address his claim for aggravation. ORS 656.273(1).

April 11, 1995

Cite as 47 Van Natta 684 (1995)

In the Matter of the Compensation of
THOMAS A. JARRELL, Claimant
 WCB Case No. 94-01374
 ORDER ON RECONSIDERATION
 Schneider, Hooten, et al., Claimant Attorneys
 Lundeen, et al., Defense Attorneys

On March 30, 1995, we withdrew our March 2, 1995 order that had modified a Director's order to find claimant eligible for vocational assistance and awarded a 25 percent out-of-compensation attorney fee. We took this action to consider claimant's contention that he was entitled to a carrier-paid attorney fee award under ORS 656.386(1).

On December 19, 1994, we had approved the parties' Claim Disposition Agreement (CDA), in which claimant fully released his rights to benefits (including vocational rehabilitation), except medical services, resulting from his November 1991 injury claim. (WCB Case No. C4-02728). Based on the previously approved CDA, claimant agrees that his request for reconsideration, as well as his request for Board review, should be withdrawn.

Accordingly, in lieu of all prior orders, we dismiss claimant's request for Board review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 11, 1995

Cite as 47 Van Natta 685 (1995)

In the Matter of the Compensation of
STEPHANIE PEARSON, Claimant
WCB Case No. 92-11792
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant has requested reconsideration of the Board's Order on Review dated January 11, 1995, which: (1) affirmed that portion of a Referee's order that affirmed a Director's order finding certain chiropractic treatments not appropriate under ORS 656.327(2) and declined to award an attorney fee under ORS 656.386(1); and (2) reversed that portion of the Referee's order that declined to consider the evidence offered at hearing. Specifically, claimant asks us to reconsider that portion of our order which found that substantial evidence supports the Director's order.

On February 9, 1995, we withdrew our January 11, 1995 order for reconsideration. The employer's response to claimant's motion has been received. Accordingly, we proceed with our reconsideration.

Claimant sustained a low back injury, for which she received chiropractic treatment. The employer sought Director review of the appropriateness of the treatment under ORS 656.327(1). The Director issued an order which found the employer's processing agent not obligated to reimburse for certain chiropractic treatment rendered to claimant. Claimant requested review of the Director's order under ORS 656.327(2).

Under ORS 656.327(2), the Referee's and Board's review of a Director's order in a medical services dispute is limited. Specifically, the statute provides that the Director's order "may be modified only if the order is not supported by substantial evidence in the record." ORS 656.327(2).

On reconsideration, claimant contends that we did not properly perform substantial evidence review of the Director's order. Specifically, claimant argues that the proper procedure for conducting substantial evidence review under ORS 656.327(1) entails: (1) examination of the Director's findings of fact to determine whether they are supported by substantial evidence, as supplemented by the facts found by the Referee; and (2) evaluation of the Director's reasoning to determine whether it is rationally related to the findings of fact made by the Referee. Claimant also argues that because the Referee makes independent findings of fact when reviewing a Director's order, the Referee must also weigh the evidence and resolve conflicts in the medical evidence. We find merit in claimant's argument.

As noted above, we review the Director's order to determine whether it is supported by substantial evidence in the record. ORS 656.327(2). In Armstrong v. Asten-Hill Co., 90 Or App 200, 205 (1988), the court explained how to conduct substantial evidence review of Board orders, stating that "we must be able to know what the board found as fact and why it believes that its findings led to the conclusions that it reached. That requires a reasoned opinion based on explicit findings of fact." Citing Home Plate, Inc. v. OLCC, 20 Or App 188, 190 (1975), the court reiterated that administrative agency orders must "clearly and precisely state what it found to be the facts and fully explain why those facts lead it to the decision [which] it makes." Id. at 205-06. Finally, distinguishing its substantial evidence review from the "any evidence" standard, as well as from "de novo" review, the court explained that "[i]f an agency's finding is reasonable, keeping in mind the evidence against the finding as well as the evidence supporting it, there is substantial evidence." Id. at 206.

In conducting our "substantial evidence" review under ORS 656.327(2), we adhere to the procedure and standard enunciated in Armstrong, to the extent practicable under the statute. Thus, in reviewing the Director's order under ORS 656.327(2), we first determine what facts the Director found. Next, we determine whether the Director's findings reasonably and logically lead to the conclusions the Director made.

However, under ORS 656.372(2), our review of a Director's order must also depart from the procedure set forth in Armstrong. Any party dissatisfied with the Director's order is entitled to a hearing before a Board referee. ORS 656.327(2). In Julie Sturtevant, 45 Van Natta 2344 (1993), we concluded, consistent with the Supreme Court's decision in Colclasure v. Wash. County School Dist. No. 48-J, 371 Or 526 (1993), that referees are to independently find facts based on the evidentiary record developed at the hearing conducted under ORS 656.327(2). Thus, instead of simply reviewing the facts found by the Director, we have held that the referee is charged with developing a record and independently finding facts based on that record. Thereafter, the Director's order is evaluated in light of the facts found by the Referee, and may be modified only if substantial evidence in the whole record does not support the Director's order.¹

In this case, the Referee made factual findings based on the record developed before the Director, but declined to consider any evidence offered at hearing. Nevertheless, the proffered evidence was received under an offer of proof, and claimant testified at the hearing. Therefore, we consider the record to be fully developed and remand to the Referee is unnecessary. Accordingly, we proceed with our substantial evidence review of the Director's order.

FINDINGS OF FACT

In our original order, we adopted the Referee's findings of fact with supplementation based on the evidence developed at hearing. The Referee's findings were based on the record before the Director. We again adopt the Referee's findings of fact, as supplemented in our original order. Also, we again adopt the Referee's finding of ultimate fact, as modified in our original order.

CONCLUSIONS OF LAW AND OPINION

The Director identified two bases for his decision finding claimant's chiropractic treatment inappropriate. First, relying on the Oregon Chiropractic Practice and Utilization Guidelines, 1991, and the treatment recommended therein for moderate to marked spinal strain, the Director concluded that continuing chiropractic treatment for claimant's condition, diagnosed by her treating physicians as "thoracic and lumbar strains" and "acute lumbar strain," was inappropriate. In relying on the guidelines, the Director noted that chart notes in the record did not document any factors extending recovery time.

At hearing, claimant testified that she required more frequent chiropractic treatment when she was involved in school activities, such as prolonged sitting (*e.g.*, during twice daily orchestra practice) and carrying a backpack. Claimant's attending physicians documented these factors in the record developed before the Director. Thus, with respect to the question of whether there were any factors extending recovery time, no additional or different evidence was developed before the Referee as compared with the evidence before the Director. We conclude that the Director did not believe there were any factors extending recovery time, after taking into consideration the effect of claimant's school activities. We find that the Director's conclusion is supported by substantial evidence in the whole record.

Second, the Director found that after March 15, 1992, claimant had no valid prescription for ancillary care because Dr. Saks had withdrawn as her attending physician as of that date. Inasmuch as the Director found that chiropractic treatment was inappropriate, and we have found his conclusion supported by substantial evidence, this additional basis for finding treatment inappropriate after March 15, 1992 is unnecessary. Therefore, we do not consider this second basis for the Director's decision.

Accordingly, on reconsideration, we adhere to and republish our January 11, 1995 order, as supplemented herein. The parties' right of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

¹ Member Hall directs the parties to his special concurrence in the original order in this case.

In the Matter of the Compensation of
DAVID R. ROBERTSON, Claimant
WCB Case Nos. 94-07295 & 94-07648
ORDER ON REVIEW
Beers, Zimmerman, et al., Defense Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant, pro se, requests review of Referee Daughtry's order that dismissed his request for hearing. On review, the issue is the propriety of Referee's dismissal.

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

On June 14, 1994, claimant retained an attorney to represent him. On September 15, 1994, claimant's attorney wrote to the Referee: "Pursuant to our discussion at hearing, please be advised that we are asking that this matter be dismissed with prejudice." On September 28, 1994, claimant's attorney wrote to the Referee correcting his previous letter and advising that he was asking that both WCB case numbers 94-07295 and 94-07648 be dismissed with prejudice. Thereafter, in response to claimant's attorney's request, the Referee dismissed claimant's request for hearing. On November 14, 1994, claimant's former attorney advised the Board that he was no longer representing claimant.

Claimant does not dispute his former attorney's authority to act on his behalf, nor does he dispute the fact that the Referee dismissed his request for hearing in response to his former attorney's express withdrawal of the hearing request. Under these circumstances, we find no reason to alter the Referee's dismissal order. See Henry B. Scott, Jr., 45 Van Natta 2392 (1993); Eul G. Moody, 45 Van Natta 835 (1993).

ORDER

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

In the Matter of the Compensation of
SHERI R. ACREE, Claimant
WCB Case No. 94-11355
ORDER OF ABATEMENT
Coughlin, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On March 31, 1995, we dismissed the insurer's request for review of Referee Hazelett's order that set aside its denial of claimant's current low back condition. We took this action in response to the insurer's withdrawal of its request for review. We have now received a proposed "Disputed Claim Settlement," which is designed to resolve the compensability of the aforementioned denied condition. Inasmuch as 30 days have not expired since issuance of our dismissal order, we retain jurisdiction to consider issues raised by the insurer's appeal of the Referee's order. In light of such circumstances, we treat the submission of the proposed settlement as a motion for reconsideration of our dismissal order.

We have no objection to those portions of the proposed settlement which seek to resolve the compensability of claimant's current low back condition because it appears that a bona fide dispute concerning the compensability of that condition exists. See ORS 656.289(4); OAR 438-09-010(2). However, because the agreement as currently drafted does not comply with other Board requirements, it cannot presently be approved.

In accordance with ORS 656.313(4)(c), a proposed disputed claim settlement must include a list of medical service providers who shall receive reimbursement in accordance with the statute, including the specific reimbursement amount and the parties' acknowledgment that the reimbursement allocation complies with the statutory reimbursement formula prescribed by ORS 656.313(4)(d). See OAR 438-09-010(2)(g). There is an exception to this requirement. It is unnecessary to comply with the "provider list" if there are no outstanding bills from medical service providers in the insurer's possession on the "settlement date." See Robert L. Wolford, 46 Van Natta 522 (1994).

Here, the parties stipulate that "they are not in possession of any medical bills eligible for payment under ORS 656.313." (Page 4, Lines 22 - 23). This provision satisfies the first part of the Wolford exception. However, the settlement does not specify the "settlement date;" i.e., the date the settlement terms were agreed on. See ORS 656.313(4)(c); OAR 438-09-010(2)(h). Without such information, the settlement cannot receive our approval.

Finally, the proposed agreement incorrectly contains a signature line for a Referee. Inasmuch as the Referee's order has been appealed, authority to consider the settlement rests with this forum, not with the Hearings Division. Therefore, the "Referee" signature line should be replaced with two "Board Member" signature lines.

Consequently, we are returning the submitted materials to the insurer's attorney. In order to retain jurisdiction over this case to consider the parties' revised agreement, we withdraw our March 31, 1995 order. On receipt of a revised agreement drafted in compliance with our rules and the matters discussed herein, we shall proceed with our reconsideration. In the meantime, the parties are requested to keep us fully apprised of any further developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
FARON K. BUTLER, Claimant
WCB Case No. 94-05603
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Baker's order that upheld the self-insured employer's denial of claimant's low back and left arm injury claim.¹ On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant, a construction worker, has had a series of work-related back injuries dating from 1987. This claim arose as a result of an alleged back injury that claimant sustained at work on March 30, 1994. Claimant saw Dr. McFie, chiropractor, on April 5, 1994, and gave a history of having injured his back while carrying a bag of concrete, and an incomplete history of his earlier low back injuries. (See Ex. 14). At hearing, claimant testified that he stopped seeing Dr. McFie, one of claimant's treating chiropractors, because McFie had told claimant's boss that claimant was faking the injury. (Tr. 38).

On April 11, 1994, claimant began treating with Dr. Hall, his family physician. Based on claimant's report of injuring his low back while carrying a bag of cement at work, Hall diagnosed lumbar strain and noted that claimant's pain complaints were exaggerated. (Ex. 17). There is no evidence that Hall was aware of all of claimant's prior back injuries. Thereafter, Dr. Hall opined that claimant "did have a lumbar strain but was demonstrating a lot of pain behaviors at the time I saw him that made an exact evaluation difficult." (Ex. 31; see Ex. 34).

In late April 1994, Dr. Hall advised claimant that he could return to work. Claimant disagreed, and began treating with Dr. McGill, chiropractor, who released claimant from work. Claimant gave McGill a history of getting his left foot stuck in the mud and twisting his hip while carrying a 90-pound bag of concrete. (Ex. 20-1). Claimant gave McGill an incomplete history of his prior back injuries. (See id.) The employer denied claimant's claim. (Ex. 24).

On June 16, 1994, Drs. Peterson, chiropractor, and Strum, orthopedist, examined claimant on the employer's behalf. (Ex. 30). They diagnosed lumbar strain by history, and found that claimant's subjective complaints were severely out of proportion with what one would normally anticipate. (Id. at 6).

Finally, Dr. McGill concluded that, based on claimant's history and physical examination, in all probability, the March 30, 1994 work incident was the major contributing cause of his current complaints, disability and need for treatment. (Ex. 32-1).

At hearing, claimant testified, for the first time, that he had fallen during the March 30, 1994 work incident.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that the Referee erred in concluding that he failed to establish that he sustained an injury at work on March 30, 1994. We need not address that issue, because we find that claimant is not a credible witness, and because none of the medical experts had a complete and accurate history of claimant's prior back injuries.

¹ The employer actually denied a left arm and hip injury. (Ex. 24). However, the parties litigated a low back injury claim with a left arm component. (See Opinion and Order at 1). We treat the denial as pertaining to low back and left arm injuries.

The Referee did not make any credibility findings. Therefore, we consider the credibility issue de novo. On this record, we find that claimant is not a credible witness.

The written reports and claimant's testimony at hearing regarding the purported mechanism of injury are, to some degree, in conflict: The medical evidence reports that claimant injured his low back as a result of getting his foot stuck in some mud and twisting his hip. However, at hearing, claimant for the first time asserted that he had fallen during the work incident. Further, we note that the record shows claimant's tendency to display functional and exaggerated pain behavior. Under such circumstances, we find that claimant is not a credible witness.

In view of this finding, and because claimant has failed to establish that anyone had an accurate history of his earlier back injuries, we find claimant's history of the alleged March 30, 1994 work incident unreliable and the reports based on that history without persuasive force. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant has failed to establish a compensable injury, and we affirm the Referee's decision upholding the employer's denial.

ORDER

The Referee's order dated August 26, 1994 is affirmed.

April 12, 1995

Cite as 47 Van Natta 690 (1995)

In the Matter of the Compensation of
JAMES R. GANN, Claimant
 WCB Case No. 93-12661
 ORDER ON REVIEW
 Coons, Cole & Cary, Claimant Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Niedig and Hall.

Claimant requests review of Referee Lipton's order which: (1) upheld the insurer's denial of claimant's left groin injury claim; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

An occupational disease is distinguished from an injury in two ways: (1) a disease is not unexpected inasmuch as it is recognized as an inherent hazard of continued exposure to conditions of the particular employment; and (2) a disease is gradual rather than sudden in onset. James v. SAIF, 290 Or 343, 348 (1980); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). The court has construed the phrase "sudden in onset" to mean occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson v. SAIF, 56 Or App 184, 188 (1982).

We agree with the Referee that claimant's claim should be analyzed as an accidental injury, as opposed to an occupational disease claim. Claimant was not symptomatic prior to August 2, 1993. On that date, he experienced an acute onset of groin pain during a discrete period of time while operating heavy equipment. See Valtinson, supra. We also agree that the rough ride on the equipment, as described by claimant, could be considered injurious.

Nevertheless, given the questions raised in the medical diagnoses, including the possible presence of a tumor, we disagree with claimant's contention that this case is not complex, and does not require medical testimony. See Uris v. Compensation Dept., 247 Or 420, 427 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). Accordingly, in light of the lack of supportive medical evidence, we agree with the Referee that claimant has failed to meet his burden of proving that his work activities were a material contributing cause of his groin injury.

ORDER

The Referee's order dated September 21, 1994 is affirmed.

In the Matter of the Compensation of
HAROLD A. EDWARDS, Claimant
WCB Case No. C5-00427
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Gatti, et al., Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On February 21, 1995, the Board received the parties' Claim Disposition Agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury.

On March 29, 1995, the Board disapproved the parties' disposition. Claimant has now requested reconsideration, submitting an addendum which would amend the original CDA.

As stated above, the parties' CDA was disapproved on March 29, 1995. Claimant's request for reconsideration was filed on April 7, 1995. Thus, we find that claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Accordingly, we will reconsider this CDA. OAR 438-09-035(3).

By letter dated March 7, 1995, the Board requested an addendum from the parties on the basis that the proposed agreement contained the following language:

"The parties agree to dispose of this claim, including settlement of any existing disputes regarding nonmedical benefits." (Emphasis supplied).

In requesting that the language in the CDA be corrected, the Board reasoned that it had previously disapproved CDA's involving or referring to denied claims. See Donald Rhuman, 45 Van Natta 1493 (1993). We reasoned that the function of a CDA was to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. Furthermore, we held that it is not the function of a CDA to dispense with disputes arising from allegedly unreasonable claims processing, and that other procedural avenues (such as stipulations and disputed claim settlements) were available to accomplish such objectives. Donald Rhuman, supra. See Frederick M. Peterson, 43 Van Natta 1067 (1991).

On March 20, 1995, the Board received the parties' response to our request to correct the above-stated language. The parties agreed that the following language should be inserted:

"The parties agree to dispose of this claim, including settlement of any existing disputes regarding non-medical disputes with ORS Chapter 656 except denial disputes."

In our March 29, 1995 order disapproving the CDA, the Board concluded that the proposed addendum did not correct the language referring to settlement of "existing disputes," and that the proposed CDA was not a proper matter for disposition of noncompensability matters because CDA's are intended for accepted (as opposed to disputed) claims, as the claims exist at the time the Board receives the CDA. Donald Rhuman, supra.

In their April 7, 1995 addendum, the parties agree that the following language should be inserted to correct the aforementioned language:

"Parties agree to dismiss with prejudice, or otherwise dispose of non-medical issues under the accepted claim that were raised or could have been raised from operative facts that were ripe for dispute at the time of this agreement."

We conclude that the corrected language does not attempt to dispose of or resolve "existing disputes" (disputed portions of the claim). In addition, we find that the addendum states that the proposed agreement will dispose only of issues pertaining to the CDA which could have been raised at the time this agreement was presented to the Board. See Barbara L. Whiting, 46 Van Natta 1684, on recon, 46 Van Natta 1715 (1994).

We find that the agreement, as amended by the parties' April 7, 1995 addendum, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). We do not find any statutory basis for disapproving the agreement. ORS 656.236(1). Accordingly, on reconsideration, the parties' claim disposition agreement is approved, as amended, for a total consideration of \$10,500, with \$7,875 of the proceeds to be paid to claimant. An attorney fee of \$2,625, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

April 12, 1995

Cite as 47 Van Natta 692 (1995)

In the Matter of the Compensation of
JODI M. JONES, Claimant
WCB Case No. 94-06342
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of that portion of Referee Nichols' order that set aside a Determination Order's classification of claimant's occupational disease claim as nondisabling. Claimant cross-requests review of those portions of the order that: (1) declined to assess a penalty and attorney fee for the employer's allegedly unreasonable claims processing; and (2) awarded claimant an out-of-compensation attorney fee. On review, the issues are claim classification, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Reclassification

Finding that claimant became entitled to time loss benefits when the employer eliminated her modified work, the Referee concluded that claimant's claim should be classified as disabling. See OAR 436-30-045(5)(a). On review, the employer argues that because claimant received her full regular wage while on light duty assignment, she has not lost wages from work as the result of her compensable claim. Thus, the employer reasons, her condition was not disabling.

We adopt the Referee's reasoning and conclusions as they pertain to this issue. Further, we find that claimant's release to modified work establishes that she was temporarily partially disabled. For this additional reason, we agree claimant's claim should be classified as disabling.

Claimant has worked for the employer as a welder since 1988. In June 1993, Dr. Caldwell, claimant's family physician, limited her to light duty work. Later, he referred claimant to neurologist Dr. Rosenbaum for treatment of her right upper extremity condition. Dr. Rosenbaum continued claimant's light duty work restriction.

In November 1993, Dr. Rosenbaum conditionally released claimant to "try" to return to work as a welder as a diagnostic test to determine appropriate future therapy for her carpal tunnel syndrome. In December 1993, the employer placed claimant on modified work at her at-injury wage. In December 1993 and January 1994, Dr. Rosenbaum repeated his recommendation that claimant be allowed to attempt her welder job. The employer never returned claimant to her at-injury job. Rather, in March 1994, after she completed the 90-day return to work program, claimant was laid off. Dr. Rosenbaum never unconditionally released claimant to work nor declared her medically stationary.

We previously rejected the employer's argument that disability equates with a reduction in post-injury wages in Sharman R. Crowell, 46 Van Natta 1728 (1994).¹ 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.

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. See George J. May, 46 Van Natta 2499 (1994); Brenda Guzman, 46 Van Natta 2161 (1994); Sharman R. Crowell, *supra*.

Finally, the employer notes that in response to the court's decision in Stone v. Whittier Wood Products, *supra*, the Department has promulgated temporary rules for the calculation of TPD payments. The employer argues that under those 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.² George J. May, *supra*; Brenda Guzman, *supra*.

Penalty

We adopt the Referee's reasoning and conclusions, with the following clarification and comment. We replace the references to Dr. Butters with Dr. Button.

On review, claimant contends that because Stone v. Whittier Wood Products, *supra*, as applied by the Board with respect to the classification of claims in Sharman R. Crowell, *supra*, was the law at the time the employer declined to reclassify claimant's claim, the employer's conduct in failing to reclassify her claim was unreasonable. We disagree.

The employer initially accepted claimant's condition as nondisabling right hand tendonitis in October 1993. In January 1994, claimant requested that the employer reclassify her claim as disabling. Based on additional information from Dr. Rosenbaum, in March 1994, the employer accepted claimant's condition as a nondisabling right carpal tunnel syndrome.

Although Stone was decided in 1993, the Board did not apply the Stone holding to the issue of claim classification in Crowell until August 1994. Under the circumstances, we do not find the employer's claim processing unreasonable.

Attorney Fee at Hearing

Claimant next contends that she is entitled to an assessed attorney fee pursuant to ORS 656.386(1). However, in Mindi M. Miller, 44 Van Natta 1671, on recon 44 Van Natta 2144 (1992), we held that the legislature has not authorized the Board to award attorney fees to a claimant's attorney for services in obtaining reclassification of a claim to disabling.

We conclude that Miller is applicable in the present case. Accordingly, no insurer-paid attorney fee is available for claimant's counsel's services pursuant to ORS 656.386(1). See also Forney v. Western States Plywood, 297 Or 628 (1984) (Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded).

¹ The employer argues that it would be inappropriate for us to apply the rationale in Sharman R. Crowell, *supra*, inasmuch as a Petition for Judicial Review of the Crowell decision has been filed with the Court of Appeals. We disagree. Until Crowell is overturned, it is applicable law under the principle of stare decisis.

² Inasmuch as claimant's claim for reclassification was received by the employer within the statutory one-year period, we find no merit to the employer's contention that, in order to establish entitlement to time loss, claimant is required to satisfy the aggravation criteria of ORS 656.273.

Claimant's counsel is entitled to an assessed attorney fee for services on review concerning the claim classification issue. ORS 656.382(2); Sharman R. Crowell, supra. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding this issue is \$1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for her unsuccessful efforts to obtain a penalty or ORS 656.386(1) attorney fee.

ORDER

The Referee's order dated September 16, 1994 is affirmed. Claimant's counsel is awarded an assessed fee of \$1,000 for services on review, payable by the self-insured employer.

April 12, 1995

Cite as 47 Van Natta 694 (1995)

In the Matter of the Compensation of
DUANE A. MENESTRINA, Claimant
 WCB Case No. 93-00511
 ORDER ON REVIEW
 Olson Law Firm, Claimant Attorneys
 Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian, and Gunn.

The decedent's widow requests review of Referee Mongrain's order that upheld the self-insured employer's denial of decedent's fatal accident 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

With the following supplementation, we adopt and affirm the Referee's findings and conclusions that claimant's alcohol impairment was the major contributing cause of his accident.¹

Claimant was a straddle lumber carrier for the employer. At approximately 9:45 p.m., a co-worker informed claimant that his tire was low. He drove off at a high rate of speed in the direction of the shop. While negotiating an "S" curve, the carrier rolled over and claimant was severely injured. He

¹ The employer's written drug and alcohol policy prohibits its employees from reporting for work with any detectable level of alcohol or controlled substance in their system. The Referee found that claimant overstepped the boundary defining his ultimate work by violating the employer's policy, because he was not even to be at work, and by being at work in his intoxicated condition. The Referee, therefore, concluded that claimant failed to establish a prima facie case of compensability under the "ultimate work" test.

Subsequent to the Referee's order, we held in David Bottom, 46 Van Natta 1485 (1994), *aff'd mem Liberty Northwest Insurance Corporation v. Bottom*, 133 Or App 449 (1995), that a claimant's violation of the employer's drug and alcohol policy, in itself, did not remove the claimant from the course and scope of employment. In reaching that conclusion, we reasoned that such a policy related to the employer's desire that its employees work unencumbered by drugs or alcohol, which merely defined the method of performing the ultimate work to be done. *Id.* at 1485.

Here, as in Bottom, claimant's violation of the employer's drug and alcohol policy related to the method of accomplishing his work as a carrier driver. Claimant, nevertheless, was performing his assigned job duties when he was fatally injured. Thus, claimant remained within the scope of his employment at the time of his accident. (Parenthetically, Member Haynes would direct the parties to her dissenting opinion in Bottom.)

died several hours later from his injuries. Blood drawn at 10:20 p.m. revealed a blood alcohol level (BAL) of .13 percent. At the time of the accident, claimant's BAL was a least .15 percent. Claimant had consumed a half of a fifth of whiskey and 40 ounces of beer between 5:30 p.m. and the accident. Medical testimony established that at claimant's BAL, he was significantly impaired at the time of the accident.

The employer can defeat a finding of compensability by proving, by clear and convincing evidence, that claimant's consumption of alcohol was the major contributing cause of the injury. ORS 656.005(7)(b)(C); Grace L. Walker, 45 Van Natta 1273 (1993), aff'd mem Walker v. Danner Shoe Manufacturing, 126 Or App 313 (1994). To be clear and convincing, the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987).

Claimant contends that the employer failed to meet its burden of proof because the lay testimony was conflicting regarding claimant's operation of the carrier at the time of the accident,² and because the medical evidence was conflicting regarding whether or not alcohol was the cause of the accident. However, if the evidence on which claimant relies to contradict the expert witnesses is not persuasive, then the mere fact that conflicts in the evidence may exist is insufficient to dissuade us that the employer met its burden of proof.

This was a lengthy and complex case with much evidence provided by qualified medical experts. In any case involving conflicting medical evidence, we give more weight to those opinions which are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Claimant relies on the opinions of Drs. Parvaresh, Turco, Smith and Grimsbo to rebut the extensive medical evidence provided by the employer. Claimant contends that their opinions rule out alcohol as the major cause because: (1) of the absence of manifestation of intoxication; (2) alcohol affects individuals differently; and (3) claimant had a high tolerance for alcohol. However, we do not find their opinions persuasive, nor do those opinions persuasively rebut the contrary medical opinions of Drs. Brady, Edwards, Burton, Garriott, and Larsen.

Dr. Parvaresh opined that claimant's alcohol consumption was not the cause of the accident. He based his opinion on the following: (1) the findings of the EMTs and emergency room physicians who did not observe any signs of intoxication; (2) as a chronic drinker, claimant had a high tolerance for alcohol, such that he would not have impaired judgment or sensory motor function at a .13 BAL; and (3) claimant's BAL was more concentrated at the time it was drawn than at the time of accident because of the loss of fluid from internal bleeding. (Ex. 16). Dr. Parvaresh further explained that a person must manifest impairment by five criteria before being diagnosed intoxicated under the DSM-III classification. Because claimant manifested no signs of intoxication, as noted by the EMTs and emergency doctors, Dr. Parvaresh concluded that claimant was not intoxicated.

Drs. Brady, Edwards, Burton, Garriott and Larsen disagreed with Dr. Parvaresh's opinion. First, Drs. Brady, Edwards, Burton and Garriott disputed Dr. Parvaresh's reliance on the Glasgow coma scale as evidence that claimant was not intoxicated. (Day 2, Tr. 36-39; Day 3, Tr. 62-63, 127, 194). The Glasgow coma scale is used to test a patient's motor and sensory response for purposes of assessing treatment. However, the Glasgow coma scale does not determine the level of alcohol intoxication. (Day 2, Tr. 36-39; Day 3, Tr. 62-63). For example, even the most severely intoxicated patient could receive the maximum score for motor and sensory response. (Day 3, Tr. 29, 127). In this case, relating the score to any signs of intoxication would be of minimal value because claimant's face was covered by an oxygen mask and he was drenched in diesel fuel. (Ex. 60 pp. 19-20). Moreover, Dr. Hanson, the emergency physician who attended to claimant, was not concerned with determining claimant's level of intoxication, nor would he have noted it. (Day 3, Tr. 33-34).

Concerning the individual effects of alcohol and the contention that claimant had a high tolerance for alcohol, Dr. Edwards and Dr. Burton explained that tolerance concerns physical impairment and, thus, physical tolerance may mask outward manifestations of intoxication. However, impairment

² In light of the medical evidence distinguishing manifestations of intoxication from alcohol impairment, the lay testimony regarding claimant's behavior and manner of operating the lumber carrier is insufficient to establish whether or not claimant was impaired. See Grace L. Walker, supra at 1275.

from alcohol relates to mental function and, thus, even if claimant had a high tolerance for alcohol, at his BAL he was impaired. (Day 3, Tr. 65, 84, 126). Dr. Burton based his explanation on the hundreds of behavioral, epidemiological, and laboratory studies correlating impairment at various blood alcohol levels. (Day 3, Tr. 126).

Dr. Larsen further explained that a regular drinker, such as claimant, learns to adapt, but he is still impaired. Dr. Larsen testified that even at claimant's blood alcohol level (of .15), he could operate a vehicle, and do routine, learned behavior so that to a casual observer he may not appear significantly impaired. However, with claimant's blood alcohol level, he was impaired. Thus, when confronted with any kind of new learning behavior or crisis episode, claimant could not appropriately respond because of his alcohol impairment. In reaching his conclusion that claimant was impaired, Dr. Larsen relied on the volume of literature and research comparing blood alcohol levels to levels of cognitive and physical functioning. (Ex. 61 pp. 11-17).

For the reasons stated above, we discount the opinions of Drs. Parvaresh, Smith and Turco³. As such, these opinions are insufficient to refute the persuasive medical evidence that claimant's alcohol consumption was the major contributing cause of the accident.

Dr. Brady reviewed medical records, observed lay testimony, and reviewed transcripts of the testimony of Dr. Parvaresh, Dr. Smith, and Randall Wilson, claimant's accident reconstruction witness. (Day 1, Tr 180-181; Ex. 60-4). Dr. Burton reviewed medical records, exhibits, OSHA statements, observed day 2 and day 3 testimony, including testimony from Dr. Brady and Tom Fries, the employer's accident reconstruction specialist,⁴ and reviewed the videotape of the lumber carrier at test drives with the tires at various inflation. (Day 3, Tr. 115, 121). Dr. Garriott, forensic toxicologist, reviewed the medical records, OSHA reports, and observed the third day of hearing, including lay testimony and testimony from Dr. Edwards and Dr. Burton. (Day 3, Tr. 180). Dr. Larsen, psychiatrist specializing in alcohol and drug use, reviewed the exhibits and the testimony of Dr. Parvaresh, Dr. Smith, and Mr. Wilson. (Ex. 61-6). Based on their testimony, we find the following.

Alcohol is a sedative that has the same effect on the brain as a general anesthetic. Alcohol affects the central nervous system and impairs the cognitive and physical functions of perception, judgment, information processing, decision making, reaction time and physical response. Alcohol stages of intoxication are divided into different categories: (1) euphoria stage; (2) excitement stage; and (3) confusion stage. Claimant was in the high stages of the excitement phase and approaching the confusion stage.

The accident occurred at approximately 9:45 p.m. Blood samples were drawn at 10:20 p.m. which revealed a BAL of .13 percent. Accounting for the seriousness of claimant's injuries, the loss of blood, shock, and dilution of body fluids from IVs, claimant's BAL at the time of the accident could have measured from .16 to possibly as high as .25 percent. At his level of blood alcohol, claimant was significantly impaired. (Day 2, Tr. 18, 20-24; Day 3, Tr. 56-57, 118, 120, 123-124; Day 3, Tr 188-189; Ex. 61-10).

³ Drs. Turco and Smith also opined that claimant's alcohol consumption was not the major cause of the accident because of claimant's high tolerance to alcohol, the individual effects of alcohol, and the lack of observable manifestations of impairment. Dr. Grimsbo did not provide an opinion on causation.

⁴ Claimant does not assert, nor do we find, any reason to give more weight to the opinion of Mr. Wilson than Mr. Fries. For the reasons stated by the Referee, we find Mr. Fries' opinion persuasive. In addition, Mr. Fries' opinion was based on more complete information. He reviewed the OSHA accident report and a video taken of the accident scene, conducted an on-site inspection, interviewed witnesses, performed experiments with a carrier operating at various speeds and tire inflation, and observed a substantial portion of Dr. Brady's testimony.

Mr. Fries opined that going too fast and driver error, rather than a low tire, were the causes of the lumber carrier tipping over. Mr. Fries explained that, prior to the carrier tipping over, there should have been a substantial suspension sway and feeling of centrifugal acceleration forces to warn claimant that he was going too fast for the curve. At that point, the proper corrective action would have been controlled braking. Mr. Fries' opinion is supported by lay testimony that claimant was driving at a higher rate of speed than he normally drove.

Drs. Brady, Edwards, Burton, Garriott and Larsen opined that, considering other potential factors such as the carrier's low tire and claimant's alleged fatigue, claimant's alcohol impairment was the major contributing cause of the accident. (Day 2, Tr. 31-33; Day 3, Tr. 57-59, 125, 191-192; Ex. 61 pp. 20-21). The doctors based their opinions on studies that correlated different degrees of impairment to various blood alcohol levels.

We are persuaded by the opinions of Drs. Brady, Edwards, Burton, Garriott and Larsen and Mr. Fries that the claim is not compensable. ORS 656.005(7)(b)(C). In other words, we find that it is highly probable that claimant's consumption of alcohol caused significant impairment, and that alcohol impairment was the major contributing cause of the accident. See Grace L. Walker, supra.⁵ We so find.

ORDER

The Referee's order dated February 4, 1994 is affirmed.

⁵ Claimant contends that this case is distinguishable from Grace L. Walker, supra; Dave D. Hoff, 45 Van Natta 2312 (1993) aff'd mem Hoff v. Leavitts Freight Service, 131 Or App 363 (1994); and Richard A. Perry, 46 Van Natta 302 (1994) based on whether or to what extent the evidence is controverted. The inquiry, however, is not whether claimant has presented evidence to rebut the employer's case. For example, in Charles D. Turner, 46 Van Natta 1541 (1994), the medical evidence was uncontroverted, yet insufficient to establish the requisite causal relationship between the claimant's marijuana consumption and the injury.

In Ronald Martin, 47 Van Natta 473 (1995), the Referee incorrectly reasoned that since there was more than one plausible cause for the claimant's accident, the employer failed to carry its burden of proof. Here, the dissent similarly contends that not all possible causes, other than claimant's alcohol consumption, have been ruled out as the major contributing cause of the accident. However, as in Martin, supra, we weigh the evidence, based on the entire record, to determine whether the employer has shown, by clear and convincing evidence, that the major contributing cause of the injury was the consumption of alcohol. For the reasons set forth in this decision, we conclude that the employer has successfully satisfied its requisite burden of proof.

Board Member Gunn dissenting.

Claimant was drinking against company policy and was drinking at a level that was both socially and legally unacceptable. However, the Referee and now the majority have made a moral, rather than a legal, judgment in finding this claim not compensable due to claimant's alcohol consumption. In doing so, the majority has disregarded the major contributing cause standard and the employer's burden of proof under that standard, as used in ORS 656.005(7)(b)(C).

"Major cause" means an activity or exposure, or combination of activities or exposures, which contributes more to causation than all other causative agents combined. See Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); David K. Boyer, 43 Van Natta 561 91991), aff'd mem 111 Or App 666 (1992). Thus, as applied under ORS 656.005(7)(b)(C), the employer must prove that claimant's consumption of alcohol, when compared to other potential causes, was the major (*i.e.*, more than 50 percent) cause of the accident. The employer must also meet this burden of proof by clear and convincing evidence.

In this case, in the order of magnitude, I would rate the causes of the accident as follows: (1) speed; (2) tire deflation and debanding; (3) impairment of claimant due to alcohol; (4) fatigue due to working a double shift; and (5) the type of the vehicle. Lay and expert evidence points to speed of the vehicle as the primary factor of the accident. However, the evidence fails to show which of the above factors was the major cause of the accident.

The employer did an excellent job with the expert opinion evidence, yet I find it difficult to assign a percentage value to the level of alcohol impairment and claimant's decision to speed. The employer proved by expert medical evidence that alcohol impairment could have caused the speed chosen and maintained by claimant. But, the evidence does not show that alcohol was the major factor in claimant's decision to speed. The evidence in the record established that claimant always drove at higher rates of speed than other lumber carrier drivers. The evidence also showed that claimant was in a hurry to get to the maintenance shop to get the lumber carrier's tire fixed. Claimant's actions the night of the accident were not outside his normal parameters. Therefore, the employer failed to prove, by clear and convincing evidencing, that claimant's consumption of alcohol impaired his ability or judgment to drive the disabled lumber carrier at an excessive speed or resulted in claimant acting outside his normal parameters.

As expressed by Dr. Parvaresh, claimant's speeding is behavioral, meaning that claimant would probably drive fast whether or not he was or was not intoxicated. Dr. Parvaresh further testified that alcohol did not play a role in claimant's judgment to drive fast because claimant's driving fast was unrelated to judgment, but rather to this pattern of behavior. Dr. Parvaresh, thus, opined that claimant's alcohol consumption was not the major cause of driver error.

Driving fast does not necessarily establish a manifestations of impairment from alcohol. Alcohol impairment may exaggerate that conduct, but it is not the cause of that conduct. Claimant's bad habits of driving fast and drinking finally caught up with him. Although both contributed to the accident, the latter was not necessarily the cause of the former.

Thus, the fact that claimant was performing his job normally and that he normally drove fast makes it less than highly probable that alcohol impairment was the major cause of the accident. Therefore, the employer failed to prove a causal connection between claimant's consumption of alcohol and his decision to drive the lumbar carrier fast.

I agree with claimant that this case is distinguishable from Grace L. Walker, supra; Dave D. Hoff, supra; and Richard A. Perry, supra. I was involved in these cases. In those cases, the claimant put on little or no evidence and therefore failed to refute the evidence offered by the employer. Also, there was evidence that the alcohol/drug impairment contributed directly to the injury. For example, in Grace L. Walker, supra, the evidence showed that the injury occurred because claimant's impairment from drugs and alcohol caused her to operate the machinery in an unorthodox manner and to bypass the safety features on the machine.

Here, in contrast, evidence shows that the behavior of claimant was not out of the norm for him. Also, the evidence does not establish a direct connection between claimant driving the carrier at an excessive speed and his consumption of alcohol. Because such a connection cannot be made, the major contributing cause standard cannot be met.

In conclusion, I would find that claimant's consumption of alcohol caused impairment. However, the evidence fails to establish that, it is highly probable, this impairment was the major contributing cause of the accident. Therefore, I would hold that the employer failed to meet its burden of proof. Accordingly, I respectfully dissent.

April 12, 1995

Cite as 47 Van Natta 698 (1995)

In the Matter of the Compensation of
MATTHEW R. ROSS, Claimant
WCB Case No. 93-15293
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Rhoten, et al., Attorneys
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Brazeau's order which upheld the SAIF Corporation's denial of his occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

The Referee found that claimant failed to establish a compensable occupational disease claim. In reaching this conclusion, the Referee reasoned that, while claimant's employment caused a worsening of the symptoms of his preexisting carpal tunnel syndrome, the medical evidence did not establish that it worsened the underlying condition. See Weller v. Union Carbide, 288 Or 27 (1979). Thus, the Referee concluded that claimant did not sustain his burden of proof.

On review, claimant contends that the Referee failed to recognize that the symptoms of carpal tunnel syndrome are the disease. Citing Georgia Pacific v. Warren, 103 Or App 275(1990), rev den 311 Or 60 (1991) and John N. Gottlieb Jr., 45 Van Natta 1562 (1993), claimant contends that his carpal tunnel condition is compensable. We disagree.

In Warren, the Court of Appeals considered whether the claimant's carpal tunnel syndrome was a compensable occupational disease when evidence showed that the claimant also suffered from an underlying condition of "entrapment neuropathy." The court explained that "sometimes the medical evidence will support the conclusion that the symptoms for which compensation is sought are the disease." The court concluded that, because the claimant sought compensation for the syndrome, a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel, and the syndrome was caused by work activity, the carpal tunnel syndrome was compensable. Id. at 278 (emphasis added); See Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990) ("If the medical evidence supports the conclusion that the manifested symptoms are the disease, the condition may be compensable.").

In Gottlieb, we found the claimant's carpal tunnel condition compensable. In doing so, we affirmed the Referee's decision setting aside the employer's "back-up" denial of the claimant's carpal tunnel condition. We particularly noted that Dr. Nathan, hand surgeon, had examined the claimant and found severe and chronic slowing of both median nerves. Dr. Nathan opined that none of the claimant's work activities would have caused or worsened the median nerve slowing. (Ex. 13-5). However, Dr. Nathan explained that the median nerve slowing represents an underlying entrapment neuropathy which causes a constellation of symptoms called carpal tunnel syndrome. (Tr. 34).

We concluded that the employer had not sustained his burden of proving by "clear and convincing" evidence that the claimant's carpal tunnel condition was not compensable. In doing so, we emphasized that, even if we accepted Dr. Nathan's opinion that the claimant has an underlying "entrapment neuropathy," which preexisted and was unrelated to his employment, the claimant sought compensation for carpal tunnel syndrome, (i.e., the symptoms caused by oxygen deprivation of the median nerves), not the median nerve slowing.

Thus, in both Warren and Gottlieb, the medical evidence established that the symptoms of the carpal tunnel condition were the disease. Inasmuch as the medical evidence demonstrated that employment was the major contributing cause of the carpal tunnel conditions in both Warren and Gottlieb, both occupational disease claims were compensable.

In this case, however, neither of the two physicians who rendered opinions on the causation of claimant's condition, the examining physician, Dr. Button, and the attending physician, Dr. Becker, opined that the symptoms were the disease. (Exs. 24, 27); See Patricia D. Randle, 46 Van Natta 350 (1994); Stephen M. Petricevic, 45 Van Natta 2372 (1993). Moreover, Dr. Button drew a clear distinction between the symptoms and the underlying carpal tunnel disease. (Ex. 24). This further reinforces our conclusion, based on the evidence in this record, that the symptoms of claimant's carpal tunnel syndrome are not the disease. See Susan M. Sanchez, 46 Van Natta 795, 796 (1994), on recon 46 Van Natta 1152 (1994) (Where attending physician drew a distinction between carpal tunnel symptomatology and the underlying condition, symptoms were not the disease); Cf. Patricia A. Jones, 46 Van Natta 965 (1994) (symptoms of carpal tunnel found to be the disease where Dr. Button testified that carpal tunnel syndrome is a "collection of symptoms," rather than an underlying pathology.). Therefore, the Referee properly concluded that claimant failed to sustain his burden of proving a compensable occupational disease.

ORDER

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

In the Matter of the Compensation of
ROBIN L. SMITH, Claimant
WCB Case No. 93-07304
ORDER OF ABATEMENT
Philip H. Garrow, Claimant Attorney
Beers, Zimmerman, et al., Defense Attorneys

The insurer requests reconsideration of our March 14, 1995 order that: (1) set aside its "de facto" denial of claimant's medical services claim for medical bills and travel / prescription reimbursement; (2) awarded an insurer-paid attorney fee under ORS 656.386(1); and (3) assessed a penalty under ORS 656.262(10) for unreasonable claim processing. Contending that the "MCO" letter it sent to claimant and his former attending physician complied with the relevant administrative rule requirements, the insurer asserts that its conduct did not constitute a denial and that penalties and attorney fees are not warranted.

In order to further consider the insurer's contentions, we withdraw our March 14, 1995 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

April 12, 1995

Cite as 47 Van Natta 700 (1995)

In the Matter of the Compensation of
EDWIN P. VINING, Claimant
WCB Case No. 94-06439
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Hazelett's order which affirmed a Director's order under ORS 656.327(2) finding that physical therapy was not appropriate treatment for his compensable condition.¹ Claimant contends that the self-insured employer was precluded from initiating Director review of the treatment. On review, the issues are res judicata and medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following exceptions. We do not adopt his finding that the Director initiated review of treatment under ORS 656.327, nor do we adopt his findings of ultimate fact.

We summarize the relevant facts as follows. Claimant compensably injured his back in 1978. His claim was processed to closure, and he received awards of temporary disability and permanent disability benefits. He continued to have chronic back pain and came under Dr. Jura's care in October 1989.

Dr. Jura prescribed physical therapy for claimant's back condition from March 1993 through December 1993, which was provided by Rockwood Orthopaedic & Sports Clinic (Rockwood). By letter dated May 5, 1993, the employer's claims processing agent, Scott Wetzel Services, advised claimant that it was denying compensability of his low back and hip condition and related treatment on the ground that his condition was not related to the compensable back injury. Claimant requested a hearing on the denial.

¹ Claimant also sought the assessment of penalties but withdrew that issue at hearing. (Tr. 6).

By Opinion and Order dated November 29, 1993, Referee Davis set aside the May 5, 1993 denial and remanded the medical services claim for processing. Referee Davis' order was not appealed.

By letter dated January 14, 1994, the employer's counsel requested Director review of the physical therapy provided by Rockwood and related services provided by Dr. Jura. Counsel asserted that the treatment appeared to be noncompensable palliative care. On January 24, 1994, the Department's Medical Review Unit advised that the Director had initiated review of the appropriateness of the physical therapy and related services.

On April 13, 1994, the Director issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute, concluding that physical therapy provided from March 1993 through December 1993 and a June 29, 1993 office visit with Dr. Jura were not appropriate treatment. Claimant requested a hearing on the Director's order, which is the matter in dispute here.

Meanwhile, claimant had requested a hearing to seek payment for the same disputed medical services and a penalty for the employer's allegedly unreasonable resistance to the payment of compensation. That hearing was convened before Referee Lipton in WCB Case No. 94-01051. By Opinion and Order dated April 25, 1994, Referee Lipton denied claimant's request for relief. On Board review, however, we reversed Referee Lipton's order. Edwin P. Vining, 47 Van Natta 283 (1995). Based on Referee Davis' final order which set aside the employer's May 5, 1993 denial, we concluded that the employer was required to accept responsibility for the disputed treatment (i.e., physical therapy from March 1993 through December 1993, and a June 29, 1993 office visit to Dr. Jura). Id. We directed the employer to pay the disputed billings and a 25 percent penalty based on the billings. Id.

CONCLUSIONS OF LAW AND OPINION

At hearing concerning claimant's appeal from the Director's order, claimant contended that the prior litigation before Referee Davis, which resulted in a final order setting aside the employer's May 5, 1993 denial of low back treatment, precluded the employer from requesting Director review of the same treatment. Referee Hazelett disagreed, concluding that the Director's review was procedurally proper and that the Director's order was supported by substantial evidence. In so concluding, Referee Hazelett found that the Director had initiated review of the disputed treatment.

On review, claimant contests the Referee's finding that the Director initiated review of medical treatment under ORS 656.327. Claimant contends that Director review was initiated by the employer and that such review was precluded by Referee's Davis' order. We agree and reverse.

The record shows that the employer requested Director review of medical treatment by letter dated January 14, 1994. It is unclear why the Director subsequently advised the parties, by letter dated January 24, 1994, that the Director had initiated review of the disputed treatment. However, based on this record, we find that it was the employer that initiated Director review of treatment by its letter dated January 14, 1994.

Claimant's contention that Director review under ORS 656.327 was precluded by Referee Davis' order, was the matter at issue in the earlier proceeding before Referee Lipton in WCB Case No. 94-01051. On Board review in that case, we held that, by virtue of Referee Davis' final order setting aside the employer's May 5, 1993 denial, the employer was required to accept responsibility for physical therapy rendered from March 1993 through December 1993 and for the June 29, 1993 office visit with Dr. Jura. Edwin P. Vining, supra. We also assessed a penalty for the employer's unreasonable refusal to pay those billings. Id.

Under the doctrine of claim preclusion, when there has been an opportunity to litigate a question along the road to a final determination, and a final judgment is entered that disposes of the matter, then further litigation of the matter is barred. See Drews v. EBI Companies, 310 Or 134, 140 (1990); King v. Building Supply Discount, 133 Or App 179, 183 (1995). Here, the matter at issue is claimant's entitlement to physical therapy from March 1993 through December 1993 and the June 29, 1993 office visit with Dr. Jura. This matter was litigated by the same parties before Referee Davis, and it was resolved by his final order setting aside the employer's denial. That final judgment barred the employer from further litigation of this matter before the Director. Accordingly, the Director's April 13, 1994 order shall be vacated. In accordance with our February 22, 1995 Order on Review in WCB Case No. 94-01051, the employer is directed to pay the disputed medical billings.

Claimant is entitled to an assessed attorney fee for services rendered at hearing and on review regarding the Director's order. See ORS 656.386(1); Lois I. Schoch, 47 Van Natta 71 (1995). 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, payable by the 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 counsel may go uncompensated.

ORDER

The Referee's order dated September 2, 1994 is reversed. The Director's Proposed and Final Order Concerning a Bona Fide Medical Services Dispute dated April 13, 1994 is vacated. For services rendered at hearing and on review, claimant's counsel is awarded an assessed fee of \$3,000, to be paid by the self-insured employer.

January 25, 1995

Cite as 47 Van Natta 702 (1995)

In the Matter of the Compensation of
PATRICIA A. VOLDBAEK, Claimant
 WCB Case Nos. 94-07550 & 94-05662
ORDER DENYING MOTION TO DISMISS
 Pozzi, Wilson, et al., Claimant Attorneys
 Lundeen, et al., Defense Attorneys
 Hoffman, Hart & Wagner, Attorneys
 Jerome Larkin (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing Liberty Northwest Insurance Corporation's request for review of a Referee's order on the ground that a copy of its request was not served on all parties. We deny the motion.

FINDINGS OF FACT

The Referee's order issued on November 3, 1994. Parties to that order were claimant, the SAIF Corporation, Liberty Northwest, and their respective insureds.

On November 21, 1994, Liberty Northwest mailed, by certified mail, a request for Board review of the Referee's order to the Board. The request included a Certificate of Mailing stating that a copy had been mailed to claimant and her counsel, as well as to Liberty Northwest and its insured; the request did not include any such certification establishing similar service on SAIF, its insured, or its attorney. See OAR 438-05-046(2)(b); 438-11-005(3).

On November 23, 1994, the Board received claimant's cross-request for review of the Referee's order. The cross-request included a Certificate of Service stating that a copy had been mailed to Liberty Northwest, its insured, and its attorney; the request did not include any such certification establishing similar service on SAIF, its insured, or its attorney. See OAR 438-05-046(2)(b); 438-11-005(3).

On November 25, 1994, the Board mailed two letters acknowledging the requests for review. The first was a computer-generated letter to all parties and their legal representatives acknowledging Liberty's request. The second was expressly directed to claimant's counsel acknowledging claimant's "cross-request for Board review." In addition, copies of the second letter were mailed to all parties and their legal representatives.

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).

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance v. King, 63 Or App 847 (1983). All parties to the referee's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. Kelsey v. Drushella-Klohk NCE, 128 Or App 53, 57 (1994); Mosley v. Sacred Heart Hospital, *supra*.

Here, based on Liberty Northwest's and claimant's certificate of services, neither SAIF nor its insured received a copy of their respective requests for review of the Referee's November 3, 1994 order. However, computer-generated letters from the Board acknowledging the requests were mailed to all parties to the proceeding on November 25, 1994.

Since the Board's acknowledgment letter was mailed to all parties to the hearing within 22 days after the Referee's order, we conclude that it is more probable than not that SAIF and its insured received actual notice of Liberty Northwest's request for Board review within the statutory 30-day period. See Wayne V. Pointer, 44 Van Natta 539 (1992); Denise M. Bowman, 40 Van Natta 363 (1988); John D. Francisco, 39 Van Natta 332 (1987). Consequently, we are persuaded that the non-served parties and / or their legal representatives received actual notice of Liberty Northwest's appeal within the 30-day statutory period. See Zurich Ins. Co. v. Diversified Risk Management, *supra*; Argonaut Insurance v. King, *supra*.

Accordingly, claimant's motion to dismiss is denied. The briefing schedule shall be revised as follows. Liberty's appellant's brief has been received. Claimant's cross-appellant's/respondent's brief and SAIF's respondent's brief shall be due 21 days from the date of this order. Liberty's reply/cross-respondent's brief shall be due 14 days from the date of mailing of claimant's cross-appellant's/respondent's brief and SAIF's respondent's brief. SAIF's cross-respondent's brief shall be due 14 days from the date of mailing of claimant's cross-respondent's brief. Claimant's cross-reply shall be due 14 days from the date of mailing of Liberty's cross-respondent's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

February 22, 1995

Cite as 47 Van Natta 703 (1995)

In the Matter of the Compensation of
HAROLD E. SMITH, Claimant
 WCB Case Nos. 94-01874 & 94-01873
 ORDER DENYING MOTION TO DISMISS
 Olson Law Firm, Claimant Attorneys
 Williams, Zografos, et al., Defense Attorneys

The self-insured employer has moved the Board for an order dismissing claimant's request for review of a Referee's order. Specifically, the employer contends that claimant's request was untimely filed. We deny the motion.

FINDINGS OF FACT

The Referee's Opinion and Order issued on December 22, 1994. On Monday, January 23, 1995, the Board received claimant's request for review of the Referee's order. The request included a Certificate of Service stating that a copy had been mailed to the employer's counsel on January 23, 1995.

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).

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance v. King, 63 Or App 847 (1983). All parties to the referee's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. Kelsey v. Drushella-Klohk NCE, 128 Or App 53, 57 (1994); Mosley v. Sacred Heart Hospital, *supra*.

"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 an employer's insurer or 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, noting that claimant's request for review was filed with the Board on January 23, 1995 (32 days after the Referee's December 22, 1994 order), the employer contends that the request was untimely filed. We disagree.

The 30th day after the Referee's December 22, 1994 order was January 21, 1995, a Saturday. Therefore, the final day to perfect a timely appeal was Monday, January 23, 1995, the first business day following the expiration of the 30 day period. See Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as claimant's request for review was received by the Board on January 23, 1995, it was timely filed. See ORS 656.289(3); 656.295(2); OAR 438-05-046(1)(a).

We apply similar reasoning to conclude that notice of claimant's appeal was timely provided to the employer. Claimant's certificate of service by mail states that a copy of claimant's request was mailed to the employer's attorney on January 23, 1995. That certification is uncontested. Furthermore, no contention has been made that the employer has been prejudiced by not directly receiving a copy of claimant's request for review. In the absence of such a finding, we hold that claimant's timely service by mail upon the employer's counsel is adequate compliance with ORS 656.295(2). See Argonaut Insurance v. King, *supra*; Nollen v. SAIF, *supra*; Franklin Jefferson, 42 Van Natta 509 (1990); Denise M. Bowman, 40 Van Natta 363 (1988).

Accordingly, the employer'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 case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNY B. CONNER, Claimant
WCB Case No. 94-01980
ORDER ON REVIEW
Van Valkenburgh, et al., Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Referee Peterson's order that: (1) set aside its denial of claimant's degenerative lumbar disc disease; and (2) awarded an assessed fee of \$3,700. On review, the issues are compensability and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

Compensability

In January 1993, claimant injured his back. The insurer accepted a claim for lumbar contusion. The Referee found that claimant proved the compensability of a degenerative disc disease condition. The insurer objects to this conclusion, asserting that the medical evidence is not sufficient to carry claimant's burden of proof.¹

The record shows that claimant has degenerative disc disease and that such condition preexisted his January 1993 accident. (Exs. 27, 28-2, 35, 41). The record also demonstrates that claimant sustained a lumbar strain as a result of the accident; the strain resolved; and claimant's continuing low back symptoms are due to degenerative disc disease. (Exs. 28-2, 34, 35, 39, 41). This proceeding concerns only the compensability of claimant's continuing symptoms from the degenerative disc disease.

According to a report to which Dr. Parsons, consulting neurosurgeon, concurred on April 18, 1994, the work injury was the major contributing cause of the onset of symptoms of the degenerative disc disease. (Ex. 39-1). However, Dr. Parsons personally added that "[i]t can not [sic] be determined whether [claimant] would be experiencing low back pain at this time from his degenerative disc disease even if he had not sustained the injury on January 14, 1993." (Id. at 2).

Based on this report, we find that the compensable injury combined with the preexisting condition to cause claimant's need for treatment and disability resulting from the symptomatic degenerative disc disease. Thus, we agree with the Referee that compensability properly is analyzed under ORS 656.005(7)(a)(B). Under that statute, the relative contribution of each cause, including the precipitating cause, is evaluated to determine which is the major contributing cause of the need for treatment and disability. Dietz v. Ramuda, 130 Or App 397, 401-02 (1994).

Because Dr. Parsons indicated that the work injury was the major contributing cause of claimant's need for treatment, we conclude that claimant carried his burden. However, we further interpret Dr. Parson's additional comment that, at least by April 18, 1994, he could not attribute claimant's continuing symptoms to the industrial injury. In other words, we find a lack of proof that, by April 18, 1994, the industrial injury continued to be the major contributing cause of the degenerative disc disease being symptomatic.

¹ In its brief on review, the insurer asserts that the Referee made his decision in reliance on finding that claimant sustained permanent disability following the injury and, to refute the Referee's conclusion, asks the Board to take administrative notice of an Order on Reconsideration awarding no permanent disability. We decline the request. We disagree with the insurer's characterization of the Referee's reasoning; instead, we find that the Referee properly decided compensability under ORS 656.005(7)(a)(B) by determining whether the January 1993 injury was the major contributing cause of claimant's need for treatment and/or disability.

The remaining opinions either do not address causation, (Ex. 40), or, as with the opinion of the treating osteopath, Dr. Alaimo, show only a material contributing cause relationship between the injury and the degenerative disc disease, (Ex. 41). Thus, we conclude that claimant carried his burden of proving the compensability of his need for treatment and disability through April 18, 1994. Accordingly, we agree with the Referee that the insurer's denial should be set aside to this extent.

Attorney Fees

Inasmuch as we have in part reversed the Referee, we also modify the assessed attorney fee award for services at hearing. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing is \$2,500. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

In view of this reduction, we do not address the insurer's assertion that the Referee's award of \$3,700 is excessive. Finally, inasmuch as claimant's compensation was reduced on review, claimant's attorney is not entitled to an assessed attorney fee for services on review. See ORS 656.382(2).

ORDER

The Referee's order dated June 20, 1994 is affirmed in part, reversed in part and modified in part. That portion setting aside the insurer's denial with regard to claimant's need for treatment and disability after April 18, 1994 is reversed. The insurer's denial is reinstated and upheld to this extent. In lieu of the Referee's \$3,700 attorney fee award, claimant's counsel is awarded an assessed fee of \$2,500 for services at hearing, to be paid by the insurer. The remainder of the Referee's order is affirmed.

April 14, 1995

Cite as 47 Van Natta 706 (1995)

In the Matter of the Compensation of
PETE PADILLA, Claimant
 WCB Case No. C5-00384

ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT

Reviewed by Board Members Neidig and Gunn.

On February 14, 1995, the Board received the parties' Claim Disposition Agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury.

On March 29, 1995, the Board disapproved the parties' disposition. Claimant has now requested reconsideration, submitting an addendum which would amend the original CDA.

As stated above, the parties' CDA was disapproved on March 29, 1995. Claimant's request for reconsideration was filed on April 7, 1995. Thus, we find that claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Accordingly, we will reconsider this CDA. OAR 438-09-035(3).

By letter dated March 7, 1995, the Board requested an addendum from the parties on the basis that the proposed agreement contained the following language:

"The parties agree to dispose of this claim, including settlement of any existing disputes regarding nonmedical benefits." (Emphasis supplied).

In requesting that the language in the CDA be corrected, the Board reasoned that it had previously disapproved CDA's involving or referring to denied claims. See Donald Rhuman, 45 Van Natta 1493 (1993). We reasoned that the function of a CDA was to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. See Donna J. Look, 46 Van Natta 1552 (1994); Barbara L. Whiting, 46 Van Natta 1684 (1994) on recon 46 Van

Natta 1715 (1994). Furthermore, we held that it is not the function of a CDA to dispense with disputes arising from allegedly unreasonable claims processing, and that other procedural avenues (such as stipulations and disputed claim settlements) were available to accomplish such objectives. Donald Rhuman, supra. See Frederick M. Peterson, 43 Van Natta 1067 (1991).

On March 22, 1995, the Board received the parties' response to our request to correct the above-stated language. The parties agreed that the following language should be inserted:

"The parties agree to dispose of this claim, including settlement of any existing disputes regarding non-medical disputes with ORS Chapter 656 except denial disputes."

In our March 29, 1995 order disapproving the CDA, the Board concluded that the proposed addendum did not correct the language referring to settlement of "existing disputes," and that the proposed CDA was not a proper matter for disposition of noncompensability matters because CDA's are intended for accepted (as opposed to disputed) claims, as the claims exist at the time the Board receives the CDA. Donald Rhuman, supra.

In their April 7, 1995 addendum, the parties agree that the following language should be inserted to correct the aforementioned language:

"Parties agree to dismiss with prejudice, or otherwise dispose of non-medical issues under the accepted claim that were raised or could have been raised from operative facts that were ripe for dispute at the time of this agreement."

In Harold Edwards, 47 Van Natta 472, on recon 47 Van Natta (1995), the Board concluded that corrected language submitted in an addendum did not attempt to dispose of or resolve "existing disputes" (disputed portions of the claim), but rather pertained to non-medical conditions of the accepted claim. We find that the corrected language in this addendum satisfies that criterion. In addition, we find that the addendum states that the proposed agreement will dispose only of issues pertaining to the CDA which could have been raised at the time this agreement was presented to the Board. See Barbara L. Whiting, supra.

We find that the agreement, as amended by the parties' April 7, 1995 addendum, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). We do not find any statutory basis for disapproving the agreement. ORS 656.236(1). Accordingly, on reconsideration, the parties' claim disposition agreement is approved, as amended, for a total consideration of \$18,750, to be paid to claimant.

IT IS SO ORDERED.

April 18, 1995

Cite as 47 Van Natta 707 (1995)

In the Matter of the Compensation of
VERNON E. FAULKNER, Claimant
WCB Case No. 93-10985
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Livesley's order that: (1) set aside its denial of claimant's facial injury claim; and (2) awarded claimant's counsel a \$6,000 assessed attorney fee. Claimant asserts that, based on the employer's post-Referee order "1502" form indicating that the employer had accepted claimant's claim, the employer is barred from appealing the Referee's compensability decision. On review, the issues are dismissal and, alternatively, compensability and attorney fees. We deny the motion to dismiss, and affirm.

FINDINGS OF FACT

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

On September 20, 1994, the Referee issued the Opinion and Order in this matter, setting aside the employer's denial of claimant's facial injuries claim. On September 29, 1994, the employer issued a "1502" form stating that it was accepting a nondisabling injury. Under the "Explanations" section was the typewritten text, "disputing attorney fee only." The employer thereafter requested Board review of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Dismissal

Claimant asserts that, in view of the employer's acceptance of his claim via the "1502" form, the employer is barred from appealing the Referee's compensability decision. We treat claimant's assertion as a motion to dismiss and we deny the motion.

In SAIF v. Mize, 129 Or App 636 (1994), prior to petitioning for judicial review of a Board order, the carrier accepted the claimant's claim by a clear and unqualified Notice of Acceptance. The court held that a carrier's acceptance rendered moot any controversy over the compensability of the claimant's claim, and dismissed the employer's petition for judicial review. Id. at 640.

In Scott C. Clark, 47 Van Natta 133 (1995) and Timothy L. Williams, 46 Van Natta 2274 (1994), we applied the Mize reasoning. In Clark, the carrier sent the claimant two letters indicating that it had accepted his claim; in Williams, the employer accepted the claimant's claim by a Notice of Acceptance.¹ In each case, we concluded that the carrier's clear and unqualified acceptance rendered moot any controversy regarding the compensability of the claimant's claim. Clark, supra, 47 Van Natta at 134; Williams, supra, 46 Van Natta at 2276. Therefore, we granted the claimants' motions to dismiss the carriers' requests for Board review.

This case is distinguishable from Mize, Clark and Williams. Here, the only indication that the employer "accepted" claimant's claim is a "1502" form indicating that it had accepted as disabling some unspecified claim. Because a "1502" form does not constitute an acceptance, EBI Ins. Co. v. CNA Insurance, 95 Or App 448 (1989); see Lawrence H. Eberly, 42 Van Natta 1965 (1990), we conclude that claimant has failed to establish that the employer accepted his claim. See also Janice M. Hunt, 46 Van Natta 1145 (1994) (carrier's issuance of "1502" form reclassifying claim consistent with referee's directive to process claim as disabling). On this ground, we find Mize and its progeny distinguishable.

In reaching this conclusion, we are mindful that the "1502" form stated that the employer had accepted a claim and that it was "disputing attorney fees only." Notwithstanding that qualification, we conclude that, on its own, the form is insufficient to establish that the employer accepted claimant's claim. See EBI Ins. Co. v. CNA Insurance, supra; see Lawrence H. Eberly, supra.

For these reasons, we deny claimant's motion to dismiss.

Compensability

The employer asserts that the Referee erred in concluding that claimant was not an active participant in an altercation that resulted in his injuries. We disagree.

Claimant was a car checker, and Clayton, a co-worker, was a car/truck loader. On the day claimant was injured, Clayton's supervisor had told him to haul to claimant's car. Clayton approached claimant, who told him to haul to the next car. Clayton asked claimant what he needed to haul. Claimant became irritated with Clayton, grabbed a clipboard with the manifest/order, and swore at Clayton, telling him to haul whatever the "f___" he wanted. Clayton responded by backhanding claimant across the face, causing the injuries for which claimant presently seeks compensation.

¹ In Williams, after the carrier accepted the claim, it purported to withdraw that acceptance via a "1502" form stating that the acceptance had been issued by mistake. In view of the unqualified nature of the Notice of Acceptance, we concluded that the carrier was required to comply with the requirements of ORS 656.262(6). Because the "1502" form did not comply with that statute, we rejected the carrier's "mistake" argument. 46 Van Natta at 2275.

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. A claimant may be an "active participant" if he assumes an active or aggressive role in a fight, and if he has an opportunity to withdraw from the encounter and not participate in the fight, but fails to withdraw. See Irvington Transfer v. Jasenosky, 116 Or App 635, 640 (1992).

In Jasenosky, the claimant was returning to his assigned work area after asking his co-worker why he still wanted to "kick his ass," when his co-worker charged him and assaulted him. The court upheld the Board's findings that the claimant did not have an opportunity to withdraw from the situation and that he did not voluntarily assume an active or aggressive role in the altercation. 116 Or App at 641. Consequently, the court held that the Board did not err in concluding that claimant was not an active participant in the fight and that, accordingly, former ORS 656.005(7)(a) (since renumbered ORS 656.005(7)(b)(A)) did not exclude the claimant's injuries from compensability.

We apply that reasoning here. After Clayton asked claimant about his work assignment, claimant became angry with Clayton, grabbed the clipboard and swore at Clayton. Clayton then, without warning, backhanded claimant, causing his facial injuries. Under the circumstances, we conclude that claimant was not an "active participant" in an assault or combat. Furthermore, we conclude that, given Clayton's swift physical response, claimant did not have an opportunity to withdraw from the situation. Accordingly, we conclude that ORS 656.005(7)(b)(A) does not exclude claimant's injuries from compensability.

For reasons set forth in the Referee's order, as supplemented herein, we agree that claimant's injuries are compensable. Accordingly, we affirm the Referee's decision setting aside the employer's denial of claimant's injury claim.

Attorney Fees

We adopt and affirm the Referee's conclusions regarding this issue.

Claimant's counsel is entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors 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 concerning the compensability issue is \$1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services concerning the attorney fee issue. Dotson v. Bohemia, 80 Or App 233 (1986). Likewise he is not entitled to an attorney fee for his counsel's unsuccessful attempt to preclude the employer's compensability appeal.

ORDER

The Referee's order dated September 20, 1994 is affirmed. For services on Board review, claimant's counsel is awarded \$1,000, to be paid by the self-insured employer.

April 18, 1995

Cite as 47 Van Natta 709 (1995)

In the Matter of the Compensation of
DAVE PERLMAN, JR., Claimant
WCB Case No. 94-02565
ORDER ON REVIEW
Brad Larson, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Hazelett's order that affirmed an Order on Reconsideration awarding no unscheduled permanent disability for a low back injury. On review, the issue is entitlement to unscheduled permanent disability.

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

Claimant challenges the Referee's finding that the medical evidence failed to show any permanent impairment due to the compensable injury. Relying on the medical arbiter panel's report, claimant asserts that he proved a loss in range of motion due to the compensable injury and is entitled to an award of 14 percent unscheduled permanent disability.

Prior to claim closure, Dr. Wilson, neurologist, and Dr. Neufeld, orthopedic surgeon, examined claimant on behalf of the insurer. They found that measurements for the range of motion of the low back were invalid because the straight leg raising while sitting was inconsistent with that for forward bending while standing. (Ex. 18-5). They concluded that there was no evidence of permanent impairment as a result of the compensable injury. (*Id.*). Claimant's treating physician, Dr. Mitchell, concurred with the report. (Exs. 21-1, 24).

The medical arbiter panel measured range of motion for the low back and diagnosed, by history, a "presumed sprain/possible contusion" of the lumbar spine. (Ex. 30-3). With regard to impairment, the panel only stated that there was no evidence showing that claimant was unable to repetitively use any body part. (*Id.*). The Order on Reconsideration found that the range of motion measurements did not "meet validity criteria" because "the total sacral motion of 12 degrees was not within 10 degrees of the tightest straight leg raising of 44 degrees." (Ex. 33-4).

Although the medical arbiter panel's report did not indicate that its range of motion measurements were invalid, we find their report insufficient to show impairment due to the compensable injury. Drs. Wilson and Neufeld expressly indicated that the measurements recorded from their examination were not valid; claimant's treating physician concurred with the report. The medical arbiter panel recorded even more limited range of motion than Drs. Wilson and Neufeld. Furthermore, the diagnosis of "presumed sprain" indicates that the panel found no evidence of such a condition during the time of its examination.

Thus, for these reasons, we find a lack of persuasive evidence of impairment due to the compensable injury. Hence, we agree with the Referee that claimant is not entitled to permanent disability.

ORDER

The Referee's order dated August 29, 1994 is affirmed.

April 18, 1995

Cite as 47 Van Natta 710 (1995)

In the Matter of the Compensation of
PEDRO C. RODRIGUEZ, Claimant
WCB Case No. 94-05855
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Nichols' order that: (1) partially upheld the insurer's denial of claimant's back injury claim; and (2) declined to assess a penalty for an allegedly unreasonable denial. Claimant seeks an increased attorney fee award. The insurer cross-requests review of that portion of the order that partially set aside the same denial. On review, the issues are compensability, penalties and attorney fees.

We adopt and affirm the Referee's order. See Reynolds Metals v. Mendenhall, 133 Or App 428, 433 (1995) ("[S]etting aside a denial is not necessarily an all or nothing proposition. So long as the evidence supports its decision, the Board may set aside the denial of some conditions and affirm the denial of others.").

In addition, we offer the following supplementation concerning the amount of the attorney fee awarded at the hearing level.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is \$1,000, as awarded by the Referee. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearing record), the complexity of the issue, the value to claimant of the interest involved, and the risk that claimant's counsel might go uncompensated.

Finally, claimant is not entitled to an attorney fee on Board review, because he filed no brief responding to the insurer's cross-appeal. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated September 6, 1994 is affirmed.

April 18, 1995

Cite as 47 Van Natta 711 (1995)

In the Matter of the Compensation of
MICHAEL SANCHAGRIN, Claimant
WCB Case No. 94-06681
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Referee Peterson's order which: (1) directed it to accept claimant's allergic contact dermatitis; and (2) awarded claimant's counsel an assessed fee for prevailing over a "de facto" denial of that condition. On review, the issue is compensability.

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

On review, SAIF contends that the Referee erred in concluding it is responsible for claimant's allergic contact dermatitis. SAIF notes that claimant began working for SAIF's insured as a printing press operator and printer in July 1992, but that he had been working in the printing industry since 1971. Based on evidence that claimant had a prior history of dermatitis on his hands, arms and face, SAIF argues there is no evidence to support the Referee's finding that its employment exposure caused the underlying allergic dermatitis. SAIF maintains that its claim acceptance was properly limited to "bilateral hand contact dermatitis." We disagree.

Although claimant's symptoms were localized to his hands and fingers, the underlying condition giving rise to those symptoms was diagnosed as allergic contact dermatitis. Dr. Storrs, consulting dermatologist, opined that chemicals contacted at work for SAIF's insured constituted the major contributing cause to the development of claimant's allergic contact dermatitis. (Ex. 25C-5). Dr. Storrs' uncontroverted opinion provided ample medical evidence to prove that claimant's allergic contact dermatitis was compensably related to his employment with SAIF's insured. In any event, if SAIF wished to assert that actual responsibility for the allergic contact dermatitis lies with a prior employer, it should have issued notice of intent to disclaim responsibility pursuant to ORS 656.308(2). Because SAIF did not do so, it is barred from asserting that responsibility for the allergic contact dermatitis lies with another employer. See Gene R. Jones, 47 Van Natta 238 (1995).

Claimant's counsel would ordinarily be entitled to an assessed attorney fee under ORS 656.382(2) for services rendered on Board review. However, inasmuch as claimant's counsel did not file an appellate brief on Board review, we conclude that an assessed fee is not warranted in this case. See Shirley M. Brown, 40 Van Natta 879, 882 (1988).

ORDER

The Referee's order dated September 23, 1994 is affirmed.

In the Matter of the Compensation of
ROBERT C. TOTH, Claimant
WCB Case No. 94-01227
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of that portion of Referee Michael V. Johnson's order that set aside its denial of claimant's injury claim for a poisonous insect bite. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is employed as a telemarketer. At the time of claimant's October 11, 1993 hiring, the employer was in the process of remodeling the upper floors of its offices. While at work on October 26, 1993, claimant's right calf began to itch and by the end of the day he had developed a raised red circular welt. The welt became a sore and grew increasingly more painful. By November 2, 1993, claimant had difficulty walking and sought medical care. His attending physician, Dr. Winkler (family physician), diagnosed his condition as "right low extremity cellulitis secondary to spider bite," and admitted claimant to the hospital. (Ex. 1). The next day surgery was performed, by Dr. McCulley, to excise the wound site and remove necrotic tissue.

Both Dr. Winkler and Dr. McCulley responded affirmatively to a "check-the-box" letter from claimant's counsel inquiring whether claimant's right leg condition and need for surgery was caused by toxins from a poisonous insect bite. (Exs. 8 & 9). Based on claimant's statement that his symptoms began after having been at work two or three hours, both doctors agreed that the insect bite probably occurred after he arrived at work. (Exs. 8 & 9). However, neither Dr. Winkler nor Dr. McCulley provided any reasoning or background on poisonous insects which would explain their conclusion. In fact, Dr. Winkler attributed the insect bite to a type of spider (Brown Recluse) that has never been found in Oregon. (Exs. 1-2, 8-1; Tr. 73).

Claimant argues that the employer probably imported a poisonous insect onto its premises during the course of its remodeling. Specifically, claimant alleges that he observed a "spider nest or something" in a roll of new carpet approximately one week before the sore on his right leg appeared. (Ex. 5A-6). However, claimant has not actually seen any spiders at the employer's place of business. (Id.). Conversely, claimant indicated that he has noticed spiders at his home. (Tr. 46).

At hearing, the employer presented an entomologist, Dr. Akre, who has extensive experience studying insects. (Ex. 14). In particular, Dr. Akre has investigated approximately 150 cases of spider bites. (Tr. 68). Dr. Akre stated that claimant's right leg condition was not consistent with what would be expected of a bite from the types of spiders indigenous to the Pacific Northwest.¹ (Tr. 68;85-86). He explained that the only type of spider that could inflict such a bite was the "aggressive house spider," a species of spider that would not be found on the third floor of the employer's business (where claimant suspects he was bitten) because such spiders are too heavy to climb. (Tr. 75). Although unable to determine what caused claimant's initial sore, it was Dr. Akre's opinion that claimant's right leg condition and need for surgery was attributable to a secondary infection, probably brought on from his scratching the sore. (Tr. 90, 106).

¹ Dr. Akre noted that there are two types of spider venom: (1) neurotoxic venom causing systemic reactions; and (2) necrotoxic venom causing the tissue surrounding the wound site to decompensate or necrose, as occurred with claimant. In Oregon, the only spider with necrotoxic venom that poses a threat to man is the aggressive house spider, or *Tegenaria agrestis*.

After reviewing Dr. Akre's published works, the Referee concluded that it was "more likely than not" that claimant was bitten by an "aggressive house spider." The Referee explained that it was unlikely that claimant brought this particular sort of spider with him onto the employer's premises because this type of spider is not a "climber" and, therefore, it is unlikely that it would have "boarded" him. Furthermore, the Referee reasoned that, given the aggressive nature of this particular spider, if claimant had encountered it before entering the employer's premises, he would have been bitten earlier as well. Instead, the Referee determined that, inasmuch as the male "aggressive house spider" roams during the time of year when claimant was bitten, the contemporaneous remodeling in the employer's building would have "made ideal spider habitat."

Accordingly, the Referee found that the alleged spider bite was compensable because the employer's work environment created an increased risk of being injured. See Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991) (In adopting the "increased danger rule," court held that where an injury would not have occurred but for the work environment having placed the worker at increased risk of being injured, the resulting injury is considered to have both arisen out of and occurred in the course of employment). We disagree.

To begin, we are not persuaded that the employer's remodeling increased the danger that claimant would be bitten by a spider. In particular, no one is exactly certain what caused claimant's sore; nor is there evidence that there were spiders on the employer's premises. In order for an otherwise noncompensable injury (*i.e.*, idiopathic) to be compensable, claimant must prove that the obligations of being a telemarketer put him in a position where the risk of being bitten by a poisonous insect was more likely. See Marshall v. Bob Kimmel Trucking, *supra*. There is no evidence that encountering poison insects was a risk of claimant's employment. Consequently, the "increased danger rule" is not applicable.

Moreover, we agree with the insurer's contention that a more fundamental inquiry is dispositive. Namely, did claimant prove by a preponderance of the evidence that his right leg condition is attributable to a spider bite he incurred while at work? We conclude that he did not. See ORS 656.266; Lynne C. Gibbons, 46 Van Natta 1698 (1994); Ruben G. Rothe, 45 Van Natta 369 (1993).

The Referee found that there were "glaring discrepancies" between Dr. Akre's testimony and the professional publications he has authored. (Exs. 12 & 13). The Referee did not specify what those discrepancies were, but claimant advances several examples of alleged inconsistencies within Dr. Akre's opinion: (1) he incorrectly believed that claimant felt the alleged insect bite when it occurred; (2) he incorrectly believed that claimant's wound did not suppurate; and (3) he incorrectly believed that claimant never suffered a fever. (Resp. Br. at 14-16).

Claimant argues that Dr. Akre based his opinion on this incorrect history and, therefore, his opinion is not persuasive. See Somers v. SAIF, 77 Or App 259 (1986). We disagree.

Whether claimant actually felt the insect bite or not is disputed, but not relevant, because the evidence indicates that a spider bite may or may not be felt. (Ex. 13-18). Similarly, whether claimant's wound site suppurated is disputed: hospital records indicate that it did not, but claimant's wife testified that she noticed pus and drainage. (Ex. 1-1; Tr. 52-53). Lastly, Dr. Akre explained that the fever claimant suffered several days after the alleged spider bite was due to the secondary infection in his right leg. (Tr. 85).

By way of comparison, Drs. Winkler and McCully were unable to provide any reasoning that would substantiate their conclusion that claimant was bit by a spider. For example, Dr. Winkler demonstrated that he has very limited knowledge concerning spiders in the region (*i.e.*, there are no Brown Recluse spiders in Oregon). Inasmuch as the medical opinions of Drs. Winkler and McCully are inadequately explained regarding the causation of claimant's right leg condition, we find those opinions to be conclusory; and, therefore, we afford them little weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Moreover, we find that the "discrepancies" noted by the Referee have not been proven to exist. Rather, Dr. Akre's opinion has consistently been premised on the dissimilarities between claimant's initial symptoms and the documented effects of venom from the "aggressive house spider." Specifically, claimant asserts that he was bit on the morning of October 26, but it was not until November 1st that his sore began to hurt and he developed a high fever and infection. (Ex. 5A-5).

Dr. Akre explained that, if claimant had been bitten by an "aggressive house spider," then he would have developed an intense headache within one to five hours, accompanied thereafter by blurred vision and severe pains in the joints. (Tr. 68). Dr. Akre also noted that itching is not a symptom associated with the bite of the aggressive house spider. (*Id.*). Furthermore, no fever would be expected. (Tr. 69-70). Instead, Dr. Akre points to that subsequent fever as evidence that a secondary infection, not a spider bite, was the cause of claimant's disability and need for treatment. (*Id.*).

We conclude that Dr. Akre's opinion comports with the evidence in the record. Specifically, Dr. Akre premised his opinion on two discrete findings: (1) claimant's right leg sore, in addition to his immediate symptoms thereafter, was not consistent with a spider bite; and (2) claimant's subsequent fever and swelling five days after the sore appeared is attributable to a secondary infection caused by his scratching. Conversely, the medical opinions of Drs. Winkler and McCully provide almost no explanation for their conclusion that claimant's right leg condition was due to a poisonous insect bite. Under these circumstances, we find that Dr. Akre's opinion is the most complete and well-reasoned. See *Somers v. SAIF*, *supra*.

Furthermore, because this case presents a unique and complex question concerning medical causation, we defer to expert analysis rather than expert external observation. See *Allie v. SAIF*, 79 Or App 284 (1986). Based on his knowledge of entomology and spider bites, we defer to Dr. Akre's expert opinion for this reason as well.

In conclusion, ORS 656.266 requires that a claimant must show that an injury or occupational disease is, in fact, related to the work environment. See *Lynne C. Gibbons*, *supra*; *Ruben G. Rothe*, *supra*. Inasmuch as we rely on the medical opinion of Dr. Akre, we hold that claimant's insect bite did not arise in the course and scope of his employment. Absent affirmative proof of the requisite casual link between his work and his alleged insect bite, claimant's injury claim for a right leg condition is not compensable.

Parenthetically, even if Dr. Akre's opinion were not persuasive, we discern no objective proof that claimant was bitten by a poisonous insect while at work. Specifically, there is no evidence that there were any spiders within the employer's premises. Claimant's testimony that he first noticed his right leg condition several hours after arriving at work is not dispositive of whether he was actually bitten at work. Furthermore, there is no extrinsic corroboration of claimant's allegation that he observed a "spider nest or something" in a roll of new carpet the week before he was bitten. The fact that the employer was importing rolls of carpeting and other materials necessary to remodel is not, in and of itself, probative concerning the issue of causation. Accordingly, even if we ignored Dr. Akre's opinion, we would find the evidence insufficient to satisfy claimant's burden to establish the requisite causal connection. ORS 656.266.

ORDER

The Referee's order dated September 23, 1994 is reversed. The insurer's denial of claimant's injury claim for a poisonous insect bite is reinstated and upheld. The Referee's attorney fee award is reversed.

April 19, 1995

Cite as 47 Van Natta 714 (1995)

In the Matter of the Compensation of
ARVEL T. CARTER, Claimant
WCB Case No. 94-02395
ORDER ON REVIEW
Galton, Scott & Collett, Claimant Attorneys
Vera Langer (Saif), Defense Attorney

Reviewed by Board Members Haynes, Turner-Christian and Hall.

Claimant requests review of Referee Thye's order that: (1) denied claimant's request to set aside the SAIF Corporation's allegedly prospective denials; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are whether SAIF issued improper prospective denials 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 September 1992 and was declared medically stationary as of October 22, 1992. Claimant sought further medical treatment in June 1993, which was denied by SAIF. In a December 13, 1993 Opinion and Order, claimant's medical treatment was determined to be compensable.

On February 2, 1994, SAIF wrote claimant:

"Your condition has been determined to be medically stationary on October 22, 1992 by a preponderance of medical opinion. This means your condition is not reasonably expected to materially improve with treatment or the passage of time.

"Future medical treatment you receive is considered palliative rather than curative. Palliative care is defined as treatment which temporarily relieves symptoms, but does nothing to diagnose, heal or permanently alleviate a medical condition." (Ex. 3).

In the letter, SAIF explained palliative treatment and said that claimant's physician may request approval for any palliative care. SAIF also said that "Payment for palliative care rendered prior to approval from SAIF may be your responsibility." (*Id.*)

Claimant's attorney wrote to SAIF, contending that the February 2, 1994 letter constituted an improper prospective denial of future medical treatment. (Ex. 4). Claimant's attorney asked SAIF to rescind the February 2, 1994 letter and provide proof of payment of all of claimant's current medical expenses.

On February 15, 1994, SAIF responded that it had paid all bills received for treatment before the February 2, 1994 letter. SAIF said that the February 2, 1994 letter "is advising all parties that future treatment is presumed to be palliative care and needs prior approval." (Ex. 5).

Claimant requested a hearing on SAIF's "denials." The Referee concluded that SAIF's February 2 and February 15, 1994 letters were not prospective denials, reasoning that SAIF's letters did not deny any future medical treatment, but merely informed claimant that it was considering his medical treatment as of February 2, 1994 to be palliative in nature. The Referee noted that claimant was not contending that the carrier had refused to pay a claim for medical treatment or that his medical treatment was curative and not palliative.¹

Claimant argues that, based on Frank L. Taylor, 45 Van Natta 2224 (1993), SAIF is precluded from presuming that future treatment is palliative. In Taylor, the Director had concluded that no bona fide medical services dispute existed because the physical therapy requested by the claimant was noncompensable palliative care. We found that the Director's order suggested that, as a matter of law, a claimant whose claim is closed has a stable medical condition and, therefore, all treatment rendered for that condition is palliative care. We set aside the Director's order, reasoning that evaluation of disputed medical services must be made without regard to the legal determination of whether or not the claim qualifies for reopening. We concluded that the issue of whether medical services are palliative or curative is determined on a case by case basis.

In Frank L. Taylor, *supra*, the parties disputed the claimant's medical services for physical therapy. Here, in contrast, claimant does not assert that SAIF has failed to pay any medical bills related to the accepted condition. Claimant does not seek payment for any subsequent medical treatment nor does he raise an argument that medical treatment is curative or palliative.

¹ We note that in Altamirano v. Woodburn Nursery, Inc., 133 Or App 16 (1995), the court held that since there was no evidence that the claimant's "current condition" required medical service or resulted in disability, there had been no "claim" and therefore, the carrier's attempted denial was ineffective. Here, there is no issue involving a current condition or a current claimed need for treatment. Instead, claimant is alleging that SAIF's letters constituted a denial of future benefits. Consequently, Altamirano is not controlling.

To the extent that SAIF's February 2, and February 15, 1994 letters suggest that all of claimant's future medical treatment will be palliative because claimant is medically stationary, that position is legally incorrect. Frank L. Taylor, supra. However, unlike in Taylor, we do not interpret SAIF's letters as declaring that claimant's future medical services are palliative as a matter of law. SAIF's statements that claimant's medical treatment is "presumed" or "considered" palliative do not necessarily mean that the treatment will be denied. SAIF's letters do not state that SAIF will deny any future claims. Rather, SAIF's February 2, 1994 letter stated that claimant's physician may request approval for any palliative care. We conclude that SAIF's letters merely indicate that future services might be denied.

Claimant relies on Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989), to argue that, by classifying all of claimant's future medical treatment as palliative, SAIF is currently denying compensability of his future medical treatments. In Striplin, the court set aside a denial which purported to deny "all further chiropractic care" as not reasonable and necessary for the compensable injury. The court held that, although a carrier may deny a specific unpaid claim or a current claimed need for treatment, it may not deny its future responsibility relating to an accepted claim.

We do not interpret SAIF's letters as denials of future responsibility for medical services. The fact that the letters did not inform claimant of his right to further curative treatment and aggravation rights does not transform the letters into denials. Notwithstanding SAIF's letters, claimant would not be precluded by the terms of SAIF's letters from filing a claim for medical treatment in the future, if his condition should warrant it. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989), rev den 309 Or 645 (1990). In other words, claimant is free to challenge SAIF's future medical services determinations in the appropriate forum.

We note that this case is distinguishable from Gary L. Best, 46 Van Natta 1694 (1994). In that case, the carrier had accepted the claimant's condition as "resolved." We determined that the acceptance necessarily implied that the carrier believed that it was no longer responsible for the claimant's benefits. We construed the carrier's actions as an attempt to deny responsibility for future benefits for the compensable condition. We held that the acceptance as "resolved" constituted an invalid prospective denial.

Here, in contrast, we do not interpret SAIF's letters as necessarily implying that future medical services will no longer be compensable. The letters merely advised claimant that future treatment would be "considered" palliative, and, as such, were subject to processing in a different manner than curative treatment. Such advice does not mean that future medical treatment will not be compensable.

Finally, the record does not establish that any compensation was unpaid at the time of the hearing. Under these 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, 108 Or App 253 (1991).

ORDER

The Referee's order dated June 6, 1994 is affirmed.

Board Member Hall dissenting

The majority's narrow reading of SAIF's February 2, and February 15, 1994 letters ignores the statutory language of ORS 656.245(1)(b) and disregards Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Because I disagree with the majority's analysis and conclusion, I respectfully dissent.

In SAIF's February 2, 1994 letter, it informed claimant that his condition was determined to be medically stationary and "[f]uture medical treatment you receive is considered palliative rather than curative." (Ex. 3). On February 15, 1994, SAIF advised claimant that "future treatment is presumed to be palliative care and needs prior approval." (Ex. 5).

Contrary to SAIF's letters, there is nothing in the text or context of ORS 656.245 to indicate that once a claimant is medically stationary, his or her medical services are automatically deemed or presumed to be "palliative." ORS 656.245(1)(a) provides, in part, that for every compensable injury, the

carrier "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." Curative medical services are compensable throughout the injured worker's lifetime, so long as those services are materially related to the compensable condition. ORS 656.245(1)(c); Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993).

Medical services can be curative even after a claimant is determined to be medically stationary and the claim is closed. Diana M. McCoy, 46 Van Natta 2220, 2222-23 (1994). There is no statutory presumption that all "future treatment" is palliative after a claimant is declared medically stationary. Instead, ORS 656.245(1)(b) provides that treatment after a claimant is medically stationary, which is in fact palliative, is, in turn, not compensable. The statute does not declare curative treatment rendered after a claimant is medically stationary to be noncompensable.

In order to understand the significance of SAIF's position, and that of the majority, we need look no further than the statute itself. ORS 656.245(1)(b) provides, in part, that " * * * after the worker has become medically stationary, palliative care is not compensable * * *." (Emphasis added). There are three exceptions: palliative care that is provided to a worker with permanent total disability, that is necessary to monitor prescription medication, or that is necessary to monitor a prosthetic device. Only if the carrier or the Director grants approval can the worker claim that palliative care that is otherwise noncompensable is a "medical service" within the meaning of ORS 656.005(8). Hathaway v. Health Future Enterprises, 320 Or 383 (1994). Simply stated, by presuming that all future care is palliative, SAIF is declaring prospectively that all future care is not compensable.

Based on Frank L. Taylor, 45 Van Natta 2224 (1993), SAIF is precluded from presuming that future treatment is palliative (*i.e.*, is not compensable). In Taylor, the Director had concluded that no bona fide medical services dispute existed because the physical therapy requested by the claimant was noncompensable palliative care. We found that the Director's order suggested that, as a matter of law, a claimant whose claim is closed has a stable medical condition and, therefore, all treatment rendered for that condition is palliative care. We set aside the Director's order, reasoning that evaluation of disputed medical services must be made without regard to the legal determination of whether or not the claim qualifies for reopening. We concluded that the issue of whether medical services are palliative or curative is determined on a case by case basis.

In the present case, SAIF's February 2, and February 15, 1994 letters impermissibly imply that, since claimant is medically stationary, all of his future medical treatment will be classified as palliative. See Frank L. Taylor, *supra*. Furthermore, SAIF's letters necessarily imply that it is denying responsibility for future benefits for claimant's compensable condition. Although a carrier may deny a specific unpaid claim or a current claimed need for treatment, it may not deny its future responsibility relating to an accepted claim. Evanite Fiber Corp. v. Striplin, *supra*. By informing claimant that his future medical services are "considered" and "presumed" to be palliative, SAIF informed claimant that future medical services are noncompensable. The letters constitute prohibited prospective denials under Evanite Fiber Corp. v. Striplin, *supra*.

This case is similar to Gary L. Best, 46 Van Natta 1694 (1994). In that case, the carrier had accepted the claimant's condition as "resolved." We determined that the acceptance necessarily implied that the carrier believed that it was no longer responsible for the claimant's benefits. We construed the carrier's actions as an attempt to deny responsibility for future benefits for the compensable condition. See Evanite Fiber Corp. v. Striplin, *supra*. We held that the acceptance as "resolved" constituted an invalid prospective denial.

Here, the majority attempts to distinguish Best on the ground that SAIF's letters merely advised claimant that future treatment would be "considered" palliative, and such advice does not mean that future medical treatment will not be compensable. The majority's analysis ignores ORS 656.245(1)(b), which provides that "palliative care is not compensable." (Emphasis added).

In my view, SAIF's letters indicate that it is classifying any future medical treatment as palliative. When read as a whole, SAIF's letters necessarily imply that it believes that it is no longer responsible for benefits for claimant's condition, since palliative care is not compensable unless the treatment complies with ORS 656.245(1)(b). The case of Evanite Fiber Corp. v. Striplin, *supra*, was

intended to govern a claimant's continued entitlement to benefits related to the accepted condition. Inasmuch as SAIF's letters place claimant's future compensation at risk, they constitute a prohibited prospective denial under Striplin. SAIF could have easily provided claimant with the necessary information regarding palliative treatment, including appeal or review rights pertaining thereto, without going the impermissible step further of declaring that future care would be presumed to be palliative (i.e., presumed to be not compensable).

For the foregoing reasons, I respectfully dissent.

April 19, 1995

Cite as 47 Van Natta 718 (1995)

In the Matter of the Compensation of
JANET R. CHAMP, Deceased, Claimant
WCB Case No. 93-03896
ORDER ON REVIEW
Max Rae, Claimant Attorney
Miller, Nash, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Decedent's putative statutory beneficiary¹ requests review of Referee Michael V. Johnson's order which found that: (1) she was not a statutory beneficiary; and (2) as such, was not entitled to receive compensation. On review, the issue is whether the decedent's putative beneficiary is entitled to pursue the matter to final determination. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Prior to her death, decedent filed a request for hearing on an Order on Reconsideration that awarded 7 percent (22.4 degrees) unscheduled permanent disability and 6 percent (9 degrees) scheduled permanent disability for the right leg (knee). Claimant sought additional scheduled and unscheduled permanent disability compensation, penalties and attorney fees.

Prior to the scheduled hearing, the parties agreed to increase the scheduled award by 10 percent. However, before a stipulation could be signed, decedent died for reasons unrelated to the compensable injury. Decedent's natural daughter, Karen Schaible, and the self-insured employer agreed to follow the unapproved agreement, unless decedent's death barred further action.

The Referee held that the employer was not statutorily obligated to pay the agreed-upon benefits to decedent's daughter. Since the daughter was not a minor child at the time of the decedent's compensable injury, the Referee reasoned that no statutory beneficiaries existed to pursue the claim. Decedent's daughter contends that, because she was an invalid dependent child, she qualifies as a statutory beneficiary and, as such, is entitled to pursue her mother's claim. We conclude that the employer is not statutorily obligated to pay the increased permanent disability.

Enforcement of the Agreement Between the Parties

The first question is whether the agreement between the parties, made prior to decedent's death, is a valid final agreement creating a legal obligation on the part of the employer to pay increased scheduled permanent disability. We conclude that, absent an order approving the settlement agreement in writing by a Referee, the parties' pre-hearing agreement is not legally valid and enforceable. See OAR 438-09-001(3); 438-09-005; 438-09-015(5); Shannon K. Hartshorn, 45 Van Natta 1243 (1993).

¹ Subsequent to requesting the hearing, Karen Schaible, the decedent's putative statutory beneficiary, died. Based on that event, the employer renews its motion to dismiss. We deny the motion. As reasoned in our prior order denying the employer's dismissal motion, because the putative beneficiary was living at the time she requested review, we proceed to review the matter. See Janet R. Champ, 46 Van Natta 1050 (1994).

In Hartshorn, at a hearing involving aggravation denials, the referee announced that the case had been "settled on the record by the parties by [the insurer's] agreeing to rescind its denial[s]. All issues related to those denials are hereby settled by this Order." No settlement stipulation was approved in writing by the referee, pursuant to the requirements set forth in OAR 438-09-001(3). Thereafter, the claimant requested another hearing, contending that the carrier had failed to begin payment of temporary disability within 14 days of the referee's oral announcement of the settlement. We concluded that the referee's oral announcement was not sufficient to create a legal obligation on the part of the insurer to begin the payment of temporary disability.

Here, as in Hartshorn, the parties came to an agreement after negotiation. However, no settlement stipulation was approved in writing by the Referee. Accordingly, there is no order creating a legal obligation on the part of the employer to increase its payment of permanent disability to decedent. Shannon K. Hartshorn, supra.

Entitlement to Pursue the Deceased Worker's Claim

The second question is whether decedent's daughter qualifies as a beneficiary who is eligible to pursue her mother's claim. The Referee reasoned that, because decedent's daughter was not a minor child at the time of the accident, she was statutorily ineligible to pursue the claim. The issue is whether decedent's daughter qualifies as a beneficiary because of her alleged status as an "invalid dependent child" under ORS 656.005(5).

Survival of actions in workers' compensation cases is governed strictly by statute. See Majors v. SAIF, 3 Or App 505 (1970); Charlotte Kuklhanek, 37 Van Natta 1797, 1798 (1985). If, as here, the worker's death occurs after the worker files a request for hearing but before the final disposition of the request, the persons described in ORS 656.218(5) are entitled to pursue the matter to final determination of all issues presented by the request for hearing, namely, to the persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal. ORS 656.218(3).

Generally, death benefits are payable to the worker's surviving spouse, children under the age of 18 years (with some exceptions not relevant here), or the worker's "dependents." ORS 656.204(2), (4) and (5). In addition, ORS 656.005(5) provides in pertinent part:

"An invalid dependent child is a child, for purposes of benefits, regardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. (Emphasis added).

Here, the putative beneficiary is the decedent's natural child. An "invalid" is defined as "one who is physically or mentally incapacitated from earning a livelihood." ORS 656.005(16).

At the time of decedent's compensable injury on August 3, 1991, decedent was supporting no one but herself. Subsequently, after undergoing lumbar surgery, decedent's daughter, age 33, moved in with her mother. Decedent's daughter was unable to work or fully care for herself, nor did she maintain a residence separate from decedent. Decedent provided care and partial financial support for her daughter until her own death.

However, in order to be eligible for benefits, a "child," regardless of age, must have been an invalid at the time of the accident. ORS 656.005(5) and (8). Here, the accident occurred on August 3, 1991. There is no evidence that decedent's daughter was physically incapacitated from earning a livelihood or substantially dependent on the worker at that time. Therefore, decedent's daughter was not an "invalid at the time of the accident." Consequently, she fails to qualify as an "invalid dependent child," and, thus, is not a statutory beneficiary. Accordingly, she is not authorized to pursue the deceased worker's claim to a final determination.

Constitutional Issues

The decedent's daughter contends that our conclusion leaves her without a remedy in violation of Article I, section 10 of the Oregon constitution.² The daughter's argument is premised on the theory that coverage under the workers' compensation law is a quid pro quo for the worker's forfeiture of her

² Article I, section 10, provides, in part: "[E]very man shall have remedy by due course of law for injury done him in his person, property, or reputation."

common law cause of action against the employer for her injuries, a cause of action that would not automatically terminate upon the worker's death. Thus, she argues, because decedent's right to compensation vested as of the date of the order on reconsideration, decedent or her estate is entitled to an adjudication as to the amount of compensation for that disability. The daughter also contends that to bar the decedent from full compensation for her permanent disability based on the fact that she died before a stipulation could be signed is to impose an artificial and inappropriate distinction in violation of Article I, section 20.³

The Referee declined to address these constitutional questions raised in decedent's daughter's closing argument. Nevertheless, we have the authority to reach a constitutional question concerning a statute's application. Carl M. Keeton, 44 Van Natta 664 (1992). Therefore, we address the daughter's arguments.

We do not find claimant's constitutional arguments persuasive. In State ex rel Borisoff v. Workers' Comp. Board, 104 Or App 603 (1990), the court addressed the constitutionality of the legislature's elimination of the Board's discretionary jurisdiction to modify permanent disability awards on its own motion. The court, after reviewing its holdings in other contexts that legislative limitations do not infringe a claimant's constitutional rights, concluded that the legislature had not violated the injured workers' rights under Article I, section 10, reasoning that "it is a permissible legislative function 'to balance the possibility of outlawing legitimate claims against the public need that at some definite time there be an end to potential litigation,' [citing Joseph v. Burns & Bear, 260 Or 493, 503 (1971)]."

Here, as in Borisoff, the legislature has chosen to limit potential litigation involving the right to death benefits to specific classes of persons who can establish a statutorily defined relationship to the decedent. Thus, our application of ORS 656.218 to find that the daughter is unable to qualify as a statutory beneficiary and thus is not entitled to pursue her mother's claim is not a violation of the decedent's rights under Article I, section 10.

Article I, section 20, prohibits the granting of privileges to any "class" of citizens. A class is a group that exists by virtue of antecedent personal or social characteristics. In contrast, a class defined only by the law in question is simply a natural result of lawmaking. Borisoff, supra. Here, there is no identifiable class cognizable under section 20, because the "favored" class exists only by reference to the challenged law, *i.e.*, those workers who died leaving beneficiaries as defined by ORS 656.218. The statute treats all injured workers the same. Thus, its application is not a violation of the decedent's rights under Article I, section 20. See id.

ORDER

The Referee's order dated April 5, 1994 is modified.⁴ Decedent's daughter is not entitled to pursue the deceased worker's claim to final determination of the issues presented by the request for hearing.

³ Article I, section 20, provides: "No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

⁴ The Referee ordered that "[the employer] is unable to pay to claimant's daughter benefits which said employer had agreed to pay to claimant before her untimely death." We interpret this order language solely to limit the putative beneficiary's right to pursue the deceased worker's claim to final determination, not to limit any voluntary payment by the employer. We modify the order language accordingly.

In the Matter of the Compensation of
MARIA S. CHAVEZ, Claimant
WCB Case No. 94-03718
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Bethlahmy's order which: (1) affirmed an Order on Reconsideration's award of 17 percent (54.4 degrees) unscheduled permanent disability for claimant's low back injury; (2) declined to authorize an offset of overpaid scheduled permanent disability against the award of unscheduled permanent disability; and (3) awarded an assessed attorney fee pursuant to ORS 656.382(2). On review, the issues are unscheduled permanent disability, offset, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Permanent Disability

The Referee affirmed the calculation of claimant's unscheduled permanent disability contained in the February 22, 1994 Order on Reconsideration, which awarded 17 percent unscheduled permanent disability. The insurer contends that claimant is not entitled to an award of permanent disability because the record does not establish that claimant has permanent impairment based on objective findings.

Both the Appellate Unit and the Referee relied on the range of motion findings that Dr. Martens, the medical arbiter, provided in his January 21, 1994 examination. The insurer cites Dr. Martens' May 26, 1994 post-reconsideration order medical report as evidence that claimant has no objective permanent impairment. (Ex. 26). Dr. Martens stated that the double inclinometer lumbosacral range of motion findings in his January 21, 1994 examination did not represent objective findings of impairment and that "range of motion is a subjective finding depending on the examinee's cooperation." (Ex. 26).

Consideration of a "supplemental" or "clarifying" medical arbiter's report is prohibited unless the arbiter's examination or initial report is "incomplete." See Daniel L. Bourgo, 46 Van Natta 2505, 2508 (1994). Inasmuch as there is no indication in the record that Dr. Martens' January 21, 1994 arbiter's examination or report was incomplete, we do not consider his "supplemental" May 26, 1994 report. Daniel L. Bourgo, *supra*. Moreover, even if we could consider that report, we would still find that claimant has permanent impairment consisting of reduced range of motion. Dr. Martens' beliefs notwithstanding, reduced range of motion is an objective finding. ORS 656.005(19). Since Dr. Martens did not indicate that his range motion findings were invalid, and in fact noted that claimant's lumbar flexion test was satisfied by reproducibility criteria and straight leg raising, the Referee properly relied on those findings in concluding that claimant demonstrated objective findings of permanent impairment.

Thus, the Referee correctly calculated claimant's permanent impairment value as 11. Inasmuch as the insurer does not contest the Referee's calculation of the claimant's age, education, and adaptability factors, we agree that claimant's unscheduled permanent disability is 17 percent. Therefore, we affirm the Referee's decision with respect to unscheduled permanent disability.

Offset

Claimant's back injury claim was initially closed by Notice of Closure on April 2, 1992. The closure notice awarded claimant 11 percent unscheduled permanent disability for injury to her low back and 5 percent scheduled permanent disability for loss of use or function of the left foot. The Notice of Closure was not appealed and became final.

Upon completion of a vocational assistance program, claimant's claim was again closed, this time by a September 13, 1993 Determination Order. Claimant's scheduled and unscheduled permanent disability was reduced to zero. The February 22, 1994 Order on Reconsideration awarded 17 percent unscheduled permanent disability, but did not make a scheduled award.

The insurer requested that the scheduled permanent disability award paid pursuant to the April 2, 1992 Notice of Closure be offset against the unscheduled award granted in the reconsideration order. The Referee declined to authorize the offset, stating that the insurer had provided no supporting authority. We affirm.

In Shirley G. Helgeson, 42 Van Natta 1941, 1942 (1990), we affirmed a referee's authorization for a carrier to offset scheduled permanent disability for injury to the claimant's right arm against increased scheduled and unscheduled permanent disability awards for claimant's left arm and back respectively. Citing Steven M. Ginther, 42 Van Natta 526 (1990), we noted that offsets of overpayments of permanent disability benefits previously paid in a claim were permissible. We also stated that an offset is not limited to compensation paid for the same body part, but that all that is required is that the offset be against compensation paid in the same claim. 42 Van Natta at 1942.

In this case, the requested offset is against compensation paid in the same claim. However, we do not find our decision in Helgeson controlling. Here, the insurer requests that we offset a final, unappealed award in a prior claim closure. By contrast, in Helgeson, the carrier requested an offset of a nonfinal award in proceedings concerning that closure. Inasmuch as the insurer in this case did not appeal the permanent disability award in the April 2, 1992 Notice of Closure, which became final by law, we do not consider that award to have been an overpayment. Thus, we agree with the Referee's decision not to allow the requested "offset."

The insurer contends that Nero v. City of Tualatin, 127 Or App 458 (1994), provides authority for the requested "offset." We disagree. In Nero, the court held that, for the purposes of assessing a penalty under ORS 656.268(4)(g), scheduled and unscheduled awards of permanent disability may be combined. 127 Or App at 463. The insurer, therefore, reasons that the unscheduled and scheduled permanent disability awards in this case may be "lumped" for the purposes of offset.

The Nero holding is likewise distinguishable from the present case. Had the scheduled permanent disability award been granted in an order which had not become final, we would agree with the insurer's "Nero" analogy. Nevertheless, as previously explained, the order granting the 5 percent scheduled permanent disability award had become final. Considering the finality of that award, it would be inappropriate to consider that award to be an "overpayment."

In conclusion, while we agree that the holdings in Helgeson and Nero support the concept that scheduled awards may be offset against or combined with unscheduled awards, we have determined that the permanent disability award in the unappealed and final April 2, 1992 Notice of Closure is not an "overpayment." Thus, we conclude that neither Helgeson nor Nero provide authority for the insurer's requested offset.

Attorney Fees

The Referee awarded an assessed attorney fee of \$2,000 for claimant's counsel's efforts in successfully defending against the insurer's appeal from the reconsideration order. ORS 656.382(2). On review, the insurer contends the Referee's award was excessive. We disagree and adopt and affirm that portion of the Referee's 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 issue, we find that a reasonable fee for claimant's attorney's services on review regarding the extent of disability issue is \$1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review regarding the Referee's attorney fee award or the offset issue. See Strazi v. SAIF, 109 Or App 105 (1991); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 25, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the insurer.

April 19, 1995

Cite as 47 Van Natta 723 (1995)

In the Matter of the Compensation of
ROBERT C. COOK, Claimant
WCB Case No. 93-13247
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Referee Mongrain's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation. We change the findings of fact to show that claimant went deer hunting on October 2, 1993, rather than September 2, 1993, as noted on page 2 of the Referee's order.

Evidence

The Referee admitted the testimony of one witness pursuant to an offer of proof. On review, the employer contends that the Referee erred in not considering that testimony. We disagree.

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. That statute gives the Referee broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). We review the Referee's evidentiary rulings for abuse of discretion. Rose M. LeMasters, 46 Van Natta 1533 (1994), aff'd mem 133 Or App 258 (1995).

We are reluctant to consider or permit consideration of evidence of "bad acts" because the prejudicial effect of such evidence tends to outweigh its probative value. John L. O'Day, 46 Van Natta 1756, 1757 n.1 (1994); Rose M. LeMasters, supra. Here, the employer offers specific instances unrelated to the low back injury in which claimant was not truthful with the employer. Even if we assume such evidence is relevant, we find that the probative value of such evidence is outweighed by the danger of undue prejudice. See ORS 40.170(3); OEC 404(3); ORS 40.160; OEC 403; Rose M. LeMasters, supra. We conclude that the Referee did not abuse his discretion in declining to consider the evidence.

Compensability

The Referee found that claimant and his wife testified in a straightforward, direct and nonevasive manner and were credible witnesses. The insurer contends that claimant was not a credible witness and that claimant gave an erroneous history to the physicians.

Although not statutorily required, the Board generally defers to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Since the Referee's credibility finding was based in part upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990).

When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our de novo review of the record, we agree with the Referee's analysis and conclusions. The Referee gave detailed explanations for his decision that the discrepancies and inconsistencies in the record were insignificant to the question of causation and to an assessment of claimant's credibility. Inconsistent statements related to collateral matters are not sufficient to defeat claimant's claim where, as here, the record as a whole supports his testimony. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

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

ORDER

The Referee's order dated October 5, 1994 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of \$1,000, payable by the insurer.

April 19, 1995

Cite as 47 Van Natta 724 (1995)

In the Matter of the Compensation of
BRUCE J. FINUCANE, Claimant
WCB Case No. 94-03993
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Referee Davis' order which set aside a Director's order finding claimant ineligible for vocational assistance. In his brief, claimant contends that the Referee erred in declining to assess a penalty for SAIF's alleged failure to timely provide claimant with a copy of an Ineligibility Evaluation. On review, the issues are vocational assistance and penalties.

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

Claimant began working for the employer in May 1991, and injured his back on July 3, 1991. A Determination Order awarded claimant 25 percent (80 degrees) unscheduled permanent disability.

Claimant has an erratic work history. Before working for this employer, claimant worked from August to November 1990 doing bridge painting. During fishing season, claimant worked for a short time on two different fishing boats. The record concerning earlier work history is vague.

The Director, relying on OAR 436-120-025(1)(b), concluded that claimant was a "seasonal or temporary" employee. Basing claimant's wages for determining eligibility for vocational assistance on earnings for the 52 weeks preceding the injury, the Director concluded that a suitable wage was \$4.75 per hour. Thus, the Director held that claimant did not have a substantial handicap to employment, and was not eligible for vocational assistance.

The Referee found that claimant was a full-time employee and, therefore, OAR 436-120-025(1)(b) was not applicable to claimant's situation. Accordingly, the Referee concluded that the Director should have used claimant's wage-at-injury in determining whether suitable employment was available. We agree with the Referee's ultimate conclusion, but add the following reasoning.

Subsequent to the Referee's order, we issued Keith D. Kilbourne, 46 Van Natta 1837 (1994). As we explained in Kilbourne, the former rules contained two provisions pertaining to "suitable employment," former OAR 436-120-005(6)(a)(A) and former OAR 436-120-005(6)(a)(B). However, because subsection (A) explicitly referred to "determining eligibility" for vocational assistance and subsection (B) explicitly cited to "providing" such benefits, we concluded that only former OAR 436-120-005(6)(a)(A) applied to cases involving initial determinations of eligibility. Id. at 1838. Furthermore, we found that, because former OAR 436-120-005(6)(a)(B) was the only rule that provided for application of former OAR 436-120-025, that rule also was relevant only for purposes of providing vocational assistance. Id. at 1839.

As explained above, the Director relied on former OAR 436-120-025 in determining that claimant was not eligible for vocational assistance. Because this case concerns claimant's initial eligibility for such benefits, we conclude that application of former OAR 436-120-025 was a violation of the Director's rules, and the Director's decision therefore may be modified. See ORS 656.283(2)(a); Keith D. Kilbourne, supra.

In turning to a determination of claimant's eligibility for vocational assistance, the Referee calculated 80 percent of claimant's wage-at-injury. After making that calculation, the Referee determined that the vocational record did not identify any job that claimant could perform that would pay 80 percent of the wage-at-injury. Inasmuch as we find the Referee's reasoning to be in accordance with the applicable administrative requirements, we affirm the Referee's conclusion that claimant is eligible for vocational assistance.

Because SAIF requested review 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 services on review is \$900, 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 July 11, 1994, as amended July 14, 1994, is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney fee of \$900, payable by the SAIF Corporation.

April 19, 1995

Cite as 47 Van Natta 725 (1995)

In the Matter of the Compensation of
MARK L. HADLEY, Claimant
WCB Case No. 90-18036
SECOND ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On March 23, 1995, we withdrew our March 2, 1995 Order on Remand which affirmed a Referee's order that had set aside the self-insured employer's "de facto" denial of claimant's medical services claim for a vehicle equipped with an automatic transmission. We took this action to consider claimant's request for a carrier-paid attorney fee for services previously performed on Board review and to allow the employer an opportunity to respond. Inasmuch as the time for submission of the employer's response has now expired, we proceed with our reconsideration.

As detailed in our Order on Remand, this case was returned to us from the Court of Appeals for reconsideration of our prior order, Mark L. Hadley, 44 Van Natta 690 (1992), which had vacated a Referee's order that had set aside the employer's "de facto" denial and awarded a \$1,000 carrier-paid attorney fee under ORS 656.386(1). See Hadley v. Silverton Forest Products, 123 Or App 629 (1994). On reconsideration, we affirmed the Referee's decision.

Claimant seeks reconsideration. Noting that the Referee and the court granted attorney fee awards for his counsel's services performed before their respective forums, claimant asks for an award for services previously expended by his counsel during Board review. We grant claimant's request.

To begin, 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. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991). Here, since claimant did not finally prevail until issuance of our Order on Remand, statutory authority to award an attorney fee for services rendered at the hearings, Board, and court levels rests with this forum. Nonetheless, pursuant to its appellate judgment, the court has already granted a \$2,550 carrier-paid attorney fee.

Inasmuch as neither party challenges the statutory basis for such an award, we shall likewise not examine that question. In any event, after considering the factors set forth in OAR 438-15-010(4), we find that such an award represents a reasonable attorney fee for claimant's counsel's services performed before the court. Likewise, based on a review of the aforementioned factors, we find that the Referee's \$1,000 attorney fee award constitutes a reasonable attorney fee for his counsel's services at the hearing level.

Finally, we turn to a determination of a reasonable attorney fee for claimant's counsel's services on Board review. Claimant's respondent's brief consisted of 1 1/2 pages which expressed claimant's intention to rely on the Referee's order. After consideration of the factors recited in the aforementioned rule, we find that a reasonable attorney fee for claimant's counsel's services on Board review is \$500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our March 2, 1995 order.

IT IS SO ORDERED.

April 19, 1995

Cite as 47 Van Natta 726 (1995)

In the Matter of the Compensation of
DONNA L. HOEFFLIGER, Claimant
WCB Case Nos. 94-10619 & 94-09086
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Liberty Northwest Insurance Corporation requests review of Referee Spangler's order that set aside its denial of claimant's occupational disease claim for a right trigger finger condition. On review, the issue is compensability.¹ We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on the opinion of Dr. Barth, neurologist, concluded that claimant's occupational disease claim for a right trigger finger was compensable. Liberty contends that claimant's condition is not compensable. We agree.

We summarize the relevant facts. Claimant had been working full time during the academic year as a school bus driver for the employer since 1973. Her duties required the repetitive use of her arms, wrists and hands in turning the steering wheel, shifting gears manually, and operating the door handle with her right hand. In 1985, claimant experienced a motor vehicle accident which resulted in, among other compensable conditions, right carpal tunnel syndrome, for which she received surgery in 1988. The claim, for which SAIF was on the risk, was closed in June 1991.

¹ The Referee dismissed claimant's request for hearing against the SAIF Corporation, which was on the risk for the 1985 motor vehicle accident and its sequelae. (O&O at 2). The sole issue contested on review is the compensability of claimant's claim against Liberty Northwest Insurance Corporation, which was on the risk at the time claimant's "new" occupational disease claim arose.

On October 25, 1993, claimant sought treatment for a right long trigger finger which had been locking for the prior three months. (Ex. 45). Dr. Butters, claimant's attending orthopedist, performed right trigger finger surgery on August 10, 1994. (Ex. 51A).

In order to establish the compensability of her occupational disease claim for right trigger finger condition, claimant must establish that her work activities were the major contributing cause of that condition. ORS 656.802; Runft v. SAIF, 303 Or 493, 499 (1987). Resolution of this question is a complex medical question and requires expert medical evidence for its resolution. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). We generally defer to the opinion of the treating physician, absent a persuasive reason not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find no persuasive reason not to defer to Dr. Butters' opinion.

When claimant initially sought treatment for her trigger finger, Dr. Butters noted that there was fusiform swelling of the finger. He injected the flexor sheath, which resulted in some improvement in the triggering. (Ex. 45). In response to a query from SAIF regarding the relationship of the trigger finger to the compensable right carpal tunnel condition, Dr. Butters explained that, if both carpal tunnel and trigger finger were caused by flexor tenosynovitis, then both conditions would be related. (Ex. 47).

In June 1994, prior to claimant's surgery, Dr. Barth performed an examination for SAIF. He noted a small, palpable tender spot at the A1 pulley, and opined that the tendon had been injured, resulting in an area of enlargement that caused a "hang up" within the sheath itself, and which was different from tenosynovitis, which is an inflammatory condition of the tendon sheath. He further opined that claimant's condition "appeared" to be work related. (Ex. 50-3). Then, without explanation, Dr. Barth stated that work was the major contributing cause of claimant's condition. (Ex. 51).

Subsequently, when Dr. Butters performed the right trigger finger release, he found some tenosynovitis, for which he performed a limited tenosynovectomy. (Ex. 51A). Dr. Butters disagreed with Dr. Barth's analysis of the pathophysiology of claimant's condition, instead opining that claimant's trigger finger problem was due to the inflammation of the sheath. Butters further opined that the inflammation of the sheath was not work related, but was idiopathic. (Ex. 51A).

Given the temporary improvement of claimant's trigger finger after injection of the sheath and Dr. Butters' discovery of an inflamed sheath at the time of surgery, we are more persuaded by his opinion than by that of Dr. Barth. Somers v. SAIF, 77 Or App 259 (1986) (we give the most weight to those opinions that are both well-reasoned and based on complete information). Consequently, claimant has failed to prove that her occupational disease claim for right trigger finger is compensable.

ORDER

The Referee's order dated November 15, 1994, as corrected November 21, 1994, is reversed. Liberty's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

April 19, 1995

Cite as 47 Van Natta 727 (1995)

In the Matter of the Compensation of
DENISE L. KOLOUSEK, Claimant
WCB Case No. 94-01907
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Robert E. Nelson, Attorney
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Lipton's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for an L4-S1 herniated disc condition. Submitting "post-hearing" medical evidence, claimant seeks remand for the taking of additional evidence. On review, the issues are compensability and evidence (remand). We reverse.

FINDINGS OF FACT

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

Claimant's cab driving for the employer was the major contributing cause of a worsening of her underlying low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to establish the compensability of her occupational disease claim, based on a finding that Dr. Franks' opinion is unpersuasive because it is inconsistent and speculative. We disagree.

Claimant has a low back degenerative condition which preexisted her cab driving work for the employer. She has a long history of low back problems, for which she sought treatment previously. Before working for the employer, claimant's condition was diagnosed as postural back pain or fibrositis.

Claimant started cab driving for the employer on April 17, 1991. On October 5, 1993, she sought treatment for low back pain and leg pain, which had existed for several months, but worsened over the previous two weeks.

A March 7, 1994 MRI revealed herniated discs at L4-5 and L5-S1. (Ex. 20).

The medical evidence concerning the cause of claimant's current need for treatment for her low back is provided by Drs. Franks, Lee, Marble, Brown and Case.

Drs. Brown and Case examined claimant, reviewed her history, acknowledged the existence of the herniated discs, but found no "clear-cut objective findings of the herniated disc [sic] which appears on the MRI scan." (Ex. 22-4). Reasoning that "sitting for prolonged periods in a cab is uncomfortable," Drs. Brown and Case opined that "it is highly unlikely that inactivity would herniate a disc for which [claimant] has no objective findings on clinical examination." Thus, although Drs. Case and Brown acknowledged the existence of claimant's herniated discs, they were perplexed by her clinical examination.

We do not rely on these examiners' conclusion that claimant's work activities driving a cab are not the major cause of her back condition, because we find that Dr. Franks provides a more complete and reasonable explanation for claimant's back problems. Specifically, we find the examiners' opinion that "it is highly unlikely that inactivity would herniate a disc" unpersuasive as it is inadequately explained. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Marble examined claimant, reviewed her history, and opined that, in the absence of a specific injurious event, claimant's disc herniations are related to simple degenerative processes, rather than to the "process of driving a taxi cab." (Ex. 23A). This conclusion is apparently based on Dr. Marble's belief that approximately 30 percent of middle aged persons would have MRI findings of disc protrusion/herniation "in the absence of either cervical or lumbar complaints." (*Id.*) Dr. Marble acknowledged that back pain may be associated with long periods of sitting in a taxi cab among those who have degenerative back changes. However, he explained the sitting process does not cause these changes "to any particular degree." Instead, Dr. Marble concluded, claimant's MRI abnormalities are more likely due to a "summation of lifetime activity." (Ex. 23A-2).

We do not rely on Dr. Marble's opinion, because it is primarily general, rather than specific, to claimant. See Sherman v. Western Employer's Insurance, 87 Or App 602 (1987). Moreover, to the extent that Dr. Marble's opinion is specific to claimant, it is not clearly based on an accurate history, because claimant does have lumbar complaints. Accordingly, we conclude that Dr. Marble's opinion is not persuasive. See Somers v. SAIF, *supra*.

Dr. Lee, treating physician, opined that the major contributing cause for claimant's low back problems, beginning in 1993, was probably prolonged sitting as a cab driver. (Ex. 18-1). However, because Dr. Lee acknowledged that his medical history regarding claimant is incomplete, we do not find his conclusions persuasive standing alone. *Id.*

The remaining medical evidence concerning causation is provided by Dr. Franks, who concurred with a letter written by claimant's attorney and commented that the letter is an "excellent and accurate description of our office conference." (Ex. 27-2). With this letter, Dr. Franks described spinal degeneration generally and disc herniations in situations without injurious events. Specifically, he explained how the sitting position subjects the disc to increased pressure. Considering the stresses caused by sitting and claimant's situation specifically, Dr. Franks concluded that claimant's prolonged sitting (while driving a cab for the employer) was the major contributing cause of the pathological worsening of her degenerative condition (represented by the herniated discs). (Ex. 27).¹ In our view, Dr. Franks' opinion is the best-reasoned medical evidence in this record. See Somers v. SAIF, supra. Accordingly, based on that opinion, we conclude that claimant has carried her burden of establishing that her work activities were the major contributing cause of a worsening of her underlying low back degenerative condition. See ORS 656.802(2).

Considering our disposition of the case on the record as developed at hearing, it is unnecessary to address claimant's motion for remand for consideration of "post-hearing" evidence.

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 436-15-101(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review regarding the compensability issue is \$3,700, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 5, 1994 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded \$3,700, to be paid by SAIF.

¹ Dr. Franks concurred with claimant's attorney's description of Dr. Franks' opinion:

"You described the degenerative process in the disc by analogy to a grape. When the disc is healthy it is a fibrous sack which tends to attract water to maintain a state of tension similar to what is seen in a fresh ripe grape. With the process of degeneration the disc desiccates and slowly loses its capacity to hold water. The disc shrinks in size and takes on characteristics similar to that of an overripe grape. You described this state as 'squishy.' In this state the disc is highly susceptible to injury, specifically herniations of the type seen in [claimant]. In the late stages, the disc loses its capacity to retain water almost entirely and shrivels like a raisin.

"We also discussed the causes of disc herniation in situations in which there is no specific episode to which a frank change can be attributed. You said that there had been specific studies in which sensors had been placed in the disc material of human cadavers. These studies demonstrate that in the sitting position the disc is subjected to increased pressure. In relation to [claimant's] specific history you indicated that she thought that the frequent need to get in and out of the cab to assist passengers, to lift luggage and etc. may have been responsible for a change in her condition. However, you stated that this is unlikely because those activities would probably actually be beneficial insofar as they relieved, temporarily the pressures applied by her prolonged sitting. You would attribute the change in her condition to those prolonged periods of sitting.

"* * * * [I]f one looks only at the question of responsibility for the pathological worsening of [claimant's preexisting degenerative disc disease] represented by the development of specific instances of herniation at L4-5 and L5-S1 the major cause of that worsening on a more probable than not basis is the prolonged sitting required in [claimant's job with the employer]. . . ." (Ex. 27).

In the Matter of the Compensation of
BETH D. MOORE, Claimant
WCB Case No. 93-12664
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scott H. Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian and Hall.

The self-insured employer requests review of that portion of Referee Garaventa's order that set aside its denial of claimant's occupational disease claim for a left carpal tunnel syndrome (CTS) condition. Claimant cross-requests review of that portion of the order awarding an assessed attorney fee of \$2,800. On review, the issues are compensability and attorney fees.

We adopt and affirm the Referee's order.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$850, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 3, 1994 is affirmed. For services on review, claimant is awarded an \$850 attorney fee, payable by the self-insured employer.

Board Member Hall concurring in part and dissenting in part.

I concur with the majority's conclusion that claimant's left carpal tunnel syndrome condition is compensable. However, I disagree with its \$850 attorney fee award and its affirmance of the Referee's \$2,800 attorney fee award.

Claimant submitted a statement of services at the hearing level for \$8,250 and another at Board level for \$1,960. These documents reference 55 hours of service at the hearing level and 14 hours on review, for which claimant requests a reasonable rate of \$140-150 per hour.

The critical issue in this case was the nature and type of claimant's work activities. During the two-day hearing, claimant presented testimony of four bus drivers (in addition to claimant) to establish the accuracy of claimant's description of the repetitive intensive nature of those activities. Claimant acknowledges that this testimony was somewhat cumulative in nature. However, he also explains that this evidence was required to reinforce the fact that claimant's job did require constant, repetitive hand and wrist movements and did subject his hands and wrists to constant vibration. He further explains that this reinforcement was necessary to overcome Dr. Button's (employer's witness) testimony to the contrary. Claimant's efforts were convincing.

First of all, as a matter of policy, I rarely vote to modify an attorney fee award ordered by a Referee. After all, the Referee has had the first-hand opportunity to observe and judge the efforts of the attorneys involved at the hearing level. As a matter of policy, I believe Referees should be given substantial discretion in awarding fees. This is one of the rare cases in which I vote to override the Referee's attorney fee award. Based upon a sworn affidavit (statements of services), claimant's counsel has declared that approximately fifty-five (55) hours were expended at the hearing level. This sworn statement stands unimpeached.

In decision after decision, we find that one of the parties failed to sufficiently develop the factual record. We note, often critically, that the factual basis for supporting or opposing medical causation is inadequate. Here, claimant thoroughly establishes the factual record and, as a result, prevailed. It is evident from the record and claimant's counsel's statement of services that substantial effort was expended by claimant's counsel to secure the compensability of this claim. As a result of the majority's attorney fee award, claimant's counsel is being punished for taking the time and effort to properly prepare claimant's case.

April 19, 1995

Cite as 47 Van Natta 731 (1995)

In the Matter of the Compensation of
JOHN F. OTT, Claimant
WCB Case No. 93-14974
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Mongrain's order that: (1) admitted, over claimant's objection, affidavits/statements from medical technicians concerning claimant's blood alcohol levels following his motor vehicle accident; and (2) upheld the SAIF Corporation's denial of claimant's injury claim stemming from the accident. On review, the issues are evidence and compensability.

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

Claimant contends that the Referee erred in admitting affidavits and statements from medical technicians concerning claimant's blood alcohol levels following the motor vehicle accident. Claimant argues that such reports consist of "hearsay" and should not have been admitted at hearing.

ORS 656.283(7) sets the standard by which evidence is admitted in workers' compensation hearings. The statute specifically 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." ORS 656.283(7). Referees have broad discretion when rendering procedural and evidentiary ruling. Jackson P. Shull, 42 Van Natta 1206 (1990).

Here, we do not agree that the Referee abused his discretion by admitting the aforementioned exhibit into evidence. First, we note that hearsay evidence is generally admissible in workers' compensation proceedings, although such evidence may be excluded when it is in the interest of substantial justice to do so. Armstrong v. SAIF, 67 Or App 498 (1984). In Marion R. Webb, 37 Van Natta 750 (1985), we noted that the courts have consistently held that under a former version of ORS 656.283(6) and analogous statutes dealing with administrative hearings, the fact that evidence may be hearsay is not a reason to exclude it, if it is relevant and of a type of evidence commonly relied upon by prudent persons, whether or not the author of the hearsay is available for cross-examination. See Armstrong v. SAIF, *supra*; Higley v. Edwards, 67 Or App 488 (1984). In Webb, we also concluded that the mere fact that a piece of evidence is admitted into the record says nothing of the weight it will be given by the factfinder.

Although we do not find that it was an abuse of discretion by the Referee to admit the exhibit, we conclude that the contested exhibit, Exhibit 8, is not completely reliable. In particular, we note that page 3 of the exhibit is an affidavit from a medical technologist which states that on October 19, 1993, the technologist performed analysis on a blood sample "bearing the above name from the locked evidence storage." (Ex. 8-3). However, notwithstanding the technologist's reference to a name on the sample, there is no name or number on the affidavit which identifies the individual from whom the blood sample was taken. Under such circumstances, we assign Exhibit 8 minimal weight.¹

¹ We are willing to give the document some weight because page 3 is read in conjunction with pages 1 and 2 of the exhibit (those pages identify claimant). Standing alone, however, page 3 would be unreliable, not probative, and thus, not entitled to any weight.

Finally, although claimant argues that Exhibit 8 was relied on by the Referee in finding the claim not compensable, we conclude that the blood sample test results were not the sole basis for the Referee's conclusion on the issue of compensability. Rather, the Referee also found, and we agree, that claimant was an unreliable historian, and that an impartial witness had observed claimant's vehicle slowly veering off the road, rather than, as claimant contended, quickly departing the road in order to avoid a deer. Additionally, we find that claimant has not rebutted the witness' statement that claimant smelled of alcohol after the accident, and claimant informed the witness that he had been drinking prior to the accident. (Ex. 33).

In addition to the unrebutted statement of the witness, claimant's counsel conceded, at hearing, that claimant had alcohol in his blood, although counsel argued that the alcohol was attributable to claimant's ingestion of a cold remedy. Claimant has also conceded that he pled guilty to the federal offense of operating a commercial vehicle while having an alcohol concentration of .04 or more. (Ex. 29).

With respect to claimant's contention that he only had a glass of beer 12 hours prior to the accident, Dr. Jacobsen, an addiction medicine specialist, persuasively concluded that, considering claimant's weight, claimant's blood alcohol level would never have reached even the level of .04, and therefore, claimant "would have had to consume more alcohol than has been accounted for." (Ex. 35-6).

Dr. Jacobsen also relied on the report submitted by SAIF's forensic investigator, Mr. Stearns, who found that claimant's degree of angle of departure from the roadway did not indicate a sudden swerving. Dr. Jacobsen stated that the eyewitness observation, the report of the Nevada state trooper and Mr. Stearns' report did not support claimant's description that he swerved to avoid an animal. Finally, Dr. Jacobsen stated that such reports and testimony were "consistent with expected impairment from alcohol and possible other additive depressant effects from over-the-counter medication." In Dr. Jacobsen's opinion, "impairment from alcohol" was the major contributing cause of claimant's accident. (Ex. 35-12).

We find Dr. Jacobsen's opinion to be persuasive. Dr. Jacobsen is an expert in addiction medicine, and he has considered claimant's weight, claimant's description of the alcohol amounts consumed, and the conceded blood alcohol levels, in finding that claimant's accounting of the amount of alcohol consumed is inaccurate. Furthermore, Dr. Jacobsen also considered claimant's description of the accident, the eyewitness' description of the accident, and the reports of the state trooper and forensic investigator in determining whether the accident was caused by alcohol impairment. Under such circumstances, we conclude that, even after assigning minimal weight to Exhibit 8, SAIF has proven by clear and convincing evidence that claimant's consumption of alcohol was the major contributing cause of his motor vehicle accident and related injuries.

ORDER

The Referee's order dated June 17, 1994 is affirmed.

April 19, 1995

Cite as 47 Van Natta 732 (1995)

In the Matter of the Compensation of
STEVEN R. PRIMUS, Claimant
WCB Case No. 94-04058
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Mongrain's order that upheld the SAIF Corporation's denial of his right ankle venous stasis ulcer occupational disease claim. On review, the issue is compensability.

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

Three physicians rendered opinions regarding the cause of claimant's right ankle venous stasis ulcers. All three determined that claimant had a preexisting venous insufficiency condition. (Exs. 4-1, 6-2; see Exs. 7-2, 8-1). Two concluded that claimant's ulcers were a "manifestation" of that condition; the third concluded that the ulcers were a symptom of venous insufficiency. (Exs. 8-1, 9; 4-2).

We agree with the Referee that the medical evidence establishes that claimant's ulcers were a symptom of the preexisting venous insufficiency. Therefore, to prevail, claimant must prove that his work activities were the major contributing cause of a pathological worsening of the underlying venous insufficiency condition. See Weller v. Union Carbide Corp., 288 Or 27 (1979).¹

Two physicians address the pathological worsening issue. Dr. Porter, examining vascular surgeon, concluded that claimant's ulcers amounted to an increase in symptomatology without any significant change in the underlying pathology of his preexisting condition. (Ex. 4-2). Dr. Hoffman, treating surgeon, determined that claimant's underlying pathology had been worsened by the stasis ulcers. Hoffman stated, "The ulcers have healed, but the skin in the region is now compromised and will be more apt to re-form ulcers in the future." (Ex. 6-2).

This evidence does not satisfy claimant's burden of proof. Dr. Porter's report does not support claimant's position. Further, while Dr. Hoffman's report addresses a pathological worsening of claimant's skin condition, it fails to address the status of claimant's underlying venous insufficiency. Under the circumstances, we conclude that claimant has failed to establish a pathological worsening of his preexisting venous insufficiency condition. Accordingly, for the reasons stated in the Referee's order, as supplemented herein, we affirm the Referee's decision upholding SAIF's denial of claimant's right ankle venous stasis ulcers.

ORDER

The Referee's order dated August 31, 1994 is affirmed.

¹ This rule does not apply when the medical evidence establishes that a claimant's symptoms are the disease; in that case, a worsening of symptoms that is caused, in major part, by work conditions, will be compensable. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990). Here, there is no persuasive evidence establishing that claimant's symptoms (the ulcers) are the underlying disease (venous insufficiency).

April 19, 1995

Cite as 47 Van Natta 733 (1995)

In the Matter of the Compensation of
SHANNA L. TRYON-ELLIS, Claimant
WCB Case No. 94-06586
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Brazeau's order that declined to increase her rate of temporary disability benefits. On review, the issue is rate of temporary disability.

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

The calculation of temporary disability depends on whether a worker is "regularly employed." See ORS 656.210(2)(c). Specifically, workers whose remuneration is not based solely upon daily or weekly wages (e.g., paid hourly wages based on a fluctuating, irregular hourly schedule) are not "regularly employed" and the Director is mandated to set forth rules which prescribe the method for establishing the weekly wage of those workers. ORS 656.210(2)(c). Pursuant to this authority, the Director has promulgated OAR 436-60-025(5)(a), which provides that, in order to calculate temporary disability for "workers * * * with varying hours, * * * insurers shall use the worker's average weekly earnings for the previous 26 weeks." See Lowry v. Du Log, Inc., 99 Or App 459, 462 (1989), rev den 310 Or 70 (1990).

Because claimant was paid on an hourly basis for varying hours prior to the injury, the Referee determined that remuneration was not based solely upon daily or weekly wages and, therefore, claimant was not "regularly employed." Accordingly, the Referee determined that claimant's temporary disability rate must be calculated by averaging weekly wages earned during the 26 weeks preceding her injury. See Kenneth W. Metzker, 45 Van Natta 1631 (1993).

Claimant contends that she entered into a "contract" with the employer in order to get her final raise to \$7/hr. (App. Br. at 2). Apparently, she is arguing that this "contract" qualifies her to have her temporary disability calculated as though \$7/hr was her weekly wage. See ORS 656.210(2)(b). Notwithstanding claimant's "contract," she continued to work irregular hours (as evidenced by the fluctuating amount of her weekly paycheck). (See Exs. 4 & 4A).

We previously addressed this same issue in Danny R. Woosley, 45 Van Natta 746 (1993). In Woosley, we held that, despite having a fixed hourly wage: "because claimant was paid on an hourly basis for varying hours prior to the injury, his remuneration was 'not based solely upon daily or weekly wages.'" Id. Furthermore, in Lowry v. Du Log, Inc., supra, the Court of Appeals held that the Director's method of averaging weekly wages earned during the 26 weeks preceding the injury is an appropriate exercise of his authority under ORS 656.210(2)(c). Id.

Accordingly, claimant's temporary disability rate is correctly calculated by averaging her weekly earnings for the previous 26 weeks. OAR 436-60-025(5)(a).

ORDER

The Referee's order dated September 1, 1994 is affirmed.

April 20, 1995

Cite as 47 Van Natta 734 (1995)

In the Matter of the Compensation of
DENNIS L. KELLER, Claimant
 WCB Case Nos. 93-11978 & 93-07002
 ORDER ON REVIEW
 Welch, Bruun, et al., Claimant Attorneys
 Larry D. Schucht (Saif), Defense Attorney
 Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn, Turner-Christian and Haynes.

The SAIF Corporation requests review of Referee Hazelett's order that: (1) set aside its denial of claimant's current low back condition; (2) upheld Standard Fire Insurance Company's (Standard's) denial of the same condition;¹ and (3) assessed a penalty for SAIF's allegedly unreasonable claims processing. On review, the issues are compensability, responsibility, and penalties. We affirm.

FINDINGS OF FACT

In August 1980, while working for SAIF's insured, claimant sought treatment for low back pain. In September 1980, SAIF accepted the claim. The claim was closed by a February 1981 Determination Order without an award of permanent disability. In 1982, claimant sought treatment for intermittent low back and left leg pain. His claim was reopened, and then closed by a January 1983 Determination Order.

In March 1983, claimant's low back and left leg pain recurred. In May 1983, a CT scan revealed mild central disc bulging at L3-4, L4-5 and L5-S1. (Ex. 11). Claimant treated for the disc bulges and chronic lumbosacral strain with Dr. Stewart over the next several months. (Exs. 12-17, 20). A December 1983 myelogram revealed a large disc protrusion at L5-S1. (Exs. 17-19).

¹ Aetna Casualty & Surety Company currently is the insurer for Standard's (former) insured. For convenience' sake, we refer to Aetna's insured as Standard's insured.

In March 1984, Dr. Zivin examined claimant on behalf of SAIF. (Ex. 21). He reported that claimant "obviously has degenerative disc disease at the three lower lumbar levels, maximal L5-S1; there are documented disc bulges by CT scanning and myelography." (*Id.* at 3).

A July 1984 Determination Order awarded claimant 35 percent (112 degrees) unscheduled permanent disability for his low back. (Ex. 24). The Determination Order's evaluator's worksheet listed "[d]isc's" and decreased range of motion and pain as claimant's conditions. (Ex. 24-2). A stipulation increased that award to 47.5 percent (152 degrees). (Ex. 36).

On September 5, 1984, Dr. Stewart listed claimant's final diagnosis as "chronic lumbosacral strain and chronic degenerative disc disease lumbosacral spine, L3,4 L4,5 L5,S1." (Ex. 25).

Thereafter, claimant entered and completed an authorized training program. An August 1986 Determination Order reclosed the claim without the award of any additional permanent disability. (Ex. 57). The Determination Order's evaluator's worksheet listed claimant's conditions as decreased range of motion, pain and "+3 bulge L3-4, L4-5 [and] L5-S1." (*Id.* at 2).

In January 1991, while working for Standard's insured, claimant was struck by a motor vehicle. Standard accepted a claim for nondisabling low back strain and right leg contusion. Claimant became medically stationary in June 1991.

In March 1993, claimant again sought treatment for low back and right leg symptoms. SAIF denied compensability and responsibility for claimant's current condition; Standard denied responsibility for that condition.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

The Referee concluded that, in 1980, SAIF had accepted claimant's degenerative condition. Then, applying the material contributing cause test of ORS 656.245(1), the Referee concluded that claimant had established the compensability of his current need for medical services.

On review, SAIF asserts that its acceptance of the 1980 claim was limited to a low back strain. Furthermore, SAIF contends that the medical evidence shows that claimant's need for treatment in 1993 was caused by preexisting degenerative disc disease and, therefore, that claimant's current low back condition is not compensable under ORS 656.005(7)(a)(B). We need not address those arguments, because we conclude that SAIF is barred by claim preclusion from denying that claimant's degenerative disc disease was part of his 1980 compensable claim with SAIF.²

Subsequent to the Referee's order, the Court of Appeals issued its decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995). 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. No one appealed the Determination Order. 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.

² We reject claimant's argument that this claim is one for medical services under ORS 656.245(1) and, therefore, that he need only prove a material relationship between the compensable condition and the need for treatment in order to establish the compensability of medical services. Although claimant characterized the claim in this manner at hearing, and continues to do so on review, that characterization ignores the fact that the compensability of claimant's current condition is the central issue. Because ORS 656.245(1) presupposes that claimant's current condition is compensable, see Beck v. James River Corp., 124 Or App 484 (1993), we conclude that it does not apply to this matter.

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 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 here. The condition at issue is claimant's degenerative disc condition. SAIF never formally accepted or denied that condition. However, claimant treated for the lumbar disc bulges during the latter half of 1983.³ In March 1984, Dr. Zivin stated that claimant "obviously has degenerative disc disease at the three lower lumbar levels, maximal L5-S1." (See Ex. 21-3). On September 5, 1984, Dr. Stewart listed claimant's final diagnosis as lumbosacral degenerative disease at the same levels as claimant's disc bulges. (Ex. 25). In view of those reports, we conclude that the medical evidence establishes that claimant's lumbar disc bulges were caused by his degenerative disc disease.

More importantly, SAIF did not challenge either the July 1984 or the August 1986 Determination Orders, which listed "[d]isc's" and "+3 bulge L3-4, L4-5 [and] L5-S1", respectively, as among claimant's conditions. In light of the medical evidence relating claimant's disc bulges to his degenerative disc condition, we conclude that the Determination Orders were based, at least in part, on that condition. Those orders became final by operation of law. Therefore, we conclude that, under Messmer, SAIF's failure to challenge the July 1984 or the August 1986 Determination Order on the ground that it included an award for a noncompensable condition, viz., the degenerative disc disease, precludes it from denying that that condition was part of the March 1980 claim. See Wayne L. Duval, 46 Van Natta 2423 (1994) (Messmer applied where pre-closure medical evidence revealed that the claimant's continuing symptoms at claim closure related wholly to his noncompensable condition).

The result is not that SAIF has accepted claimant's degenerative disc condition; rather, it is that SAIF is barred by claim preclusion from denying that it is part of claimant's August 1980 claim. Messmer, supra, 130 Or App at 258. Accordingly, we affirm the Referee's conclusion that claimant's current low back condition is compensable.

Our analysis is not altered by our consideration of the Court of Appeals' decision in Olson v. Safeway Stores, Inc., 132 Or App 424 (1995). The court distinguished that case from Messmer, because "it [was] not obvious from [the] review of the determination orders and the evaluators' worksheets that the award included any compensation related to the [claimant's noncompensable] degenerative condition." Id. at 428 n.1 (emphasis added). One could argue that the highlighted language means that, to ascertain whether a Determination Order is "based on" a noncompensable condition, one may only consider the Determination Order and the evaluator's worksheet. We do not read Olson so broadly. Rather, we understand the Olson court to have decided that, on the facts presented, the claimant failed to establish that the Determination Order was based on her degenerative condition. On the facts presented here, we conclude otherwise.

³ There is no direct evidence regarding whether SAIF paid for the services in 1983 related to claimant's bulging discs/degenerative disc disease. Regardless of whether SAIF paid for those services, we conclude that, under Messmer, the critical inquiry is whether claimant received treatment for those conditions sometime before claim closure. On this record, we conclude that the answer is "yes." (Exs. 12-17, 20).

We turn to the responsibility issue. ORS 656.308(1) operates to shift responsibility from a carrier with an accepted condition to a subsequent carrier only if a worker sustains a "new compensable injury involving the same condition." (Emphasis added). See Smurfit Newsprint v. DeRosset, 118 Or App 368, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). Because SAIF is precluded from denying that claimant's degenerative disc condition is a part of claimant's 1980 claim, we conclude that it has the burden of proving that claimant suffered a new compensable injury involving that condition while working for Standard's insured. See ORS 656.308(1); Steven K. Bailey, 45 Van Natta 2114, 2116 (1993).

SAIF relies on Dr. Cowan's opinion that the major contributing cause of claimant's current low back condition was the 1991 injury with Standard's insured and that the 1980 injury with SAIF's insured "was separate and distinct." (Ex. 111). Because that opinion is inconsistent with our analysis under Messmer, we afford it minimal weight.⁴

Furthermore, we note that, in 1991, Standard accepted low back strain, not degenerative disc disease. We conclude that claimant's 1991 low back strain was not the same condition as degenerative disc disease, which the preponderance of the medical evidence establishes is the major contributing cause of claimant's current symptoms. It follows that claimant's present claim does not involve a "new compensable injury involving the same condition" as that which Standard accepted in 1991. Accordingly, we conclude that SAIF has not established that responsibility for claimant's current low back condition should be shifted to Standard under ORS 656.308(1).

For these reasons, we agree with the Referee's decision assigning responsibility for claimant's current low back condition to SAIF.

Penalties

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

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 \$1,100, to be paid by SAIF. In reaching this conclusion, we have considered the time devoted to this case (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. Claimant's attorney is not entitled to a fee for services regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated February 4, 1994 is affirmed. For services on Board review, claimant's counsel is awarded \$1,100, to be paid by the SAIF Corporation.

⁴ We also discount Dr. Cowan's reports because they fail to address the import, if any, of claimant's degenerative disc condition with respect to his current need for treatment, and because his final causation opinion lacks any meaningful supportive analysis. (Ex. 111).

Board Member Haynes dissenting in part and concurring in part.

The majority concludes that, under Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) (Warren, J.), rev den 320 Or 507 (1995), SAIF is barred by claim preclusion from denying that claimant's degenerative disc disease was part of his 1980 compensable claim with SAIF. Because I find Messmer distinguishable from this case, I dissent.

On review, SAIF asserts that its acceptance of claimant's 1980 low back claim was limited to a low back strain. Further, SAIF contends that the medical evidence shows that claimant's need for treatment in 1993 was caused by preexisting degenerative disc disease and, therefore, that claimant's current low back condition is not compensable under ORS 656.005(7)(a)(B). I agree. Before I address SAIF's arguments, however, I consider the impact of Messmer on this case.

In Messmer, the court held that, by virtue of the carrier's failure to appeal a Determination Order that was based in part on the effects of a surgery for the claimant's apparently noncompensable degenerative disc disease, the carrier was barred by claim preclusion from denying that the degenerative condition was part of the claimant's compensable claim. It was unclear how the unappealed Determination Order was "based on" the effects of the claimant's degenerative condition.

Subsequent to Messmer, the Court of Appeals issued its decision in Olson v. Safeway Stores, Inc., 132 Or App 424 (1995) (Warren, J.). The court distinguished that case from Messmer, because "it [was] not obvious from [the] review of the determination orders and the evaluators' worksheets that the award included any compensation related to the [claimant's noncompensable] degenerative condition." Id. at 428 n.1 (emphasis added). In my view, the highlighted language reveals that, to ascertain whether a Determination Order is "based on" a noncompensable condition, one may only consider the Determination Order and the evaluator's worksheet, not any preclosure medical evidence.¹

Here, the condition at issue is claimant's degenerative disc disease. That condition, as well as lumbar disc bulges, were diagnosed in the course of treating claimant's compensable low back injury. SAIF never formally accepted or denied those conditions. In July 1984 and August 1986, the claim was closed by Determination Order. Although the orders listed "[d]isc's" and "+3 bulge L3-4, L4-5 [and] L5-S1", respectively, as among claimant's conditions, there is no mention of "degenerative disc disease" in either of the orders or the evaluators' worksheets. (Exs. 24, 57). Under Olson, then, I conclude that the Determination Orders were not "based on" claimant's degenerative disc disease.

In reaching this conclusion, I acknowledge that there is some preclosure evidence that claimant's disc bulges may have been caused by his degenerative condition. (See Exs. 21-3, 25). However, because neither the Determination Orders, nor the underlying evaluators' worksheets, specifically refer to degenerative disc disease, I would hold that that condition was not, under the Messmer/Olson analysis, a basis for the orders.

I also acknowledge that, in Wayne L. Duval, 46 Van Natta 2423 (1994), the Board applied Messmer even though a Determination Order failed specifically to mention the claimant's noncompensable condition. Duval issued without the benefit of the court's decision in Olson v. Safeway Stores, Inc., supra. Therefore, to the extent that Duval conflicts with the foregoing analysis, I would disavow it.

In sum, I find this case distinguishable from Messmer. Accordingly, I conclude that SAIF is not barred by claim preclusion from denying that the degenerative condition was part of claimant's compensable low back claims.

I turn to SAIF's arguments on review. SAIF first argues that it did not accept claimant's degenerative disc condition. I agree.

Claimant's original low back injury occurred in August 1980. (See Ex. 1). On September 3, 1980, SAIF issued a Notice of Claim Acceptance that identified claimant's injury by an unexplained code, and that did not specify what condition was being accepted. (Ex. 4).

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). Because the specific condition SAIF accepted was not identified in the notice, I look to the contemporaneous medical records to determine what SAIF accepted. John Q. Emmert, 46 Van Natta 997 (1994).

In August 1980, claimant had normal spinal x-rays and was diagnosed with lumbosacral strain. (Ex. 1). An August 1980 "827" form listed the same diagnosis. (Ex. 3). Claimant's degenerative disc condition did not become apparent until well after the notice issued. On this record, I find that, in September 1980, SAIF accepted claimant's lumbosacral strain, not his degenerative disc condition. SAIF v. Tull, supra; John Q. Emmert, supra.

¹ The Olson court's intent to read Messmer narrowly is also evident because it distinguished Messmer on the ground that, although the claimant had argued that the employer was barred from denying that her degenerative condition was compensable, the claimant had not asserted that argument in terms of "claim preclusion." Id. at 428 n.2.

Further, SAIF's subsequent payment for services related to claimant's degenerative disc condition did not constitute an acceptance of that condition. ORS 656.262(9). Finally, I reject claimant's argument that SAIF's failure to appeal either the July 1984 or August 1986 Determination Orders constituted an acceptance of his degenerative disc condition. See Messmer v. Deluxe Cabinet Works, *supra*, 130 Or App at 258 (failure to appeal Determination Order based on preexisting degenerative condition did not constitute an acceptance of the condition).

SAIF next argues that, because the persuasive medical evidence establishes that claimant's current need for treatment was caused, in major part, by his preexisting degenerative disc disease, under ORS 656.005(7)(a)(B), claimant's current claim fails. I agree.

In view of claimant's preexisting degenerative disc condition, his current condition is compensable, if at all, under ORS 656.005(7)(a)(B). Under that statute, claimant must prove that one or both of his compensable low back injuries is and remains the major contributing cause of his current disability and need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993). Claimant has failed to meet that burden.

Drs. Reimer, neurologist, Peterson, orthopedist, and McKillop, orthopedic surgeon, examining physicians, concluded that claimant's current need for treatment was caused, in major part, by his degenerative disc condition. (Exs. 106 - 109). They reasoned that, in view of the relatively simple nature of claimant's 1980 and 1991 back injuries, his recurring low back symptoms were more likely related to his degenerative disc condition. (See *id.*) Dr. Bower, treating general practitioner, concurred with Dr. McKillop's report. (Ex. 110). The analysis set forth in those reports is compelling.²

The only contrary opinion is authored by Dr. Cowan, treating chiropractor, who concluded that claimant's 1991 low back injury with Standard's insured was the major contributing cause of claimant's current low back condition. (Ex. 111). I agree with the Referee that Dr. Cowan's reports are unpersuasive. Although Cowan issued numerous reports, he never addressed claimant's degenerative disc condition. Furthermore, his causation opinion lacks any meaningful supportive reasoning. Accordingly, I give his reports no weight.

For these reasons, claimant has failed to establish a compensable claim under ORS 656.005(7)(a)(B). Accordingly, I would reverse the Referee's decision finding claimant's current low back condition compensable.

Responsibility

Having found that claimant's current low back condition is not compensable, I would further reverse the Referee's decision assigning responsibility for that condition to SAIF.

Penalties

I agree with the majority's decision to adopt and affirm the Referee's conclusions regarding penalties.

For the foregoing reasons, I dissent from the majority's analysis under Messmer v. Deluxe Cabinet Works, *supra*, but agree with its decision regarding the penalty issue.

² In his brief, claimant urges us to rely on Drs. McKillop's and Reimer's reports (Exs. 108, 109).

In the Matter of the Compensation of
JAMES D. LOLLAR, Claimant
WCB Case Nos. 94-03241 & 94-00738
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Neal's order that: (1) declined to award an attorney fee pursuant to ORS 656.386(1); and (2) declined to award attorney fees pursuant to ORS 656.307(5). On review, the issue is 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

We agree with the Referee that, since no "307" order issued in this case, there should be no fee under ORS 656.307(5). Moreover, no ORS 656.386(1) fee for counsel's services at hearing is appropriate since responsibility was the only issue at hearing. See Bonnie A. Stafford, 46 Van Natta 1539 (1994).

However, if the denials of SAIF or Liberty raised compensability issues, claimant's attorney would be entitled to an attorney fee under ORS 656.386(1) if he was instrumental in obtaining rescission of the compensability portions of the carrier's denials. See, e.g., Bonnie A. Stafford, *supra*; Johnny M. Davis, 45 Van Natta 2282 (1993).

In Davis, we concluded that the carrier's denial raised an issue of compensability. We based our decision on the fact that, although the carrier had requested a "307" order, its "disclaimer" stated that it was not waiving other issues of "compensability" and it included "notice of hearing" provisions consistent with a denial of compensation pursuant to OAR 438-05-053(4). Specifically, its "disclaimer" stated that "[t]his is a denial of your claim for benefits."

Similarly, in Linda K. Ennis, 46 Van Natta 1142 (1994), we determined that a "Disclaimer of Responsibility and Claim Denial" raised an issue of compensability which entitled the claimant to an attorney fee pursuant to ORS 656.386(1). The disclaimer/denial letter in Ennis contained notice of hearing provisions, as well as a statement that it was a denial of a claim for benefits. Finally, the letter expressly stated that designation of a paying agent had not been requested.

Here, SAIF's January 5, 1994 letter contained "notice of hearing" provisions. Although the denial did not state that it was a claim denial as in Ennis and Davis, the denial did not indicate whether SAIF had requested a "307" order. We find that SAIF's denial, which contains notice of hearing provisions and which does not indicate that a "307" order has been requested, raises issues of compensability. Accordingly, we find that claimant is entitled to an attorney fee under ORS 656.386(1) for his counsel's services in obtaining a pre-hearing rescission of SAIF's January 5, 1994 denial.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$600 is a reasonable attorney fee for claimant's counsel's pre-hearing services in obtaining SAIF's concession of the compensability of claimant's low back condition. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Liberty's disclaimer indicates that it is a denial of responsibility for the current condition. (Ex. 35). It further indicates that a paying agent under ORS 656.307 has been requested. It states that it is a denial of the claim for benefits and contains "notice of hearing" provisions. However, the disclaimer also states:

"After review of the investigation material available, it appears that your condition is compensable; however, responsibility may rest with one of the employers identified above." (Ex. 35).

In James McGougan, 46 Van Natta 1639 (1994), we distinguished Davis and Ennis and held that while a carrier's denial did contain notice of hearing provisions and stated that it was a denial of benefits, it also contained express language conceding compensability and specifically denying responsibility only. Under these circumstances, the Board found that the carrier's denial did not raise an issue of compensability.

Liberty's disclaimer is very similar to the document discussed in McGougan. Liberty's disclaimer concedes that claimant's condition is compensable, but denies responsibility only.¹ The disclaimer also states that a "307" order has been requested. Like the document in McGougan, it contains "notice of hearing" provisions and states that it is a denial of the claim for benefits. Based on the reasoning in McGougan, we conclude that this disclaimer did not raise a compensability issue.

Accordingly, for the foregoing reasons, we conclude that claimant is not entitled to an ORS 656.386(1) fee on the basis of Liberty's denial.

Finally, claimant seeks an ORS 656.382(2) fee. There is no basis for a fee under this statute since an insurer/employer did not request the hearing. See ORS 656.382(2).

ORDER

The Referee's order dated April 19, 1994, as reconsidered May 27, 1994, is reversed in part. That portion of the Referee's order which declined to award an attorney fee for claimant's counsel's services in obtaining rescission of the compensability portion of SAIF's denial is reversed. For services prior to hearing, claimant's attorney is awarded \$600, payable by SAIF. The remainder of the Referee's order is affirmed.

¹ We consider Liberty's request for a "307" order, in conjunction with its statement that, "it appears that your condition is compensable; however, responsibility may rest with [another employer]," to be a clear concession that the claim is compensable. Thus, we disagree with the argument, advanced in the dissenting opinions, that there has not been a clear and express concession of compensability.

Board Member Hall dissenting.

Because I find that claimant's compensation remained at risk as a result of Liberty's "responsibility denial," I respectfully dissent. Liberty's denial indicated only that "it appeared" that claimant's condition was compensable. I believe that to avoid an ORS 656.386(1) fee, a carrier must clearly state that compensability of the claimant's claim is admitted and that only responsibility for the claim is at issue. The carrier would then be bound by the express language contained in its denial. See Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993). With compensability admitted, and responsibility being truly the only issue, the carriers would then be subject to ORS 656.307 and any fee payable under that statute.

In this case, I do not believe that Liberty's denial expressly admitted compensability. Liberty's denial did not make it clear to claimant that only responsibility was at issue. In fact, the document merely states that "it appeared" claimant's condition was compensable. The subject document contains two statements, one indicating that the letter represents a "denial of responsibility," and one (in the notice of hearing rights) indicating that "this is a denial of your claim for benefits."

While Liberty's denial indicated that a "307" order had been requested, there is no evidence that such an order was requested and no such order appears in the record. In any case, it is well-settled that agreement to a "307" order is not the equivalent of a concession of compensability by a carrier. Allen v. Bohemia, Inc., 125 Or App 205 (1993). Thus, where compensability is not clearly and expressly admitted by a carrier, a compensability issue remains viable. See, e.g., Allen v. Bohemia, Inc., supra. (compensability was still at issue even where a carrier requested issuance of a "307" order and denied responsibility only); see also, Davis v. R & R Truck Brokers, 112 Or App 485 (1992). Accordingly, in order to protect the claimant's rights to compensation, an attorney fee should be awarded pursuant to ORS 656.386(1) absent an express and unequivocal admission of compensability by the carrier.

For the foregoing reasons, I believe that Liberty is liable for an attorney fee under ORS 656.386(1). Therefore, I respectfully dissent from the majority's decision.

Board Member Gunn dissenting.

The majority has abandoned the long established standards for insurers' and employers' communications to claimants. The majority would hold that their decision is actually pro-worker because it expands the ambiguities in such communications to constitute a concession of compensability, at least in this limited responsibility context.

The majority decision does violence to our judicial policy, and is unfair to employers and insurers, subjecting them to interpretive caprice. Prior to this decision, the standard for determining whether a notice conceded compensability was its lack of ambiguity. The standard of review was that the denial specifically contained an acknowledgment of compensability. See James McGougan, supra at 1640.

The standard made sense both as a matter of law and policy. As a matter of law, a clear, unambiguous concession removed any question of litigation on compensability. This served to limit the scope of litigation. A clear unambiguous concession also served the purpose of better informing claimants who were not lawyers and had not retained counsel.

Moving from the current standard of no ambiguity to determining ambiguity on a case-by-case basis is unfair to employers and insurers. Before, the test was easy. Any response less than a specific acknowledgment of compensability resulted in this Board finding compensation at risk and awarding the attendant attorney fee. Now the standard is that anything that can be construed, ascertained or calculated to be a concession becomes one. This new interpretive standard places employers at risk for concessions they may not want to make and do not believe they have made.

For these reasons, I must respectfully dissent.

April 20, 1995

Cite as 47 Van Natta 742 (1995)

In the Matter of the Compensation of
WILLIAM K. YOUNG, Claimant
WCB Case No. 94-05731
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Gunn and Turner-Christian.

The SAIF Corporation requests review of those portions of Referee Lipton's order which: (1) declined to consider SAIF's "amendment" of its prior acceptance of thoracic and lumbar strains to include "lumbosacral and thoracic sprains;" (2) set aside SAIF's alleged "de facto" denial of claimant's lumbar strain; and (3) awarded a \$1,500 attorney fee under ORS 656.386(1). In his respondent's brief, claimant contests those portions of the Referee's order which upheld SAIF's "de facto" denial of claimant's rib segment joint dysfunction and thoracic strain. On review, the issues are claim processing, compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, an electrician, injured his back on March 7, 1994. Claimant signed a March 15, 1994 form 827, in which he described his injury as occurring while pulling a pump out of a well. Dr. Platt, a chiropractor, diagnosed thoracic and lumbar spine sprain/strains and rib segment joint dysfunction.

On April 4, 1994, claimant changed his attending physician to Dr. Verzosa, who diagnosed a lumbosacral and thoracic sprain. SAIF, however, formally accepted thoracic and lumbar strains on April 11, 1994.

On July 25, 1994, Dr. Platt opined that all the diagnoses listed on the March 15, 1994 form 827 were related to claimant's March 7, 1994 injury. Claimant was subsequently evaluated by examining physicians, Drs. Strum and White, on July 28, 1994. They diagnosed a resolved lumbar strain, but did not mention rib segment joint dysfunction.

CONCLUSIONS OF LAW AND OPINION

At the hearing, during which claimant was not present, SAIF attempted to amend its acceptance so as to accept lumbosacral and thoracic sprains. SAIF's counsel stated that SAIF had "incorrectly" accepted a thoracic and lumbar strain. (Tr. 9). Claimant's counsel argued that SAIF's attempt to amend its acceptance was an improper "de facto" denial. (Tr. 7). Citing Dolph M. Wiedenmann, 46 Van Natta 1584 (1994), the Referee refused to allow SAIF to amend its acceptance.

The parties framed the issue at hearing as "de facto" denial of rib segment joint dysfunction and strains of the lumbosacral and thoracic spines. (Tr. 5, 6). Although not explicitly stated in his order, the Referee apparently considered SAIF's attempt to correct/amend its acceptance as a "back-up" denial of the previously accepted thoracic and lumbar strains. Reasoning that the medical evidence was sufficient to establish the compensability of the lumbar strain, but not the thoracic strain, the Referee set aside the "de facto" denial of claimant's lumbar strain and upheld SAIF's denial of the thoracic strain. The Referee further awarded an assessed attorney fee of \$1,500 for claimant's counsel's efforts in obtaining "acceptance" of the lumbar strain.

Claim Processing

On review, SAIF contends that the Referee erred in not allowing it to amend its acceptance to include lumbosacral and thoracic sprains. SAIF further asserts that it was not attempting to issue a "back-up" denial of the lumbar and thoracic strain conditions that it had formally accepted on April 11, 1994. We agree that SAIF could accept the lumbosacral and thoracic sprains, but we construe its attempted "correction" of the previously accepted conditions as a "back-up" denial.

As previously noted, the Referee cited Dolph M. Wiedenmann, *supra*, as authority for his refusal to allow SAIF to amend its acceptance at hearing. In Wiedenmann, we held that the insurer could not orally amend its denial at hearing over the objections of the claimant. 46 Van Natta at 1585.

We find Wiedenmann distinguishable because this case involves an amendment of an acceptance, as opposed to a denial. Moreover, unlike the claimant in Wiedenmann, claimant here did not object procedurally to the attempted amendment of SAIF's acceptance, but rather on the grounds that the amendment created a "de facto" denial of his previously accepted lumbar and thoracic strains. Inasmuch as claimant wished to have the compensability issue decided by the Referee, SAIF's amendment of its acceptance was permissible. *Cf. Tattoo v. Barrett Business Service*, 118 Or App 348, 351-52 (1993) (employers are bound by the express language of their denials).

Having concluded that SAIF's amendment of its acceptance was permissible under the circumstances of this case, we next address the issue of whether SAIF was withdrawing its prior acceptance of the lumbar and thoracic strain conditions. If so, this would constitute a "back-up" denial of the previously accepted conditions. *See* ORS 656.262(6); SAIF v. Andrews, 130 Or App 620 (1994) (two-year "back-up" denial period under ORS 656.262(6) runs from the date of claim acceptance). Although SAIF asserts that it did not intend a "back-up" denial of the previously accepted conditions, SAIF's counsel acknowledged in recorded closing arguments that SAIF had "incorrectly" accepted a thoracic and lumbar strain. (Tr. 9). Given this concession, we conclude that SAIF was in effect attempting to revoke its acceptance of the lumbar and thoracic strain conditions.

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."

ORS 656.262(6), therefore, requires that a "back-up" denial be based on "[later obtained] 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, SAIF does not allege, nor does the record indicate, the presence of later obtained evidence that claimant's thoracic and lumbar strain conditions were not compensable. Moreover, there is also no "clear and convincing evidence" that those conditions are not compensable. Thus, we set aside SAIF's "back-up" denial of claimant's thoracic strain and affirm the Referee's decision to set aside SAIF's denial of claimant's lumbar strain. Consequently, that portion of the Referee's order that upheld SAIF's "de facto" denial of claimant's thoracic strain is reversed.

Rib Injury

The Referee upheld SAIF's "de facto" denial of claimant's diagnosed rib segment joint dysfunction. The Referee reasoned that, since the etiology of this condition was a complex medical question, claimant required more medical evidence than Dr. Platt's conclusory diagnosis to establish the compensability of that condition.

Inasmuch as claimant's rib segment joint dysfunction has never been accepted, we do not conclude that SAIF's "de facto" denial constitutes a "back-up" denial as well. Therefore, the "clear and convincing" evidence standard of ORS 656.262(6) is not applicable.

The medical evidence supporting the compensability of this condition is sparse. Claimant did not testify at hearing, but his statement on the signed form 827 indicates that he injured himself while pulling a pump out of a well. Based on this history, Dr. Platt diagnosed a rib injury that he would later relate in major part to the March 7, 1994 incident. (Ex. 9).

Claimant has the burden to prove that he experienced a rib injury in the course and scope of his employment on March 7, 1994. ORS 656.266; ORS 656.005(7)(a). The only evidence that claimant's rib injury occurred at work is in the form of claimant's hearsay statement in the form 827. Although such evidence is admissible for the truth of claimant's statement to the extent that it is reasonably pertinent to medical diagnosis and treatment, such evidence is not probative evidence concerning what caused claimant's injury or where it occurred. See ORS 656.310(2); Zurita v. Canby Nursery, 115 Or App 330 (1992), rev den 315 Or 443 (1993); see also Emery R. Miller, 43 Van Natta 1788 (1991) (Statements that an injury happened at work are not reasonably pertinent to the physician's diagnosis and treatment and are not prima facie evidence of the fact asserted). Thus, we conclude that claimant has failed to establish legal causation.

Moreover, even if we considered claimant's statement to be probative evidence concerning what caused claimant's rib injury and where it occurred, we would still conclude that the rib injury was not compensable. Dr. Platt provided no reasoning to support his conclusion that the rib injury was work-related. See Somers v. SAIF, 77 Or App 259, 263 (1986) (most weight given to well-reasoned medical opinions); Wilma H. Ruff, 34 Van Natta 1048, 1051 (1982); Edwin Bollinger, 33 Van Natta 559 (1981) (even uncontradicted medical opinion need not be followed). Thus, we find that claimant has also failed to sustain his burden of proving medical causation. Accordingly, we uphold SAIF's "de facto" denial of claimant's rib condition.

Attorney Fees

We have now approved SAIF's amendment of its acceptance at the August 8, 1994 hearing to include lumbosacral and thoracic sprains, based on Dr. Verzosa's April 5, 1994 diagnoses. Because the acceptance occurred more than 90 days after SAIF had notice of the "claim" for the sprain conditions, SAIF's acceptance is equivalent to the rescission of a "de facto" denial without a hearing. See Patricia L. Row, 46 Van Natta 1794 (1994). Inasmuch as the rescission occurred after claimant's request for hearing, claimant's counsel has been instrumental in obtaining compensation without a hearing. See Nancy S. Jenks, 46 Van Natta 1441 (1994). Thus, an award of a reasonable attorney fee is appropriate pursuant to 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 regarding the pre-hearing acceptance of the low back and thoracic sprains is \$500 to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues, the complexity of the issues, the value of the interests involved, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is also entitled to an attorney fee for prevailing over SAIF's request for review of the Referee's decision concerning the compensability of claimant's lumbar strain. 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 issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Claimant is also entitled to an assessed attorney fee for finally prevailing on the issue of the compensability of his thoracic strain. 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 thoracic strain issue is \$2,000, to be paid by SAIF. 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.

Finally, SAIF contends that the Referee's attorney fee award of \$1,500 for claimant's counsel's efforts regarding the lumbar strain issue was excessive. We disagree.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's counsel's services at hearing regarding the lumbar strain issue is \$1,500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 1, 1994 is reversed in part and affirmed in part. Those portions which refused to allow SAIF to amend its acceptance and upheld its "back-up" denial of claimant's thoracic strain are reversed. SAIF's acceptance is amended to include claimant's lumbosacral and thoracic sprains. SAIF's "de facto" denial of claimant's thoracic strain is set aside and the claim is remanded to SAIF for processing according to law. Claimant's counsel is awarded \$2,000 for services at hearing and on review concerning the compensability of his thoracic strain, to be paid by SAIF. Claimant's counsel is further awarded an assessed attorney fee of \$500 for pre-hearing services in obtaining rescission of SAIF's "de facto" denial of his lumbosacral and thoracic sprains, as well an assessed attorney fee of \$1,000 for services rendered on review regarding the compensability of claimant's lumbar strain, all to be paid by SAIF. The remainder of the Referee's order is affirmed.

April 21, 1995

Cite as 47 Van Natta 745 (1995)

In the Matter of the Compensation of
ROY A. PHILLIPS, Claimant
WCB Case No. 92-05790
ORDER ON REMAND
Pozzi, Wilson, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Phillips v. Dean's Drywall, 132 Or App 436 (1995). The court reversed that portion of our prior order which declined to consider claimant's request for an attorney fee under ORS 656.382(1) for allegedly unreasonable claims processing because we found that claimant had not raised the issue at hearing. Concluding that the issue of attorney fees was raised at the hearing, the court has remanded for reconsideration.

The relevant facts are as follows. A June 11, 1992 Order on Reconsideration affirmed the December 6, 1991 Notice of Closure, awarding no permanent disability. In reaching the conclusion that claimant was not entitled to permanent disability, the Director (as did the insurer) relied on the concurrence of Dr. Kendrick, attending physician, with the October 1, 1991 report of the physicians at First Northwest Health who found no permanent disability related to claimant's April 27, 1989 injury. (Exs. 4, 5-1). Furthermore, on reconsideration, the Director specifically did not consider Dr. Kendrick's response to a May 26, 1992 questionnaire concerning extent of permanent disability because the response was based on a post-closure examination. See ORS 656.268(5); OAR 436-30-050(2) & (4)(e), (f); (Ex. 16-3).

Claimant requested a hearing. The Referee, relying on Agnes C. Rusinovich, 44 Van Natta 1544 (1992), concluded that Dr. Kendrick's "post-closure" responses to the May 26, 1992 questionnaire could be considered to evaluate claimant's permanent disability. Based on that "post-closure" response, the Referee awarded 16 percent (51.2 degrees) unscheduled permanent disability. However, the Referee did not address claimant's contention that the insurer had unreasonably closed the claim without a permanent disability award.

Claimant requested Board review. We modified the Referee's permanent disability award, increasing the unscheduled award from 16 percent to 19 percent (60.8 degrees). Concluding that claimant had not raised the issue of an attorney fee under ORS 656.382(1) at hearing, we did not address the issue on review.

The court has reversed our decision. Phillips v. Dean's Drywall, *supra*. The court concluded that claimant had listed attorney fees as an issue in his request for hearing, and had also argued his entitlement to attorney fees under ORS 656.382(1) in a Hearing Memorandum given to the Referee at the time of hearing. Consequently, the court has remanded for reconsideration. In accordance with the court's mandate, we proceed with our reconsideration.

Claimant is entitled to an attorney fee under ORS 656.382(1) if the insurer unreasonably resisted the payment of compensation. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Claimant contends that he is entitled to an attorney fee under ORS 656.382(1) because the insurer unreasonably resisted the payment of compensation by awarding no unscheduled permanent disability in the Notice of Closure, whereas the Referee and Board subsequently found that a significantly increased award was appropriate. We disagree with claimant's contention.

At the time of the Notice of Closure, the insurer had claimant's attending physician's concurrence with First Northwest Health's opinion that claimant had no injury-related permanent disability. See Tektronix, Inc. v. Watson, 132 Or App 483 (1995). Dr. Kendrick did not examine claimant and change his opinion concerning permanent disability until after the Notice of Closure had issued. Therefore, at the time of the Director's review of the Notice of Closure, pursuant to ORS 656.268(5) and OAR 436-30-050(2) & (4)(e), (f), the Director specifically declined to consider "post-closure" evidence from Dr. Kendrick's examination.

Subsequent to the Director's order, the court held that "post-closure" evidence from the attending physician could be considered by the Referee and Board. See Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). Accordingly, in light of the evidence that was available to the insurer at the time it closed the claim, we conclude that the insurer had a legitimate doubt as to any permanent disability when it issued the Notice of Closure. International Paper Co. v. Huntley, *supra*. In particular, we rely on the concurrence from Dr. Kendrick, attending physician, with the report from First Northwest Health finding no permanent disability related to claimant's April 27, 1989 injury. Tektronix, Inc. v. Watson, *supra*. Therefore, we find that the insurer's Notice of Closure that awarded no permanent disability was not unreasonable, and claimant is not entitled to an attorney fee under ORS 656.382(1). Brown v. Argonaut Insurance Company, *supra*.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA L. SERPA, Claimant
WCB Case No. 93-10053
ORDER ON REVIEW (REMANDING)
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of that portion of Referee Crumme's order which set aside its denials of claimant's current low back condition. On review, the issues are claim processing and compensability. We vacate and remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On December 23, 1992, the employer accepted claimant's low back injury of September 1, 1992 as a disabling lumbar strain. On June 9, 1993, the employer issued a Notice of Closure, awarding temporary but no permanent disability. The employer subsequently issued a denial of claimant's current low back condition on August 5, 1993, contending that it was not related to the compensable September 1992 injury. (Ex. 163).

On February 14, 1994, the employer issued a denial "clarifying" that its previous denial had been of claimant's low back condition as of April 21, 1993. (Ex. 180). Referring to an Order on Reconsideration of January 31, 1994 (which had set aside the June 1993 Notice of Closure as premature), the denial stated that claimant's lumbosacral strain claim had once again been closed. This closure also occurred on February 14, 1994, pursuant to the employer's Notice of Closure.

The hearing convened on November 17, 1993 and was continued and reconvened on May 20, 1994 and July 25, 1994. The record closed on the later date. Exhibits were admitted and testimony was taken concerning the compensability issue. The parties' arguments focused on whether claimant's low back condition was compensable under ORS 656.005(7)(a)(B).

Reasoning that the employer had denied claimant's current low back condition as of a date prior to the June 9, 1993 closure notice, the Referee found that the employer's August 3, 1993 denial, as clarified on February 14, 1994, constituted an invalid "pre-closure" partial denial under Sheridan v. Johnson Creek Market, 127 Or App 259 (1994) and United Airlines, Inc. v. Brown, 127 Or App 253 (1994). The Referee further reasoned that conditions that preexisted the September 1992 injury contributed to claimant's subsequent disability and need for treatment, and that claimant's condition as of April 21, 1993 did not involve solely a new injury unrelated to her accepted injury. Thus, the Referee concluded that the employer's denial was not permissible under Zora A. Ransom, 46 Van Natta 1287 (1994). Finally, citing Jean K. Elliott-Moman, 46 Van Natta 991 (1994), the Referee concluded that claimant's failure to raise the issue of an invalid "pre-closure" partial denial did not mean that she had waived the argument.

Thus, the Referee set aside the employer's August 3, 1993 denial, as "clarified" by the February 14, 1994 denial. The employer has requested Board review.

On review, the employer argues that it was fundamentally unfair for the Referee to have decided an issue neither party argued at hearing. Based on the following reasoning, we agree with the employer's contention.

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 of the referee's order upholding the employer's denial on the merits of the claim, 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. Since the Brown and Sheridan decisions issued in April 1994 and our initial order in Elliott-Moman was abated in March 1994, it was 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.

In Zinaida I. Martushev, 46 Van Natta 2410 (1994), we noted that the Brown and Sheridan decisions had issued after the parties' written arguments had been filed with the Board. We, thus, followed our reasoning in Elliott-Moman and addressed on reconsideration the claimant's contention that the employer's "pre-closure" denial was invalid. Inasmuch as the employer in Martushev had issued its denial of the claimant's "resultant condition" before it had closed the claim, we set aside the employer's denial as an invalid "pre-closure" denial of an accepted condition.

We find Elliott-Moman and Martushev distinguishable from this case. Here, the court's decisions in both Sheridan and Brown were issued prior to the record closing in the present case on July 25, 1994. In contrast, in both Elliott-Moman and Martushev, the Sheridan and Brown decisions had issued after the hearing. Inasmuch as this claimant could have raised before the Referee the "pre-closure" partial denial issue based on Sheridan and Elliott-Moman, but did not do so, we agree with the employer that the Referee should not have addressed the issue on his own initiative. See Nikki Burbach, 46 Van Natta 265, 268 (1994) (a referee's review is limited to issues raised by the parties); see also Lucky L. Gay, 46 Van Natta 1252 (1994) (Inasmuch as an aggravation issue was not presented for resolution, the referee erred in addressing such an issue). Accordingly, we conclude that the Referee should have addressed the merits of the compensability dispute as the parties desired.

Although the Referee admitted exhibits and testimony was given concerning the compensability issue, the Referee did not reach the merits. Therefore, the Referee did not render findings concerning claimant's credibility (demeanor) as a witness or evaluate the evidence concerning the compensability issue. Under such circumstances, we consider the current record to be insufficiently developed. See ORS 656.295(5); Neil W. Walker, 45 Van Natta 1597, 1598 (1993) (Where the referee did not make credibility findings and did not evaluate evidence concerning occupational disease issue, remand was appropriate); Refugio Guzman, 39 Van Natta 808 (1987). Accordingly, we find it appropriate to remand this matter to Referee Crumme for reconsideration.

The Referee shall make a determination as to whether claimant's current low back condition is compensable on the merits, to include, if appropriate, any findings concerning claimant's credibility. The Referee shall proceed in any manner he determines will achieve substantial justice. The Referee shall then issue a final, appealable order.

ORDER

The Referee's order dated August 23, 1994, as reconsidered on October 20, 1994, is vacated. This matter is remanded to Referee Crumme for further proceedings consistent with this order.

In the Matter of the Compensation of
JUDITH A. CURRY, Claimant
WCB Case No. 94-11102
ORDER ON REVIEW
Furniss, Shearer, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Davis' order that upheld the SAIF Corporation's "de facto" denial of medical bills for fusion surgery. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We do not adopt his findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant experienced a compensable low back injury that resulted in a compensable disc condition at L4-5. Claimant also had a noncompensable degenerative condition at L5-S1. After consultation with Dr. Misko regarding proposed fusion surgery to correct claimant's accepted low back condition, Dr. Flemming, claimant's treating orthopedic surgeon, proposed a surgical procedure for fusion at L4-5 and L5-S1 with internal fixation. After the procedure was approved by Caremark Comp, the managed care organization with which SAIF contracts, Dr. Flemming performed a decompressive laminectomy at L4-5 with bilateral L5 nerve root foraminotomies and bilateral fusion of L4 to the sacrum with pedicle screw fixation. SAIF declined to pay for that portion of the surgery it attributed to the L5-S1 level. The Referee concluded that SAIF's denial of payment was appropriate, reasoning that the fusion of claimant's spine at L5-S1 was not reasonable and necessary.

On review, claimant contends that inclusion of the L5-S1 level was essential in order to treat her compensable L4-5 instability. We agree.

Medical services "for conditions resulting from the injury" are compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245(1); Beck v. James River Corp., 124 Or App 484, 487 (1993), rev den 318 Or 478 (1994). If the prescribed medical services constitute an integral part of the total medical treatment for the condition due to the compensable injury, the medical services are compensable. Williams v. Gates McDonald & Co., 300 Or 278 (1985); Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987). Claimant is entitled to treatment, even of a noncompensable condition, reasonably necessary to permit treatment of a compensable condition. SAIF v. Roam, 109 Or App 169 (1991).

Claimant had marked instability at L4-5 that resulted in significant back pain. In his discussion of the surgery, Dr. Flemming stated that the primary reason for performing the surgery was to correct claimant's instability at L4-5 that resulted in severe back pain. He also stated that it was necessary to extend the fusion to include the L5-S1 level in order to alleviate claimant's back pain condition, as a failure to include that level would permit the pain for which claimant sought treatment to have continued. (Ex. 9). Moreover, Dr. Misko, neurosurgeon, who provided a second opinion prior to the surgery, agreed that the two-level fusion was appropriate and was to be done primarily to alleviate the motion at L4-5. (Ex. 4B-b). Additionally, CareMark Comp, whose medical review staff screened the request for surgery, certified that spinal fusion at L4-5 and L5-S1 was medically necessary and appropriate. (Ex. 5).

There is no contrary medical evidence.

We conclude that the compensable injury is the major contributing cause of the need for fusion surgery, including the L5-S1 component. Thus, the L5-S1 portion of the surgery is compensable. Williams v. Gates McDonald & Co., *supra*; Beck v. James River Corp., *supra*; SAIF v. Roam, *supra*; Van Blokland v. Oregon Health Sciences University, *supra*.

Because SAIF neither accepted nor denied claimant's surgery claim, nor paid the bills within 90 days, its conduct was consistent with a denial of a medical services claim not confined to the amount of compensation or extent of disability. See Snowden A. Geving, 46 Van Natta 2355, 2356 (1994). Inasmuch as claimant has prevailed over a "rejected" medical services claim, claimant's counsel is entitled to an attorney fee for his efforts both at hearing and on review. See ORS 656.386(1); 656.382(2); SAIF v. Allen, 320 Or 192, 218 (1994).

Claimant submits his counsel's statement of services requesting a \$3,600 fee for services at hearing and on review. SAIF objects to the amount of the attorney fee in connection with overturning its "de facto" denial of claimant's medical bills.

Claimant's attorney is entitled to an assessed 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 fee for claimant's attorney's services at hearing and on review is \$2,800, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record, claimant's appellate briefs, counsel's statement of services and SAIF's objections to the attorney fee award), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The Referee's order dated October 31, 1994 is reversed. The SAIF Corporation's "de facto" denial of spinal fusion surgery is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded \$2,800, to be paid by SAIF.

April 18, 1995

Cite as 47 Van Natta 750 (1995)

In the Matter of the Compensation of
ELIZABETH BEAIRSTO, Claimant
 WCB Case No. 94-06747
 ORDER ON REVIEW
 Malagon, Moore, et al., Claimant Attorneys
 Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Poland's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. SAIF objects to the amount of the attorney fee requested by claimant. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant's repetitive work activities for the employer were the major contributing cause of her bilateral CTS condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to establish a compensable occupational disease. In reaching this conclusion, the Referee declined to rely on the opinions of Drs. Jewell and Teal, treating physicians, because she determined that their opinions were based on a history regarding the onset of claimant's symptoms which was inconsistent with claimant's testimony. In addition, the Referee found the treating physicians' opinions unpersuasive, because they failed to explain why claimant's symptoms were initially left-sided even though she is right-handed. We disagree.

Claimant bears the burden of proving that her employment activities as a librarian were the major contributing cause of her bilateral CTS condition or its worsening. ORS 656.802(2). Here, because there is no evidence that claimant's CTS condition preexisted her work exposure with the employer, claimant need only establish that her employment activities were the major cause her CTS.

We generally defer to the opinion of an injured worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find no such reasons.

Claimant's 21-year employment as a librarian involved continuous repetitive hand movements. Although she is right-handed, she uses both hands at work, lifting, handling, and shelving books and other materials constantly. In addition, in 1987, the employer installed computers, which required recataloging of thousands of books and significant data entry activities.

In May 1992, claimant first noticed tingling and numbness in her hands (primarily on the left) upon waking in the morning. (Tr. 8, 30; Ex. 1-1-2). She did not initially experience symptoms at work. (Ex. 2-1, Tr. 30). By 1994, claimant's night symptoms had increased and she began to have discomfort in the daytime as well.

Dr. Jewell was aware of the nature of claimant's work and the fact that her symptoms began in 1992. He reported:

"The claimant references the onset of symptomatology in 1992 concerning her hands. She states that she was utilizing a computer software program "Alliance" for the cataloguing of thousands of books. This involved both the use of direct keyboard data entry and the use of a light pen. During the course of the book cataloguing she noted tingling and numbness in both of her hands, more so on the left than the right." (Ex. 8-1).

As we understand Dr. Jewell, "during the course of the book cataloguing" means at that point in time generally (as in calendar months), rather than specifically, on certain days at certain times. Moreover, there is no medical evidence indicating that the fact that claimant's symptoms initially occurred at home diminishes the likelihood that her CTS is work related. Accordingly, we conclude that Dr. Jewell's history concerning claimant's work and her symptoms is consistent with claimant's testimony and her reporting to other physicians, including Drs. Teal and Radecki. (See Exs. 6, 7A, 9). Under these circumstances, we further conclude that all physicians had materially accurate histories regarding claimant's work and her symptoms.

Drs. Jewell and Teal opined that claimant's work activities were the major contributing cause of her CTS condition. Dr. Radecki provides the only opinion to the contrary, indicating that claimant's work activities did not cause or contribute to her CTS. Instead, Dr. Radecki concluded that claimant's age and "wrist ratio" are the major contributing cause of her condition, because those "risk factors" render her statistically likely to develop CTS.¹ He did not explain why he believes that claimant's age and build are more significant than her 21-year work exposure. Because Dr. Radecki discounted claimant's extensive work exposure without further explanation, we find his opinion concerning claimant to be insufficiently explained. As such it is not particularly persuasive. See Somers v. SAIF, 77 Or App 259 1986; Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Darlene L. Bartz, 45 Van Natta 32, 33, aff'd mem Jeld-Wen, Inc. v. Bartz, 123 Or App 359 (1993).

Under these circumstances, we rely on the opinion of Drs. Jewell and Teal. See Somers v. SAIF, supra. Based on those opinions, we conclude that claimant has carried her burden of proving that her CTS condition is compensable.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). SAIF contends that the \$5,000 fee requested by claimant is excessive.

¹ Dr. Radecki noted that claimant's left CTS is worse than her right CTS, even though claimant is right-handed. In his view, this apparent discrepancy increases the likelihood that claimant's CTS is idiopathic, rather than work-related. In contrast, Drs. Teal and Jewell were untroubled by claimant's more severe left CTS even though they were aware that claimant is right handed. Because we find Dr. Radecki's opinion otherwise unpersuasive herein (as it is general rather than specific to claimant), and we find no reason to discount the opinions of Drs. Jewell and Teal, we conclude that the perceived inconsistency between claimant's right-hand dominant characteristic and her more severe left CTS is not material to the causation question.

After considering the factors set forth in OAR 438-15-101(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review regarding the compensability issue is \$3,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's counsel's statement of services, as well as after consideration of SAIF's objections), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 28, 1994 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded \$3,000, to be paid by SAIF.

April 24, 1995

Cite as 47 Van Natta 752 (1995)

In the Matter of the Compensation of
SUE A. SPRINGER, Claimant
WCB Case No. 93-14317
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of those portions of Referee Daughtry's order which: (1) directed it to reimburse claimant for home health care services, including child care, at the full rate requested by claimant; and (2) assessed penalties and attorney fees for unreasonable claim processing. On review, the issues are medical services, penalties and attorney fees.

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

Claimant sought reimbursement for 24-hour child care and housekeeping services rendered during the acute phase of her recovery from compensable shoulder surgery. The services included assisting claimant with personal hygiene and dressing, cooking, washing dishes, house cleaning, and yardwork, as well as care for two young children who were 1-1/2 and 3-1/2 years old at the time of claimant's surgery. Claimant's attending physician prescribed the 24-hour care for a period of 6-8 weeks following surgery, in order to aid claimant's healing process. (Exs. 12, 22A at 13-14). Claimant's attending physician opined that the services were reasonable and necessary because claimant was unable to use her shoulder following surgery without risk of disrupting the healing process (e.g., tearing out the sutures). (Ex. 22A at 14-16).

The insurer does not object to reimbursement for child care services. However, it does object to characterizing the services as "other related services" within the meaning of ORS 656.245(1)(c). In doing so, the insurer relies on Lorenzen v. SAIF, 79 Or App 751, rev den 301 Or 667 (1986), in which the court held that child care expenses incurred while the claimant was hospitalized were not "other related services" within the meaning of ORS 656.245. In addition, the insurer objects to the rate of payment for the services, contending that the rate cannot exceed the rates established by the Children's Services Division for family child care, as codified at OAR 436-60-095(3). Those rates were \$1.60 per hour for an infant to a maximum of \$350 per month, and \$1.33 per hour for a non-infant to a maximum of \$292 per month.

The Referee found the services compensable under ORS 656.245 and ordered the insurer to reimburse claimant in the full amount requested (at the rate of \$3.00 per hour, for a total of 666.75 hours in June, 744 hours in July, and 192 hours from August 1 to 8, 1993). The Referee found that \$3.00 per hour is a reasonable rate, based on claimant's testimony that she has paid that rate for child care services, and that she has charged that rate herself when providing child care services in the past. We agree with the Referee's reasoning and conclusion, and offer the following supplementation.

We have recently held that home health care services, prescribed to prevent the worsening of compensable conditions, are compensable medical services. Pamela J. Panek, 47 Van Natta 313, 314 (1995) (on remand). In Panek, we relied on our prior decision in Robert P. Holloway, 45 Van Natta 2036, 2038 (1993), holding that home health care services which included housekeeping, shopping for food, meal preparation, and personal hygiene assistance were not mere housekeeping, because, without such services, claimant's compensable conditions would worsen. We find that our reasoning in Panek applies equally in the present case. Without child care, housekeeping and personal grooming assistance claimant's compensable shoulder condition would worsen because it could not properly heal after surgery.

We distinguish Lorenzen, *supra*, on its facts. In Lorenzen, the court held that child care expenses incurred while the claimant was hospitalized were not "other related services" within the meaning of ORS 656.245. Here, however, the child care and housekeeping services were prescribed during the acute recovery stage following surgery for a compensable condition. The attending physician testified that, without such services, claimant's compensable shoulder condition would have worsened. By contrast in Lorenzen, the lack of child care services would not have worsened the claimant's condition, since she was hospitalized. We conclude that the circumstances in this case are more similar to the circumstances in Panek and Holloway, *supra*, than to the circumstances in Lorenzen. Accordingly, we conclude that the housekeeping and child care services rendered during claimant's recovery from surgery are compensable medical services under ORS 656.245(1)(c).

We also agree with the Referee's reasoning that reimbursement for the services at the rate of \$3.00 per hour is reasonable. We disagree with the insurer that OAR 436-60-095(3) applies in this case, since that rule simply prescribes the appropriate rate of reimbursement for child care services necessitated by attendance at an independent medical examination. Here, by contrast, the child care and housekeeping services were necessitated by the process of recovery for a compensable condition and, therefore, are authorized under ORS 656.245. The maximum rate set by the Children's Services Division is particularly inappropriate here, where claimant's attending physician prescribed care on a 24-hour basis. Accordingly, based on this record, we conclude that the rate of reimbursement authorized by the Referee was reasonable.

Finally, we agree with the Referee's reasoning and conclusion that penalties and attorney fees are warranted for the insurer's unreasonable claim processing.

Inasmuch as we have not disallowed or reduced the compensation awarded by the Referee, claimant is entitled to an assessed attorney fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the medical service issue is \$900, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services rendered by her counsel on review regarding the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 12, 1994 is affirmed. Claimant's attorney is awarded \$900 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
LARRY G. TABOR, Claimant
WCB Case No. 93-09985
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Neidig, Turner-Christian and Gunn.

The self-insured employer requests review of those portions of Referee Brown's order which: (1) affirmed the Director's July 15, 1993 Proposed and Final Order Concerning A Bona Fide Medical Services Dispute finding a proposed surgery to be appropriate; (2) set aside the employer's "de facto" denial of claimant's medical bills; (3) set aside the employer's denial of claimant's aggravation claim for a cervical condition; (4) assessed penalties and attorney fees for allegedly unreasonable claim processing; and (5) assessed a penalty pursuant to ORS 656.382(3) for a request for hearing allegedly filed for the purpose of vexatious delay. On review, the issues are medical services, compensability, aggravation, penalties and attorney fees. We affirm in part, vacate in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

"De Facto Denial"

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

Aggravation

We adopt and affirm the Referee's reasoning and conclusions regarding this issue. The employer contends, however, that claimant's aggravation claim was filed after expiration of his aggravation rights on December 2, 1992. Thus, it asserts that the Referee had no jurisdiction to consider the aggravation claim. We disagree.

While we can consider the jurisdictional issue raised for the first time on appeal, *see S M Motor Company v. Mather*, 117 Or App 176 (1992), the employer's contention is clearly without merit. Claimant filed his aggravation claim on November 24, 1992, which was within five years of the first claim closure on December 2, 1987. (Ex. 111); ORS 656.273(4)(a). Therefore, the Referee properly considered the merits of claimant's aggravation claim.

Medical Services Dispute

On November 6, 1992, claimant's attending neurosurgeon, Dr. Berkeley, requested authorization from the employer for a cervical discectomy and fusion at C5-6, C6-7, C7-T1. (Ex. 110). Dr. Berkeley directly related claimant's need for surgery to his compensable September 23, 1985 injury. (Ex. 112).

The employer arranged an examination with a neurosurgeon, Dr. Rosenbaum. Dr. Rosenbaum reported on January 5, 1993 that, while claimant's cervical condition (which he diagnosed as a chronic cervical strain) was related to the compensable injury, the surgery Dr. Berkeley proposed was not indicated. (Ex. 113-6). Dr. Rosenbaum found no evidence of cervical radiculopathy or neurological abnormalities on examination.

On April 8, 1993, the employer requested Director's review of the proposed surgery pursuant to ORS 656.327(1)(a). (Ex. 119). The employer certified that the causal relationship between claimant's cervical condition and compensable injury was not at issue. In the meantime, Dr. Berkeley continued to opine that the proposed surgery was appropriate based on MRI findings, as well as on neurological abnormalities claimant demonstrated on clinical examination. (Ex. 121-3).

The Director selected Dr. Purtzer, a neurosurgeon, to review claimant's medical records and perform an examination. Dr. Purtzer reported that claimant's condition was consistent with a diagnosis of cervical radiculopathy secondary to cervical disc disease and spondylosis at C5-6 and C6-7. (Ex. 127). Although he, personally, would feel more comfortable with recommending surgery after additional diagnostic studies, such as a cervical myelogram and CT scan, were performed, Dr. Purtzer explained that such studies were not mandatory. Opining that Dr. Berkeley's recommendation of surgery was reasonable based on the MRI findings, Dr. Purtzer concluded that it was "entirely appropriate" that claimant undergo the recommended surgical procedure. (Ex. 128). Dr. Purtzer emphasized that there was a "good correlation" between claimant's complaints, the diagnostic studies and the findings on clinical examination. (Ex. 128-3).

Dr. Rosenbaum continued to express his opposition to the proposed surgery both in a deposition and in a July 9, 1993 letter in which he responded to Dr. Purtzer's medical report. (Exs. 126A, 129A).

The Director issued his Proposed and Final Order regarding the medical services dispute on July 15, 1993. The Director concluded that the proposed surgery was appropriate. (Ex. 130-5). The Director's decision was based on claimant's clinical history, the demonstrable herniations evident on MRI scan, and Dr. Berkeley's and Dr. Purtzer's clinical findings of sensory loss and positive Spurling test, indicating nerve root irritation related to cervical disc disease and cervical spondylosis.

On August 2, 1993, the employer requested a hearing, contesting the Director's order. (Ex. 132). The hearing convened and closed on May 18, 1994. Reasoning that the Director's order could be modified only if it was not supported by "substantial evidence," see ORS 656.327(2), the Referee affirmed the order. The Referee noted that both Dr. Berkeley and Dr. Purtzer had found evidence of cervical radiculopathy, which supported the Director's finding that surgery was appropriate.

On review, the employer continues to assert that there is no "substantial evidence" to support the Director's order. It cites medical evidence from Dr. Rosenbaum generated subsequent to the Director's order as supporting its position. The employer also notes an August 19, 1993 "check-the-box" medical report from Dr. Purtzer, who agreed that he would not perform surgery without obtaining additional diagnostic studies. Dr. Purtzer also confirmed that: (1) he would not favor surgery based solely on a clinical examination plus an MRI; (2) he believed claimant's problem was at a different cervical level than Dr. Berkeley; and (3) the MRI study indicated that claimant's defect was "a little more" left-sided than right-sided, whereas claimant's symptoms were more right-sided. (Ex. 133). Dr. Purtzer also agreed, however, that cervical surgery would "to some extent" alleviate claimant's cervical condition. (Ex. 133).

As previously noted, the Referee affirmed the Director's order applying a "substantial evidence" standard of review. However, prior to the May 1994 hearing, the Court of Appeals had held that disputes regarding proposed medical treatment were within the exclusive jurisdiction of the Hearings Division and the Board. Jefferson v. Sam's Cafe, 123 Or App 464 (1993). Subsequent to the Referee's order, the Supreme Court also held that review of proposed medical treatment was within the exclusive jurisdiction of the Board, rather than the Director. Martin v. City of Albany, 320 Or 175 (1994). Inasmuch as this medical services dispute involves a question concerning the reasonableness and necessity of proposed surgery, original jurisdiction resided with the Hearings Division. Martin v. City of Albany, supra; Jefferson v. Sam's Cafe, supra. Therefore, the Director's order was invalid. Thus, this proposed surgery must be reviewed de novo, rather than pursuant to the substantial evidence standard under ORS 656.327(2).

Inasmuch as the record concerning the reasonableness and necessity of the proposed surgery is fully developed, we find that the case was not "improperly, incompletely, or otherwise insufficiently developed or heard by the referee." See ORS 656.295(5). We, accordingly, find it unnecessary to remand to the Referee for additional evidence taking. We now proceed with our de novo review.

Claimant is entitled to medical services for conditions resulting from the compensable injury "for such period as the nature of the injury or the process of recovery requires." ORS 656.245. Claimant carries the burden of proving by a preponderance of the evidence that the proposed surgery is reasonable and necessary. Helen J. Bohnenkamp, 46 Van Natta 1587, 1589 (1994).

We find that claimant has sustained his burden of proof. In reaching this conclusion, we rely on the medical opinion of the attending neurosurgeon, Dr. Berkeley, who has consistently opined that claimant requires surgery to alleviate his cervical condition. We generally give greater weight to the opinion of the attending physician absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reason not to rely on Dr. Berkeley's opinion that a cervical discectomy and fusion is appropriate treatment for claimant's cervical condition.

We note that Dr. Purtzer, the examining physician appointed by the Director, also agreed with Dr. Berkeley's recommendation. His examination confirmed that claimant has demonstrable cervical radiculopathy and that there is a correlation between claimant's symptoms, clinical findings and diagnostic studies. Although Dr. Purtzer, himself, would not operate without additional diagnostic studies, he never revoked his prior agreement with Dr. Berkeley's surgical recommendation. In fact, Dr. Purtzer agreed in his final report that the proposed surgery would alleviate "to some extent" claimant's cervical condition.

We find further support for our conclusion in the report of a consulting radiologist, Dr. Coit, who evaluated claimant's MRI scans. (Ex. 131A). Comparing prior MRI scans in 1987 and 1989 with claimant's most recent study on October 19, 1992, Dr. Coit confirmed that there was at least a slight increase in the degree of broad-based disc bulging at C5-6 and a definite progression in the extent of disc bulging and cord flattening at C6-7. Although Dr. Coit does not comment on the appropriateness of the proposed surgery, his report does document objective evidence of a progression of claimant's cervical condition which lends further support to Dr. Berkeley's recommendation.

Although Dr. Rosenbaum has repeatedly and forcefully advised against surgery, his lone opinion is insufficient to overcome the medical evidence from the attending physician, Dr. Berkeley (as supported by Dr. Purtzer). Thus, based on our de novo review, we conclude that a preponderance of the medical evidence supports the conclusion that the proposed surgery is both reasonable and necessary. We, therefore, set aside the employer's "de facto" denial of the proposed surgery.

Penalties and Attorney Fees

The Referee assessed a 25 percent penalty and a \$500 attorney fee "on the penalty" pursuant to ORS 656.382(1) because of the employer's allegedly unreasonable resistance to the payment of compensation. In reaching his conclusion that the employer unreasonably resisted payment of compensation, the Referee reasoned that the employer "did not come close" to meeting its burden of showing a lack of substantial evidence to support the Director's order. We disagree with the Referee's reasoning and conclusion.

First, we note that ORS 656.382(1) does not authorize a penalty for unreasonable resistance to the payment of compensation. Rather, the statute authorizes the assessment of an attorney fee only. Moreover, we disagree with the Referee's finding that the employer acted unreasonably for the purposes of ORS 656.382(1) in litigating the medical services issue at hearing.

Although we have found that the proposed surgery was reasonable and necessary after reviewing the record de novo, we conclude that the employer's litigation of the reasonableness and necessity of the proposed surgery was not unreasonable under that standard. Dr. Rosenbaum's medical reports and deposition provided the employer with a legitimate doubt concerning its liability for the proposed surgery. See Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Thus, we reverse the Referee's assessment of a penalty and attorney fee pursuant to ORS 656.382(1).

The Referee also assessed a \$750 penalty pursuant to ORS 656.382(3), reasoning that the employer's request for hearing concerning the Director's order could only have been for the purposes of "vexatious" delay. ORS 656.382(3) provides:

"If upon reaching a decision on a request for hearing initiated by an employer it is found by the referee that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, the Referee may order the employer to pay to the claimant such penalty not exceeding \$750 and not less than \$100 as may be reasonable in the circumstances."

At the time the employer requested its hearing on August 2, 1993, prevailing case law provided that proposed medical treatment was to be reviewed by the Director, where, as here, an employer "wished" Director review under ORS 656.327(1). See Keven S. Keller, 44 Van Natta 225 (1992). Under those circumstances, review of a Director's order in the Hearings Division was for "substantial evidence." See ORS 656.327(1)(b).

To begin, we find no evidence to support a conclusion that the employer's appeal of the Director's order constituted a "vexatious delay." No claims examiner or any other employer representative testified or submitted written evidence concerning the employer's intention in seeking a hearing from the Director's order. In light of such circumstances, we are unable to conclude that the employer's conduct represents a "vexatious delay."

We next turn to the question of whether the employer's hearing request was based on a reasonable ground. Both Dr. Berkeley and Dr. Purtzer opined that surgery was appropriate. (Exs. 118, 121, 127, 128). However, Dr. Rosenbaum disagreed both in his medical reports and in his deposition, which the Director apparently did not consider in drafting his Proposed and Final Order. Although Dr. Purtzer did not subsequently retract his opinion that surgery was reasonable and necessary, he did agree that he would perform more diagnostic studies prior to proceeding with surgery.

Considering the "pre" and "post" Director's order medical evidence from Dr. Rosenbaum, as well as Dr. Purtzer's "post-Director's" medical report, we find that the employer had reasonable grounds to request a hearing contesting the Director's medical treatment order, even under a "substantial evidence" standard of review. Cf. Westfall v. Rust International, 314 Or 553 (1992) (an appeal is "frivolous" within the meaning of ORS 656.390 if every argument on appeal is one that a reasonable lawyer would know is not well grounded in fact, or that a reasonable lawyer would know is not warranted either by existing law or by a reasonable argument for the extension, modification, or reversal of existing law). In other words, in light of the aforementioned reports (particularly Dr. Purtzer's "post-Director's" report supporting additional diagnostic studies), we are persuaded that the employer had a legitimate basis on which to contend that the Director's order (which found the surgery to be appropriate) was not supported by substantial evidence. We, thus, reverse the Referee's assessment of a penalty under ORS 656.382(3).

Claimant is entitled to an assessed attorney fee for prevailing on the "de facto" denial, medical services 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 concerning these issues is \$1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interests involved.

ORDER

The Referee's order dated June, 17, 1994 is affirmed in part, reversed in part and vacated in part. Those portions which assessed a penalty and attorney fee under ORS 656.382(1) and assessed a penalty under ORS 656.382(3) are reversed. That portion of the order which affirmed the Director's order is vacated. However, the employer's "de facto" denial of claimant's proposed surgery is set aside and the claim is remanded to the employer for processing. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an attorney fee of \$1,000, to be paid by the employer.

Board Member Gunn Dissenting in Part.

While I agree with most of the majority's opinion, I part company with its finding that the Referee erroneously assessed a penalty under ORS 656.382(3). Because I believe that our review of the Referee's penalty assessment under that statute is limited to abuse of discretion, I must respectfully dissent.

ORS 656.382(3) provides that "the Referee may order" the employer to pay a penalty not exceeding \$750 if "it is found by the Referee" that the employer initiated a hearing for the purpose of delay or other vexatious reason or without reasonable ground. By its terms, the statute gives a referee the sole discretion to award a penalty if he or she determines that the employer filed a hearing request for any of the reasons proscribed by the statute.

Inasmuch as the assessment of a penalty under ORS 656.382(3) is discretionary on the part of a referee, our review ought to be limited to abuse of discretion. It seems patently obvious from my

review of the record that, when the employer requested its hearing in August 1993, the Director's order was supported by "substantial evidence." This was the standard of review in effect when the employer requested its hearing. Keven S. Keller, 44 Van Natta 225 (1992). It, therefore, follows that the Referee in this case could reasonably conclude that the employer's request for hearing was for the purposes of "vexatious delay" of payment of medical benefits to which this Board has determined claimant is entitled. Accordingly, I would find that the Referee did not abuse his discretion in awarding a penalty under ORS 656.382(3) and would affirm that portion of the Referee's order.

April 25, 1995

Cite as 47 Van Natta 758 (1995)

In the Matter of the Compensation of
PHILIP ESTES, Claimant
WCB Case No. 93-15273
ORDER ON RECONSIDERATION
Nancy F.A. Chapman, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our April 5, 1995 order that awarded claimant's counsel a \$1,500 attorney fee award under ORS 656.386(1) for services in securing a "pre-hearing" rescission of a "de facto" denial of claimant's neck injury claim. Asserting that a significant amount of time was expended in obtaining adequate discovery from the insurer, claimant disagrees with our modification of the Referee's \$3,000 attorney fee award.

In addition to referring to the efforts expended by her counsel during the discovery procedures for a "frivolous" issue, claimant relies on copies of another carrier's claim ledger regarding payments made to the insurer's counsel's firm in another case. Based on that claim ledger, claimant suggests that this case be remanded for the introduction of a deposition from the insurer's counsel.

Since our review is limited to the record developed at hearing, we have previously reminded claimant's counsels of the need to provide documentation of their efforts, as well as an explanation concerning the application of the relevant factors set forth in OAR 438-15-010(4). See Sam L. Hoover, 44 Van Natta 458, on recon 44 Van Natta 517, on recon 44 Van Natta 718 (1992). Thus, to the extent that claimant refers to materials that were not presented to the Referee, we treat such references as a motion to remand for the taking of additional evidence. See ORS 656.295(5). To merit remand, it must be clearly shown that the proffered 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. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, no showing has been made that either the materials submitted or proposed to be obtained on remand by claimant were unobtainable with due diligence at the hearings level. In any event, even if such materials were obtained, it is unlikely that consideration of such matters would affect the outcome of this case. Consequently, remand for further development of this record is not warranted.

Finally, claimant advances several policy reasons justifying the need for his counsel to vigilantly represent his interests. We fully recognize that such services are vitally important to achieve the goals of the workers' compensation system. Consequently, claimant can be assured that such policy matters are reflected in any determination made regarding a reasonable attorney fee. This case was no exception.

In conclusion, after further consideration of the factors recited in OAR 438-15-010(4), (particularly those mentioned in our prior order), we continue to find that a reasonable attorney fee under ORS 656.386(1) for claimant's attorney's services concerning the "pre-hearing" rescission of the insurer's "de facto" denial is \$1,500.

Accordingly, we withdraw our April 5, 1995 order. On reconsideration, as supplemented herein, we republish our April 5, 1995 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
GENEVIEVE V. BROOKS-BISHOP, Claimant
WCB Case No. 94-05845
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Nichols' order that upheld the self-insured employer's denial of claimant's toxic exposure claim. On review, the issue is compensability.

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

On review, claimant alternatively argues that, even if the toxic exposure claim itself is not compensable, the diagnostic services provided for purposes of determining a causal relationship are compensable. We have previously rejected a similar argument.

Pursuant to ORS 656.245(1)(a), for every "compensable injury," a worker is entitled to "medical services for conditions resulting from the injury." The statute extends to payment of diagnostic services relating to noncompensable conditions if such procedures are performed to determine whether or not a causal relationship exists between the industrial injury and the noncompensable condition. See Brooks v. D & R Timber, 55 Or App 688, 691-92 (1982); Kenneth M. Simons, 41 Van Natta 378, 380 (1989). However, where it has been determined that claimant does not have a compensable injury or condition, claimant is not entitled to any medical services under ORS 656.245(1), including diagnostic services. See Nathan A. Stevens, 44 Van Natta 1742 (1992) (The claimant's dementia condition was not compensable and, therefore, because the diagnostic service provided in relation to that condition was not related to a compensable condition, the procedure itself was not compensable under ORS 656.245(1).)

Here, we conclude that, because we have affirmed the Referee's order which found that the toxic exposure was not compensable, any diagnostic procedures provided in relation to a toxic exposure are similarly not compensable.

ORDER

The Referee's order dated September 7, 1994 is affirmed.

In the Matter of the Compensation of
ELSIE M. CULP, Claimant
WCB Case No. 94-06146
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Mills' order that declined to award penalties and attorney fees for the SAIF Corporation's alleged "de facto" denial of claimant's bilateral flexor tenosynovitis condition. On review, the issues are scope of acceptance, attorney fees and penalties. We affirm.

FINDINGS OF FACT

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

In a May 26, 1994 note, Dr. Swanson, treating surgeon, stated that he had spoken with a SAIF claims adjuster, explaining that carpal tunnel syndrome (CTS) "always has a component of tenosynovitis and if you accept the fact that the patient has bilateral [CTS] and treat those appropriately, then you have de facto accepted the tenosynovitis condition as well." (Ex. 22).

Thereafter, Swanson agreed with a letter drafted by the claims adjuster, which summarized their conversation and stated that SAIF "had accepted bilateral [CTS] and, by our analysis, the tenosynovitis was included in the overall syndrome. I further indicated our position is: by accepting [CTS], we had accepted tenosynovitis. You stated it seemed like that to you too." (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that the Referee erred in concluding that SAIF had accepted claimant's bilateral flexor tenosynovitis. Rather, claimant asserts that, by accepting her CTS only, SAIF "de facto" denied the tenosynovitis, and should be found liable for attorney fees and penalties for unreasonable claim processing. We agree with the Referee's conclusion that neither penalties nor attorney fees are warranted, but offer the following analysis.

Claimant was diagnosed with bilateral CTS and flexor tenosynovitis. (Exs. 4, 7, 9, 10, 11B-1, -2). SAIF's Notice of Acceptance specified that it only accepted claimant's bilateral CTS. (Ex. 8). After claimant's counsel discovered that SAIF had not expressly accepted claimant's tenosynovitis, he requested that SAIF amend the Notice of Acceptance to include that condition. (Ex. 16). SAIF responded that, because tenosynovitis is a component of CTS, the former condition was encompassed by the acceptance. (Ex. 17). Claimant requested a hearing. Subsequently, Dr. Swanson, treating surgeon, expressed his view that CTS always involves a component of tenosynovitis, and his agreement with SAIF that acceptance of claimant's CTS operated as an acceptance of her tenosynovitis. (Exs. 22, 23).

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 issue is whether claimant's CTS included her tenosynovitis. On this record, we conclude that the answer is "yes." The only medical evidence on point is from Dr. Swanson. Claimant asserts that, because Dr. Swanson separately diagnosed CTS and tenosynovitis, it was incumbent on SAIF to accept or deny each of those conditions. We disagree, because we read Dr. Swanson's later reports to say that claimant's tenosynovitis is a component, or an element, of her CTS. In the absence of any contrary medical evidence, therefore, we conclude that SAIF's acceptance of the carpal tunnel syndrome included the tenosynovitis.¹

¹ Although the medical evidence establishes that claimant's tenosynovitis is a component of her CTS, there is no persuasive evidence that the tenosynovitis is merely a symptom of the CTS. Therefore, Georgia-Pacific v. Piwowar, 305 Or 494 (1988), which holds that acceptance of a symptom is acceptance of the cause of the symptom, is inapplicable.

This case is distinguishable from Craig E. Chamberlain, 47 Van Natta 226 (1995). There, we held that the carrier, who had accepted a claim for costochondritis, had "de facto" denied the claimant's pectoral muscle strain claim. In so holding, we relied on medical reports that separately diagnosed costochondritis and shoulder sprain and that concluded that the claimant's two diagnoses were separate and distinct. Id. at 227.

Here, although Dr. Swanson separately diagnosed CTS and tenosynovitis, his later, uncontroverted reports reveal that claimant's tenosynovitis was a component of the CTS; there is no persuasive evidence that the two diagnoses were separate and distinct. On that ground, we find Chamberlain distinguishable.

Accordingly, we conclude that SAIF did not "de facto" deny claimant's tenosynovitis. Therefore, we affirm the Referee's decision declining to grant claimant any relief related to an alleged "de facto" denial.

ORDER

The Referee's order dated September 2, 1994 is affirmed.

April 27, 1995

Cite as 47 Van Natta 761 (1995)

In the Matter of the Compensation of
GERALD D. DUREN, Claimant
 Own Motion No. 91-0640M
 OWN MOTION ORDER REVIEWING CARRIER CLOSURE
 Emmons, et al., Claimant Attorneys

Claimant requests review of the insurer's February 8, 1995 Notice of Closure which closed his claim with an award of temporary disability compensation from November 4, 1991 through January 30, 1995. The insurer declared claimant medically stationary as of January 30, 1995. Claimant contends that his claim was prematurely closed.

Claimant's compensable condition must be medically stationary in order for the insurer to properly close a claim which has been reopened under the Board's own motion authority for payment of temporary disability compensation. See OAR 438-12-055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). 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 February 8, 1995 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

We begin our analysis with a brief history of claimant's current claim. In April 1981, claimant sustained compensable right knee and low back injuries. His claim was last reopened under the Board's own motion jurisdiction in November 1991 for right knee surgery. By May 1993, claimant's knee condition was medically stationary. However, the claim remained open for lumbar surgery. Specifically, in June 1993, claimant underwent a right L5-S1 microdecompression and microdiscectomy performed by Dr. Berkeley, treating neurosurgeon.

On September 1, 1994, the insurer issued a Notice of Closure closing claimant's claim. By order dated October 26, 1994, the Board set aside that Notice of Closure as premature based on the opinion of Dr. Puziss, attending physician. Specifically, Dr. Puziss recanted his earlier opinion that claimant was medically stationary and opined that claimant's marked improvement as a result of treatment with a Raney Flexion Jacket indicated that lumbosacral fusion may be a worthwhile option.

By letter dated January 30, 1995, Dr. Puziss stated that treatment with the flexion jacket had become palliative, since claimant was not able to tolerate it that much. In addition, Dr. Puziss opined

that "[s]ince a spinal fusion appears not to be indicated at this time according to Dr. Waldrum, then as far as I can tell there is nothing to keep this patient from becoming medically stationary at this point." Based on this letter, the insurer issued its February 8, 1995 Notice of Closure and declared claimant medically stationary as of January 30, 1995.

By letter dated February 9, 1995, Dr. Puziss reported that he had spoken with claimant on that date and that:

"[claimant] continues to worsen over the last two months. His pains are increasingly severe. Since [claimant's] pains in the left leg have not decreased with rest, a new MRI scan is now indicated and probably a new neurosurgical consultation with [claimant's] neurosurgeon, Edward Berkeley, M.D.. His need for Vicodin continues to increase.

* * * *

"I would have to conclude at this time, that [claimant] is not medically stationary. If his claim was recently closed, then it should be reopened since it would be considered a premature claim closure based on the above information. He is not medically stationary because he continues to worsen and requires further diagnosis and possibly treatment."

The record indicates that Dr. Puziss last examined claimant on September 13, 1994, before declaring him medically stationary on January 30, 1995. (See September 13, 1994 letter from Dr. Puziss to the insurer). Dr. Puziss next examined claimant on February 24, 1995, at which time he affirmed his February 9, 1995 report that claimant continued to slowly worsen. (See February 24, 1995 letter from Dr. Puziss to the insurer).

We find that Dr. Puziss rescinded his January 30, 1995 opinion that claimant was medically stationary. At the time Dr. Puziss rendered that opinion, he had not examined claimant for several months. After consulting with claimant, Dr. Puziss found that claimant's low back condition had worsened over the past two months, which would place the start of the worsening before Dr. Puziss declared him medically stationary. Thus, claimant's condition had "worsened" before Dr. Puziss declared him medically stationary, and Puziss was unaware of that "worsening" at the time he gave his initial opinion regarding claimant's medically stationary status. Once Dr. Puziss became aware of claimant's actual condition, he recanted his earlier opinion. Dr. Puziss provides the only opinion regarding claimant's medically stationary status.

Furthermore, although a "worsening" prior to closure does not preclude a finding that a worker is medically stationary if no material improvement is reasonably expected from medical treatment or the passage of time, that is not the case here. ORS 656.005(17). The day after closure, after becoming aware of claimant's actual condition, Dr. Puziss indicated that further treatment was possible. In addition, this possibility was confirmed by Dr. Berkeley's subsequent recommendation for microdecompression right L4-5 and L5-S1. (See Dr. Berkeley's examination report dated March 29, 1995). Dr. Puziss concurred with that recommendation and opined that the recommended surgery would provide claimant "significant improvement." (See letter dated April 6, 1995 from Dr. Puziss to the insurer).

Moreover, although claimant's condition continued to worsen after claim closure, and we are precluded from considering post-closure changes, we are persuaded that claimant's worsened condition at the time of claim closure prompted Dr. Puziss to consider further treatment for improvement in claimant's condition. (See February 9, 1995 letter from Dr. Puziss to the insurer).

Thus, based on Dr. Puziss' opinion read as a whole, we find that claimant was not medically stationary when his claim was closed. Therefore, we set aside the insurer's February 2, 1995 Notice of Closure and direct it to resume payment of temporary disability compensation beginning February 1, 1995. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LEE J. JOHNSON, Claimant
WCB Case No. 93-04238
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Montgomery W. Cobb, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Referee Bethlahmy's order that upheld the insurer's denial of claimant's surgery/aggravation claim for his current right shoulder condition. On review, the issues are scope of acceptance and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with one exception. On page 7, the last sentence in the sixth full paragraph is changed to: "The post operative diagnosis was of rotator cuff tendonitis, impingement syndrome and acromioclavicular arthritis."

CONCLUSIONS OF LAW AND OPINION

The Referee rejected claimant's argument that his current shoulder complaints were part of his accepted claim. The Referee concluded that claimant's current shoulder complaints were not related to the compensable injury. Alternatively, the Referee concluded that even if claimant's current shoulder condition was part of his accepted claim, the January 1993 surgery was not reasonable and necessary treatment.

Relying on Georgia Pacific v. Piowowar, 305 Or 494 (1988), claimant argues that the "blanket" acceptance issued by the insurer in 1989 included both his neck and shoulder conditions. The insurer contends that, even where an acceptance is general in nature or is silent as to a specific condition, claimant must still prove that the current condition is causally related to the subject matter of the original acceptance. The insurer asserts that claimant has not proven the existence of his current condition or the causal relationship between the current condition and his original injury.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). For purposes of adjudicating a back-up denial, acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. SAIF v. Allen, 320 Or 192, 215 (1994); Johnson v. Spectra Physics, 303 Or 49 (1987). However, where a carrier accepts a symptom of a disease, it also accepts the disease causing that symptom. Georgia Pacific v. Piowowar, *supra*. When the acceptance does not identify the specific condition, we look to contemporaneous medical records to determine what condition was accepted. Timothy Hasty, 46 Van Natta 1209 (1994); Cecilia A. Wahl, 44 Van Natta 2505 (1992).

Here, the insurer did not accept a specific condition. Claimant was injured at work on May 1, 1989 and the claim was accepted sometime in August 1989¹ on the 801 claim form. (Ex. 3A). Claimant described the body part affected as "right" and reported on the form that he had previously suffered an injury to that body part. Claimant described that accident as occurring when he was "beating back off-beavertail slipped off and caused right arm to be jammed." (*Id.*) The insurer also issued a form 1502 that indicated that the claim was accepted as disabling. (Ex. 3Q). The form 1502 was not dated, although it noted that temporary disability was paid from August 17, 1989 to August 30, 1989. Since the insurer did not specify it was accepting a particular condition, we turn to contemporaneous medical records to determine what condition was accepted.

At Dr. Mandiberg's examination on June 27, 1989, claimant stated that since the work injury he had had discomfort in the wrist and arm and up into the neck and right trapezius muscle. (Ex. 3B). Dr. Mandiberg reported that claimant had a classic tennis elbow and he injected claimant's first dorsal compartment and his elbow and recommended physical therapy for his neck. The July 6, 1989 report from the physical therapy office described claimant's neck and shoulder pain and noted that the right acromion process was more prominent on the right and moderate edema was present over the anterior aspect of the right shoulder. (Ex. 3C). On July 10, 1989, Dr. Mandiberg reported that the major

¹ The date of acceptance on the 801 form is not clear. (Ex. 3A).

discomfort was coming from claimant's right lower trapezius muscle. (Ex. 3D). Dr. Mandiberg reported one week later that claimant's elbow and wrist were doing quite well, but he still had a lot of discomfort in the trapezius area. (Ex. 3E).

Dr. Mandiberg's July 24, 1989 report listed claimant's chief complaint as "right shoulder" and reported that claimant continued to have neck pain. (Ex. 3H). Claimant still complained of neck and shoulder pain on August 8, 1989 and Dr. Mandiberg noted that "he almost seems like he has a rotator cuff tenderness." (Ex. 3J). On August 10, 1989, Dr. Mandiberg injected claimant's shoulder and questioned "whether the shoulder pain is causing his neck pain, or the neck pain is secondary to something central to his neck." (Ex. 3L). One week later, Dr. Mandiberg reported that claimant had significant improvement after the shoulder injection. (Ex. 3N). Dr. Mandiberg said that claimant had three separate areas of tenosynovitis - in his elbow, wrist and shoulder. On August 31, 1989, Dr. Mandiberg said that claimant continued to have a lot of discomfort in the posterior shoulder area and in the trapezius muscle. (Ex. 3R).

The foregoing medical records indicate that claimant had been diagnosed and treated for right shoulder symptoms at the time the insurer accepted the claim. We are persuaded that the insurer accepted all of the conditions that caused claimant's shoulder symptoms and need for treatment following his 1989 compensable right arm injury. Based on our review, we find that claimant's current right shoulder condition is the same condition he had at the time of the insurer's 1989 acceptance. See Timothy Hasty, supra.

Having found that claimant's current right shoulder problems are the same as his prior accepted condition, we conclude that the portion of the insurer's denial which denied those conditions constitutes a "back-up" denial of compensability. Insofar as the insurer's April 6, 1993 denial is an attempt to back-up deny the current right shoulder conditions, it is invalid because it issued more than two years after claim acceptance and there is no allegation that the acceptance was induced by fraud, misrepresentation or other illegality. See ORS 656.262(6); Michael T. Crouse, 45 Van Natta 1057 (1993); Anthony G. Ford, 44 Van Natta 240 (1992). Consequently, we conclude that the portion of the insurer's "back-up" denial that denied compensability of claimant's current right shoulder condition is invalid and we set aside that portion of the denial.

The Referee concluded that, in any event, claimant's January 1993 right shoulder surgery was not reasonable and necessary. The Referee relied on medical reports prepared after surgery in reaching her conclusion. Claimant argues that the issue is not whether the surgery proved to be beneficial. Rather, the issue is whether the evidence indicates that the surgery was reasonable and necessary.

On July 3, 1991, Dr. Takacs said that claimant's MRI showed an osteophyte extending from the AC joint impinging on the rotator cuff. (Ex. 77). If there were no previous findings of degenerative joint disease, Dr. Takacs recommended approval of the surgery recommended by Dr. Harris. Dr. Takacs was concerned that claimant's surgical outcome might not be optimal because of severe chronic pain syndrome, but she said that she would work with him on that aspect. According to an August 6, 1991 report from Dr. Takacs, the insurer approved shoulder surgery, although claimant declined to proceed with shoulder surgery at that time. (Ex. 77A).

After claimant moved to Arkansas, he had further conservative treatment for his shoulder symptoms. On December 21, 1992, Dr. Bowen reported that claimant had primary shoulder pain from the rotator cuff injury and the AC joint. (Ex. 99). Dr. Bowen injected the subacromial space with steroid and he recommended a diagnostic arthroscopy. Dr. Bowen subsequently reported that neither the injection nor therapy had helped to any great degree. (Ex. 105). Dr. Bowen concluded that the only option left was to arthroscopically assess claimant's shoulder to assess the rotator cuff.

Here, we find no persuasive reasons not to rely on Dr. Bowen's opinion. In light of the insurer's earlier approval of claimant's shoulder surgery and Dr. Bowen's reports, we conclude that claimant's shoulder surgery was reasonable and necessary treatment for his shoulder condition.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial of claimant's right shoulder claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's

services at hearing and on Board review concerning the compensability denial of the shoulder condition and the shoulder surgery 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 the hearing record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the likelihood that claimant's counsel will go uncompensated.

ORDER

The Referee's order dated July 28, 1994 is reversed in part and affirmed in part. The insurer's denial of claimant's right shoulder surgery claim is set aside and the claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded an assessed attorney fee of \$4,000 for prevailing over the insurer's denial, to be paid by the insurer. The remainder of the Referee's order is affirmed.

Board Member Haynes specially concurring.

This case illustrates the problems that can result when a carrier does not clearly specify the conditions it is accepting. Since the insurer's acceptance did not identify the specific condition it was accepting, we must review the contemporaneous medical records to determine what condition was accepted. On the basis of the medical records, I feel compelled to conclude that the insurer accepted all of the conditions that caused claimant's shoulder symptoms and need for treatment following his 1989 compensable injury. See *Georgia Pacific v. Piwovar*, 305 Or 494 (1988).

One problem in this case is that the insurer did not have a specific diagnosis at the time it accepted the claim. Furthermore, shortly after the insurer accepted the claim, the medical reports began to focus on claimant's cervical condition rather than the shoulder condition. I recognize that an insurer has a statutory duty to timely accept or deny a claim. See ORS 656.262(6). Although the insurer could not disregard that duty, its potential liability might have reduced if it had delayed acceptance until a definitive diagnosis was offered or amended its earlier diagnosis to reflect the condition directly caused by the industrial episode.

April 27, 1995

Cite as 47 Van Natta 765 (1995)

In the Matter of the Compensation of
SHIRLETTE M. KENWORTHY, Claimant
WCB Case No. 93-11274
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian and Hall.

The insurer requests review of Referee Hazelett's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) assessed penalties for an allegedly unreasonable aggravation denial. On review, the issues are aggravation and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and supplementation. We do not adopt the last sentence of the ultimate findings of fact.

At the time the insurer issued its aggravation denial, it was aware that, when bending over while on a June 19, 1993 camping trip, claimant felt a pop in her low back which resulted in pain and numbness across her lower back and into her right leg and foot. (Exs. 14, 18). These symptoms sent claimant to the emergency room. (Ex. 14). In an August 17, 1993 chart note, Dr. Alanko, treating physician, noted that it was questionable whether claimant's injury was related to the previous work injury two years earlier, although he stated that, if claimant ended up having a herniated disc as the cause of her L4 problem, the prior work injury was the only injury severe enough to "pop out" a disc. (Ex. 16). Subsequent to the denial, Dr. Alanko opined that the 1993 camping trip incident, rather than the 1991 compensable injury, was the cause of claimant's current condition, a disc injury. (Exs. 19A, 20).

CONCLUSIONS OF LAW AND OPINIONAggravation

We adopt the Referee's reasoning and conclusions regarding the compensability of the aggravation claim.

Penalties

The Referee found that the insurer's aggravation denial was unreasonable and assessed penalties on that basis. We disagree.

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the employer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Here, at the time of the denial, the insurer had an indication that claimant may have hurt herself during a July 1993 camping trip. (Ex. 14). The camping incident caused symptoms sufficiently severe to send claimant to the emergency room. Id. In addition, prior to the denial, Dr. Alanko questioned whether claimant's current low back condition was related to the 1991 compensable injury, although he opined that, if claimant had a herniated disc, the 1991 injury was the only previous injury severe enough to "pop out" a disc. (Ex. 16).

We find that the insurer's knowledge of the camping incident, the resulting emergency room treatment, and Dr. Alanko's questioning of the relationship between claimant's current low back condition and the 1991 compensable injury gave the insurer legitimate doubt regarding its liability for claimant's aggravation claim when it issued its denial. Furthermore, subsequent new medical evidence did not destroy the insurer's legitimate doubt that it was responsible for claimant's current low back condition. Georgia-Pacific Corp v. Arms, 106 Or App 343 (1991); Brown v. Argonaut Insurance Company, supra, 93 Or App at 592. In this regard, although subsequent treating physicians and independent medical examiners opined that claimant's current low back condition was caused in major part by the 1991 work injury, Dr. Alanko opined that the 1993 camping incident was the major contributing cause of claimant's condition. (Exs. 19A, 20). Based on Dr. Alanko's subsequent opinions, we find that the insurer continued to have legitimate doubt as to the compensability of claimant's aggravation claim. Therefore, while we find that claimant has established a compensable aggravation claim, we conclude that the insurer's denial was not unreasonable. Accordingly, we reverse the penalty assessed by the Referee.

Attorney Fee

Claimant is entitled to an assessed attorney fee for her counsel's efforts on review regarding the aggravation issue. ORS 656.382(2). After considering all the factors in OAR 438-15-010(4), we find a reasonable assessed attorney fee for claimant's counsel's services on review concerning the aggravation issue is \$1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 19, 1994 is affirmed in part and reversed in part. That portion of the order that awarded a penalty for an unreasonable denial is reversed. The remainder of the order is affirmed. For services on review concerning the aggravation issue, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the insurer.

Board Member Hall dissenting.

I agree with the majority that claimant has established a compensable aggravation claim. However, I respectfully dissent from that portion of the majority's opinion that reversed the Referee's assessment of a penalty for the insurer's unreasonable denial.

I would recognize that the insurer had a legitimate doubt as to its liability for the aggravation claim at the time its denial was issued. This doubt was based on the indication in the Emergency Room notes that claimant may have injured herself during a camping trip. In addition, Dr. Alanko, treating physician, questioned whether claimant's current low back condition was related to the 1991 compensable injury, although noting that, if claimant had a herniated disc, the 1991 injury was the only prior injury severe enough to cause it.

However, an insurer's reasonable denial becomes unreasonable if the insurer continues that denial in light of new medical evidence that destroys any legitimate doubt about its liability. Brown v. Argonaut Insurance Company, 93 Or App 588, 592 (1988). That is the case here.

Following the insurer's denial, claimant's subsequent treating physicians and the physicians who examined claimant on behalf of the insurer all attributed claimant's current low back condition to the 1991 work injury. (Exs. 19, 20A, 20B, 20C, 21, 24, 23, 25). In addition, claimant was determined to have a herniated disc, the precise condition that Dr. Alanko had earlier opined that only the 1991 work injury was severe enough to cause.

Given this overwhelming evidence that the 1991 work injury was responsible for claimant's current condition, including evidence from all of the physicians that the insurer itself had selected, I conclude that the insurer's legitimate doubt regarding its liability was destroyed. Furthermore, Dr. Alanko's unexplained change of opinion that the camping trip caused claimant's current low back condition does not change this conclusion. The very fact that Dr. Alanko's later opinion is an unexplained change of opinion that is diametrically opposed to his earlier opinion that only the 1991 work injury was severe enough to cause a herniated disc makes it unpersuasive. Such an opinion cannot be the basis for legitimate doubt.

For these reasons, I would find that the insurer's continued denial was unreasonable. Accordingly, I would affirm the Referee's penalty assessment.

April 27, 1995

Cite as 47 Van Natta 767 (1995)

In the Matter of the Compensation of
KAREN L. NELSON, Claimant
WCB Case No. 94-01653
ORDER OF DISMISSAL
Scheminske & Lyons, Defense Attorneys

Claimant, pro se, has requested Board review of Referee Peterson's February 2, 1995 order. We have reviewed this request to determine if we have jurisdiction. Because the record does not establish that the other parties timely received notice of claimant's request, we dismiss.

FINDINGS OF FACT

The Referee's Opinion and Order issued February 2, 1995. Parties to that order were claimant, her employer, and its insured. The order contained a statement explaining the parties' rights of appeal, including a notice that copies of any request for Board review must be mailed to the other parties within the 30-day appeal period.

On March 1, 1995, claimant mailed, by certified mail, a letter to the Board, which listed the WCB Case number contained in the Referee's February 2, 1995 order. In the letter, claimant stated that she was "appealing this denial of compensation." Claimant's letter did not indicate that copies had been provided to the other parties.

The Board received claimant's letter on March 7, 1995. The letter was processed as a request for a new hearing. (WCB Case No. 95-02819). On March 17, 1995, hearing notices were mailed to all parties. On April 11, 1995, finding that claimant's letter was actually a request for Board review of the Referee's February 2, 1995 order, another referee dismissed the hearing request in WCB Case No. 95-02819.

On April 14, 1995, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review of the Referee's February 2, 1995 order.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.298(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance v. King, 63 Or App 847 (1983). All parties to the referee's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. Kelsey v. Drushella-Klohk NCE, 128 Or App 53, 57 (1994); Mosley v. Sacred Heart Hospital, *supra*.

Here, the 30th day after the Referee's February 2, 1995 order was March 4, 1995, a Saturday. Therefore, the last day in which to timely file a request for review was Monday, March 6, 1995. Anita L. Clifton, 43 Van Natta 1921 (1991). Assuming that claimant's letter constituted a request for Board review, the request was timely filed because it was mailed to the Board by certified mail on March 1, 1995. See OAR 438-05-046(1)(b).

However, the record fails to establish that the other parties to the proceeding before the Referee were either provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, the record indicates that the employer and its insurer's first notice occurred when they received a copy of the Board's April 14, 1995 letter acknowledging claimant's request for Board review.¹

Under such circumstances, we conclude that notice of claimant's request was not provided to the other parties within 30 days of the Referee's February 2, 1995 order.² Consequently, we lack jurisdiction to review the Referee's order. See ORS 656.289(3); 656.295(2).

We are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the Referee's order. Moreover, we are not free to relax a jurisdictional requirement. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

¹ It could be argued that the Board's March 17, 1995 notice of hearing provided actual notice to the other parties of claimant's appeal of the Referee's February 2, 1995 order. We need not resolve that question, because, even if such a notice constituted actual notice of claimant's request for Board review, the notice was not provided within 30 days of the Referee's order. Therefore, such a notice would likewise be untimely.

² In the event that claimant can establish that she provided notice of her request for Board review to the employer, its insurer, or their attorneys within 30 days of the Referee's February 2, 1995 order, she may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Since our authority to reconsider this order expires within 30 days from the date of this order, claimant must file her written submission as soon as possible.

In the Matter of the Compensation of
VIRGINIA S. PERRY, Claimant
WCB Case No. 94-05063
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The insurer requests review of Referee Hazelett's order that affirmed an Order on Reconsideration that awarded 20 percent (64 degrees) unscheduled permanent disability for a low back injury, 21 percent (31.5 degrees) scheduled permanent disability for loss of use or function of the left leg (hip), and 20 percent (30 degrees) scheduled permanent disability for loss of use or function of the right leg (hip). On review, the issues are extent of unscheduled and scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and supplementation. We do not adopt the first sentence of the Referee's ultimate findings of fact.

At the time of the August 17, 1993 Determination Order, claimant had returned to her at-injury job of driving a forklift. (Exs. 10, 11, 12-2, Tr. 3). At hearing, claimant conceded that, although there were "some minor modifications" in the way she performed the forklift driving job, she "returned back to substantially her regular work activities both pre-injury and post injury." (Tr. 3).

Dr. Martens, the medical arbiter, opined that claimant "can continue working driving the Hyster [claimant's regular work]." (Ex. 19-3). He also found claimant capable of performing medium work, with lifting less than 50 pounds, and with no limitations on sitting, standing, or walking. He opined that these restrictions are not due to claimant's work injury. Id.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

The Referee affirmed the April 15, 1994 Order on Reconsideration award of 20 percent unscheduled permanent disability. We modify.

The parties have stipulated to the values for age (1), formal education (1), skills (3), and impairment (14). (Tr. 9-10). In addition, the Referee determined that claimant is entitled to a training value of 1. The insurer does not dispute this determination on review. Therefore, the only remaining dispute between the parties concerning the unscheduled award is the correct value for the adaptability factor.

In applying the standards for rating permanent disability, the Referee applied the temporary rules set forth in WCD Admin. Order 93-052. The insurer contends that those rules should not apply in rating claimant's permanent disability. In support of its contention, the insurer argues that the rules in effect at the date of the reconsideration order (WCD Admin Order 93-056) should apply to this claim. In addition, the insurer argues that the Director exceeded his discretion in making WCD Admin. Order 93-052 applicable to all ratings of permanent disability made on or after June 17, 1993, regardless of whether the injury occurred before or after the 1990 amendments to ORS 656.214(5).

We need not address the insurer's arguments because, for the reasons discussed below, we find that the temporary rules set forth in WCD Admin. Order 93-052 do not apply to claimant's claim. Michelle Cadigan, 46 Van Natta 307 (1994)¹; Hubert W. Johnson, 46 Van Natta 2404 (1994); Sarah E. Eckhart, 46 Van Natta 2366 (1994).

¹ Board Member Hall directs the parties to his dissenting opinion in Michelle Cadigan, *supra*.

WCD Admin. Order 93-052 expired on December 14, 1993, months before the July 1994 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, *supra*. 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 her claim was closed by Determination Order on August 17, 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 or had returned to his or her regular work. Former OAR 436-35-310(2). "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 determine whether claimant was released to, or returned to, her regular work at the time of determination.

At the time of the August 17, 1993 Determination Order, claimant had returned to her at-injury job of driving a forklift. (Exs. 10, 11, 12-2, Tr. 3). In addition, claimant conceded at hearing that, although there were "some minor modifications" in the way she performed the forklift driving job, she "returned back to substantially her regular work activities both pre-injury and post injury." (Tr. 3).

Under these circumstances, we conclude that at the time of determination claimant had returned to her regular job. Former OAR 436-35-270(3)(c). Therefore, claimant is entitled to a value of zero for the adaptability factor. Former OAR 436-35-310(2).

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 436-35-280(7).

Applying these rules to the instant case, when the total value for claimant's age and education (6) is multiplied by the adaptability value (0), the total is 0. When this value is added to the value for impairment (14), the result is 14. Therefore, claimant's unscheduled permanent disability under the standards is 14 percent. Consequently, the Order on Reconsideration award of 20 percent unscheduled permanent disability is reduced to 14 percent.

Scheduled Permanent Disability

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

Attorney Fees

The insurer requested a hearing seeking reduction of the awards of scheduled and unscheduled permanent disability made by the Order on Reconsideration. Affirming the Order on Reconsideration awards, the Referee granted a \$1,400 insurer-paid attorney fee under ORS 656.382(2). On review of the insurer's appeal, we have determined that claimant's award of unscheduled permanent disability shall be reduced to 14 percent. However, we have also affirmed the awards of scheduled permanent disability.

Inasmuch as claimant's conditions have been considered separately for purposes of rating permanent disability and since the insurer has presented separate and distinct arguments regarding each condition which claimant has been required to defend, claimant is entitled to an attorney fee award for her counsel's services regarding the awards for the specific conditions which are not reduced by the insurer's appeal. Debra L. Cooksey, 44 Van Natta 2197 (1992). Consequently, pursuant to ORS 656.382(2) and Cooksey, claimant is entitled to an assessed attorney fee for her counsel's services at hearing concerning her scheduled permanent disability awards and for services on review concerning the defense of those awards. We note that the Referee's assessed attorney fee award included a fee for services at hearing relating to the extent of unscheduled permanent disability issue. Because claimant did not prevail on that issue, the Referee's assessed attorney fee award shall be reduced accordingly.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services regarding the scheduled disability award at hearing and on Board review regarding the scheduled permanent disability issues is \$2,000. This fee is in lieu of the Referee's \$1,400 attorney fee award. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 8, 1994 is modified in part and affirmed in part. Claimant's 20 percent (64 degrees) unscheduled permanent disability award, as granted by the Order on Reconsideration and the Referee's order, is reduced to 14 percent (44.8 degrees) unscheduled permanent disability. In lieu of the Referee's \$1,400 assessed attorney fee award, claimant's attorney is awarded an assessed attorney fee of \$2,000 for services rendered at hearing and on review concerning the extent of scheduled permanent disability issues, to be paid by the insurer. The remainder of the order is affirmed.

April 27, 1995

Cite as 47 Van Natta 771 (1995)

In the Matter of the Compensation of
MARLEEN PITSINGER, Claimant
WCB Case No. 94-06712
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Peter C. Davis (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Lipton's order that modified the Director's order determining that claimant was not eligible for vocational assistance. On review, the issue is vocational assistance.

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

We briefly recap the relevant facts. Claimant, a dance instructor, filed a claim on June 18, 1993 for an "ongoing condition" of her back, legs, feet and toes. (Ex. 2). At that time, she was employed part-time and earned \$11.50 per hour. Claimant was advised not to dance because of her chronic lumbar condition. SAIF accepted claimant's lumbar strain condition on November 22, 1993 as part of the parties' stipulation. (Ex. 9). On December 14, 1993, claimant was examined for her foot condition by Drs. Bald and Rothstein. They concluded that claimant could not return to her job as a dance instructor because of her foot condition. (Ex. 9A).

On February 15, 1994, SAIF declared claimant ineligible for vocational assistance because she could obtain suitable employment within her physical capacities and skills. (Ex. 14). A Director's Review and Order issued on May 19, 1994, affirming the determination that claimant was not eligible for vocational assistance because she had no substantial handicap to employment. (Ex. 20). Claimant's weekly wage was calculated to be \$157.90, which was the wage used to calculate her temporary total disability benefits. The Director determined that, for the purpose of determining eligibility for vocational assistance, a suitable wage for claimant was 80 percent of \$157.90 per week, or \$4.75 per hour working 27 hours per week. (*Id.*).

Claimant requested a hearing. The Referee found that the Director had relied on former OAR 436-120-025(2) (WCD Admin. Order 11-1987),¹ which grants the Director the discretion to develop a

¹ We note that the Director has since amended the vocational assistance rules. WCD Admin. Order No. 058-1994. The new rules govern disputes under the jurisdiction of the Director on or after January 1, 1995. OAR 436-120-003(2). The Director's decisions under OAR 436-120-008(1) regarding eligibility are based on the rules in effect on the date the insurer issued the notice. *Id.* Here, since SAIF's notice was issued on February 15, 1994, effective January 19, 1994, the former rules apply. We do not address the validity of the new rules.

formula to calculate a suitable wage for situations not covered in former OAR 436-120-025(1). The Referee concluded that the Director's exercise of discretion in implementing former OAR 436-120-025(2) violated ORS 656.340(6)(b)(B). The Referee reasoned that the Director's calculation gave no value to education and experience and focused only on earnings. The Referee noted that claimant did not work 27 hours per week; rather, she worked about half those hours to achieve her average weekly wage.

SAIF argues that the Referee erred in concluding that claimant's "hourly wage" is the wage to be used for purposes of determining suitable employment. SAIF asserts that the Director's policy of using the worker's average weekly wage is within the Director's discretion. We disagree.

Based on the record developed before the Referee, we may modify the Director's vocational assistance order only if it: (1) violates a statute or rule; (2) exceeds the agency's statutory authority; (3) was made upon unlawful procedure; or (4) constitutes an abuse of discretion. ORS 656.283(2); Colclasure v. Wash. Co. School Dist. No. 48-J, 317 Or 526 (1992).

A worker is eligible for vocational assistance if the "worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment." ORS 656.340(6)(a). "Suitable employment" is defined, in part, as "[e]mployment 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)(iii).

Mr. Gammon, a vocational consultant who prepared the Director's order, testified that the calculation of claimant's wage at injury was determined by establishing the wage used to calculate her time loss benefits. (Tr. 38). In other words, claimant's wage was determined by using the weekly wage figure used to calculate her temporary disability benefits. (Ex. 3A). Mr. Gammon used the "time loss wage basis" for claimant because her employment situation did not conform to any of the conditions in former OAR 436-120-025(1). Instead, he relied on former OAR 436-120-025(2), which allows the Director to prescribe additional standards. (Tr. 39). Mr. Gammon said that he uses the average weekly wage for people who work more than 40 hours per week² and less than 40 hours per week, if they are not seasonal or temporary employees. (Id.).

The Referee concluded that the Director's exercise of discretion in implementing former OAR 436-120-025(2) violated ORS 656.340(6)(b)(B). SAIF argues that in former OAR 436-120-025(2), the Director "codified" its authority to engage in "case by case rulemaking." According to SAIF, the Board's holding in Keith D. Kilbourne, 46 Van Natta 1837, on recon 46 Van Natta 1908 (1994), was limited to former OAR 436-120-025(1)(b) and did not apply to former OAR 436-120-025(2). We disagree.

In Keith D. Kilbourne, supra, we found that the Director had created a distinction between determining eligibility for vocational assistance, which was controlled by former OAR 436-120-005(6)(a)(A), and providing vocational assistance, which was addressed by former OAR 436-120-005(6)(a)(B). In Kilbourne, we found that an initial determination of eligibility was involved, and therefore, former OAR 436-120-005(6)(a)(A) applied. Id. at 1839. Furthermore, we found that, because former OAR 436-120-005(6)(a)(B) was the only rule that provided for application of former OAR 436-120-025, that rule was relevant only for purposes of providing vocational assistance.

Although in Kilbourne we decided that the Director erred in applying former OAR 436-120-025(1)(b) to calculate claimant's base wage, the same analysis applies here, where the Director applied former OAR 436-120-025(2). Since this case concerns claimant's initial eligibility for vocational assistance, we conclude that application of former OAR 436-120-025(2) was a violation of the Director's rules and the Director's decision therefore may be modified. See ORS 656.283(2)(a); Thomas R. Jarrell, 47 Van Natta 329 (1995); Keith D. Kilbourne, supra.

² In David M. Morris, 46 Van Natta 2316 (1994), the issue was whether the claimant's regular overtime should be added to his base hourly rate for purposes of determining the claimant's suitable employment. We found that the claimant had established that the overtime was both "regular" and "considerable." We concluded that, although there were no specific vocational rules that 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 the calculation.

SAIF contends that the term "wage" in ORS 656.340(6)(b)(B)(iii) is ambiguous. SAIF argues that the Director's policy of using the worker's average weekly wage in cases where the work is part-time or where no other rule applies is within the Director's discretion and does not violate any statute or rule.

On the other hand, claimant argues that ORS 656.340(6)(b)(B)(iii) requires that wages are to be determined by how they were currently being paid, *i.e.*, if the worker is paid by the hour, the hourly wage is used; if the worker is paid on the basis of a monthly salary, the monthly wage is used. Claimant contends that since her base wage is \$11.50 per hour, under ORS 656.340(6)(b)(B)(iii), her suitable wage should be determined by multiplying \$11.50 by 80 percent. Alternatively, claimant asserts that even if the term "wage" requires agency interpretation, the Director's decision violated the terms and spirit of the statute.

In interpreting a statute, the task is to determine the intent of the legislature. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The starting point is with the text and the context of the statute. Id. The words of a statute are to be given their common, ordinary meaning unless there is a clear indication that some other meaning was intended. Welliver Welding Works v. Farnen, 133 Or App 203, 208 (1995).

ORS 656.340(6)(b)(B)(iii) provides that "suitable employment" is "[e]mployment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment."³ (Emphasis added). Thus, ORS 656.340(6)(b)(B)(iii) defines the worker's wage in terms of how it is currently being paid. The parties do not dispute that claimant's wage at the time of her injury was \$11.50 per hour. Claimant's "regular employment" at the time of the injury was part-time employment, which was paid on an hourly basis. Under these circumstances, we find that claimant's "suitable employment" should be determined by multiplying \$11.50 per hour by 80 percent. Because the statutory language plainly reveals the legislature's intent in enacting ORS 656.340(6)(b)(B)(iii), we do not resort to the context or history of the statute. Furthermore, because the language in question is, on its face, unambiguous, we need not, and do not, resort to legislative history. See PGE v. Bureau of Labor and Industries, *supra*.

There is no basis in the text or context of ORS 656.340(6)(b)(B)(iii) to support the Director's application of the worker's "average weekly wage" for determining claimant's vocational eligibility. ORS 656.211, which defines "average weekly wage," provides, in part: "As used in ORS 656.210(1), 'average weekly wage' means the average weekly wage of workers in covered employment in Oregon." (Emphasis added). The legislature limited the application of "average weekly wage" to the calculation of temporary total disability in ORS 656.210. If the legislature had intended to use the "average weekly wage" for determining eligibility for vocational assistance, it would have said so. Instead, eligibility for vocational assistance is determined, in part, by whether claimant will be able to return to employment that produces a "wage within 20 percent of that currently being paid." ORS 656.340(6)(b)(B)(iii).

The Director's application of claimant's "average weekly wage" gives no consideration to the difference between the goal of vocational assistance and the goal of temporary disability benefits. The calculation of temporary total disability benefits is based on the replacement of wages lost as a result of a compensable injury or disease. See ORS 656.210(1); Cutright v. Weyerhaeuser Co., 299 Or 290, 298 (1985). On the other hand, vocational assistance aims to ameliorate lost earning capacity by retraining. Tee v. Albertson's, Inc., 314 Or 633, 641 (1992). The statutory objectives of vocational assistance are "to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of the injury." ORS 656.340(5); see also former OAR 436-120-004(1).

³ Former OAR 436-120-005(6)(b) defined "regular employment" as "employment of the kind the worker held at the time of the injury or the claim for aggravation * * * or the worker's customary employment." "Customary employment" was defined as the worker's regular employment when it is other than the job at injury and is the primary means by which the worker earns a livelihood. Id. In Welliver Welding Works v. Farnen, *supra*, the court concluded that eligibility for vocational assistance is based on a worker's wage at the time of the injury, not the time of the aggravation. The court held that former OAR 436-120-005(6)(b) conflicts with ORS 656.340(6) and is therefore invalid.

Claimant has approximately 40 years of experience in ballet, including 30 years of teaching, and, as a result of her injury, can no longer dance or teach dancing. Before claimant's compensable injury, she earned \$11.50 per hour working part-time. The effect of the Director's order is to return claimant to employment at a wage substantially less than her wage at the time of the injury, which is not even close to her "regular employment."⁴ The Director's policy in this case is inconsistent with the legislature's expressed purpose of vocational assistance.

Even if we agree with SAIF that the term "wages" in ORS 656.340(6)(b)(B)(iii) is ambiguous, we would conclude that the Director was not statutorily authorized to apply the "average weekly wage" to ORS 656.340(6)(b)(B)(iii). The "general definition" section of the Workers' Compensation Law includes a definition of "average weekly wage," ORS 656.005(1), and "wages," ORS 656.005(27). However, in ORS 656.340(6)(b)(B)(iii), the legislature used the term "wages" rather than "average weekly wage." ORS 656.005(27) defines "wages," in part, as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident." Here, the money rate at which claimant's services were rendered at the time of the injury was \$11.50 per hour, not the figure of \$4.75 per hour determined by the Director. Thus, even if we assume that ORS 656.340(6)(b)(B)(iii) is ambiguous, the application of the general definition of "wages" in ORS 656.005(27) would lead us to the same result.⁵

SAIF argues that even if claimant's "suitable wage" is 80 percent of \$11.50 per hour, claimant is still not eligible for vocational assistance because she is capable of performing work paying a wage within 20 percent of that currently being paid for her regular employment. At hearing, claimant stated that she was not prepared to provide vocational testimony on that issue. Claimant's hearing request was to decide only the legal issue of claimant's wage at injury. Claimant asked the Referee to decide only that issue and, if necessary, to allow the case to go back to the Director. SAIF did not object to claimant's request. (Tr. 7-8). Under such circumstances, it would have been inappropriate for the Referee to proceed to the "eligibility" question. Likewise, it is inappropriate for us to decide that question and we decline to do so. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

ORDER

The Referee's order dated October 4, 1994 is affirmed.

⁴ We note that former OAR 436-120-005(6)(a)(B) provided 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. In Lee R. Jones, 46 Van Natta 2179 (1994), we held that former OAR 436-120-005(6)(a)(B) impermissibly expanded on OAR 656.340, the authorizing statute.

⁵ For purposes of this analysis, we find that the use of the general definition of "wages" in ORS 656.005(27) is appropriate and its use does not conflict with the statute's structure or purpose. See SAIF v. Allen, 320 Or 192, 203 (1994); Astleford v. SAIF, 319 Or 225, 233 (1994) (ORS 656.003 calls for the 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.")

In the Matter of the Compensation of
GERALD W. WEAVER, Claimant
WCB Case No. 93-01013
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of those portions of Referee Garaventa's order which: (1) upheld the SAIF Corporation's denial of claimant's low back condition; (2) found that claimant's claim had not been prematurely closed; (3) affirmed an Order on Reconsideration that awarded no permanent disability; and (4) affirmed a Director's Order that found claimant ineligible for vocational assistance. In its brief, SAIF contends that claimant is not entitled to temporary disability compensation from August 3, 1992 to June 1, 1993. On review, the issues are compensability, premature claim closure, extent of permanent disability, temporary disability and vocational assistance.

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

Claimant has a work-related out-of-state low back claim, which includes degenerative disc disease. Since this 1987 back injury, claimant has received ongoing treatment for recurrent low back pain. The most recent exacerbation occurred in June 1992 at which time claimant complained of a dull aching pain radiating down both legs. Examination findings included almost complete loss of range of motion, muscle spasm, tenderness, and guarded straight leg movement. Dr. Takush diagnosed recurrent low back pain and prescribed physical therapy and medication. The doctor also took claimant off work. Claimant returned to work on July 13, 1992.

Claimant sustained a compensable right leg injury on July 13, 1992 when he sustained a severe calf laceration with partial muscle tear. As a result of that injury, claimant was required to use crutches. On or about July 19, 1992, while exiting his residence, claimant lost his balance on his crutches, did not fall, but twisted and grabbed a workbench to catch his fall. Claimant testified that he felt his back pop or snap, but did not experience immediate back pain.

The Referee found that the July 19, 1992 crutches incident was a consequence of claimant's compensable July 13, 1992 leg injury, but that the July 19, 1992 incident was not the major contributing cause of claimant's current low back condition. We agree that claimant's current low back condition is not a compensable consequence of his July 13, 1992 right leg injury. We base our conclusion on the following.

Subsequent to the Referee's order, in Kathleen A. Robinson, 46 Van Natta 833, on recon 46 Van Natta 1677 (1994), we reexamined and reaffirmed the appropriateness of the Board's analysis and decision in George Hames, Jr., 45 Van Natta 2426 (1993). We further clarified our analysis for determining the compensability of a consequential condition caused by treatment for a compensable injury:

"[W]hen a consequential condition arises as the result of compensable medical treatment for a compensable injury, the compensable injury is the major contributing cause of the consequential condition if the medical evidence establishes that the compensable treatment was the major contributing cause of the consequential condition. [Citations omitted]. In other words, ORS 656.005(7)(a)(A)'s major contributing cause standard will be satisfied if the claimant establishes that: (1) the medical treatment for a compensable injury was the major cause of a consequential condition; and (2) the medical treatment was materially related to the compensable injury. [Citations omitted]." 46 Van Natta at 1680. (Emphasis in original).

The court affirmed our decision in Hames. Barrett Business Services v. Hames, 130 Or App 190 (1994). In Hames, the court disagreed with the carrier's contention that we had erroneously equated consequences of the treatment of a compensable injury with consequences of the compensable injury itself. Specifically, the court held that where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A).

In ascertaining the legislative intent of ORS 656.005(7)(a)(A), the court in Hames referred to the "trip over your crutches and you break your leg" illustration provided by Jerry Keene's testimony as an example of an injury that is a direct result of pursuing a reasonable and necessary course of treatment. Here, claimant's use of the crutches caused him to slip and twist. As such, claimant's crutches incident on July 19, 1992 was a direct result of pursuing reasonable and necessary medical treatment for his compensable right leg injury. Therefore, that incident is a compensable consequence of the July 13, 1992 right leg injury. Barrett Business Services v. Hames, supra.

However, the question remains whether the reasonable and necessary medical treatment; *viz.*, the crutches and resulting slip and twist, was the major contributing cause of claimant's current low back condition. Resolution of that issue is a medical question which must be resolved on the basis of expert medical evidence. Kathleen A. Robinson, supra.

We agree with and adopt the Referee's analysis and conclusions that the medical evidence is insufficient to establish that the July 19, 1992 crutches incident, and consequently the July 13, 1992 right leg injury, was the major contributing cause of claimant's current low back condition. Accordingly, SAIF's denial is upheld.

ORDER

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

April 27, 1995

Cite as 47 Van Natta 776 (1995)

In the Matter of the Compensation of
ROY WEEDMAN, Claimant
WCB Case No. 94-05647
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Gunn.

The insurer requests review of Referee Herman's order that: (1) awarded claimant temporary disability benefits; and (2) assessed a penalty for the insurer's allegedly unreasonable refusal to pay temporary disability benefits. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with one modification. We change the date in the fourth paragraph of page 2 to "February 17, 1994."

CONCLUSIONS OF LAW AND OPINION

Claimant was a driver for the employer and injured his right shoulder at work on July 22, 1992. The claim was accepted for right shoulder strain. Claimant's medical treatment was conservative and he returned to regular work. On September 29, 1993, claimant's employment was terminated for reasons unrelated to the compensable injury. On October 4, 1993, claimant filed a grievance protesting his termination as wrongful. The union, on behalf of claimant, pursued the grievance until June 9, 1994, when it was withdrawn.

Claimant's claim was closed on October 27, 1993 and he was awarded 9 percent unscheduled permanent disability. Claimant continued to experience right shoulder symptoms. On February 17, 1994, claimant's treating physician found an objective worsening of claimant's right shoulder condition. Claimant was diagnosed with rotator cuff tendinitis with impingement of the right shoulder. Surgery was performed on claimant's right shoulder on March 28, 1994. The insurer accepted claimant's aggravation claim as disabling, but did not pay temporary total disability (TTD) benefits on the ground that claimant was "removed" from the work force. (Ex. 23).

Claimant filed a request for hearing, asserting his entitlement to TTD benefits. The Referee found that on the date of disability, February 17, 1994, claimant was not working and was not actively seeking employment with other employers. Nevertheless, the Referee reasoned that, in light of claimant's grievance proceedings, it was not unreasonable for claimant to wait until the dispute was resolved before embarking on a broader work search. The Referee concluded that claimant was willing to work and was making reasonable efforts to seek work. Therefore, the Referee held that claimant was in the work force at the time of his worsening and was entitled to TTD benefits.

The insurer argues that claimant was not making reasonable efforts to obtain employment. The insurer contends that, as a matter of law, filing a grievance should not excuse claimant from making other efforts to obtain employment.

The question of whether a claimant has withdrawn from the work force is one of fact. Sykes v. Weyerhaeuser Company, 90 Or App 41 (1988). Therefore, we disagree that this issue is a matter of law. 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).

The insurer asserts that the Referee's decision is inconsistent with Roseburg Forest Products v. Phillips, 113 Or App 721, rev den 314 Or 727 (1992), and Roseburg Forest Products v. Wilson, 110 Or App 72 (1991). The insurer's reliance on those cases is misplaced. In Wilson, supra, the court upheld an employer's termination of TTD benefits because the claimant refused modified work due to a strike at the worksite. In Phillips, supra, the claimant did not look for or perform other work during the strike with the employer. The claimant stipulated that, even if work with the employer had been available during the strike, he would not have crossed the picket line. The Phillips court held that the employer was not required to begin paying TTD benefits because the claimant "withdrew from the work force when he decided to participate in the strike." 113 Or App at 725.

Unlike those cases, claimant has not refused to work for the employer. Rather, between September 1993 and June 1994, claimant's efforts were focused on protesting his termination and obtaining reemployment with the employer. Claimant did not refuse to work and did not voluntarily remove himself from the work place. See Safeway Stores, Inc. v. Hanks, 122 Or App 582, rev den 318 Or 60 (1993) (the claimant was entitled to TTD benefits when she was prevented from working due to a labor dispute lock out at the employer); Roseburg Forest Products v. Gibson, 115 Or App 127 (1992) (since the claimant would have gone to work someplace else during the strike if he had been able to work, he was entitled to TTD benefits).

The critical time for determining whether claimant has withdrawn from the work force is at the time of the aggravation. See Dawkins v. Pacific Motor Trucking, supra; Weyerhaeuser v. Kepford, 100 Or App 410, 414, rev den 310 Or 71 (1990). Here, the "date of disability" was February 17, 1994. Claimant was not "engaged in regular gainful employment" on that date. Claimant does not argue that efforts to obtain employment at the time of the worsening were futile. Therefore, we focus on whether claimant was willing to work and was making reasonable efforts to obtain employment. See Dawkins v. Pacific Motor Trucking, supra.

Claimant testified that he filed a grievance because he wanted his job back. (Tr. 42). At the time of the disability, claimant did not look for work with other employers because he was seeking reemployment with the employer and because he was in a lot of pain and felt that surgery would be necessary. (Tr. 15, 20-21). On February 17, 1994, Dr. Switlyk reported that claimant "has not returned to work because of other difficulties with his driving record which are due to be resolved at the end of March. He plans on returning to work then." (Ex. 18). Claimant testified that he told Dr. Switlyk that he planned on returning to work because "I had just won the case against the State of Oregon where I had proved that I was not notified of my driver's license suspension, and I had just won both cases and that's when I was going -- getting ready to go to the [employer's] hearing." (Tr. 35). Claimant testified that if everything would have worked out with the grievance, he would have been reinstated in March or April. (Id.).

In light of claimant's testimony that he wanted to return to work and was actively pursuing a grievance to obtain reemployment, we agree with the Referee that claimant was willing to work and was making reasonable efforts to seek work. Our conclusion is supported by Dr. Switlyk's comments that claimant planned on returning to work after the difficulties with his driving record were cleared up. This is not a situation in which claimant has refused further wage earning employment. Rather, claimant had a desire to obtain reemployment with the employer and was seeking to do so by the grievance proceedings. We conclude that, at the time of the disability, claimant was "in the work force." See Dawkins v. Pacific Motor Trucking, *supra*.

The insurer contends that claimant's grievance was not a reasonable effort to obtain employment because the grievance was without merit. The insurer relies on claimant's proceeding with the Employment Review Board concerning his unemployment benefits and asserts that claimant's argument in that proceeding was preposterous.

The Employment Review Board's conclusions are neither dispositive nor binding in this case, particularly since the issue here is whether the grievance was valid. The grievance had at least enough merit for the union to pursue the claim. Moreover, the final result was that the grievance committee that decided the case was deadlocked. (Exs. 21, 22B). Based on these facts, we find that the grievance procedure was valid. The fact that the union decided not to pursue the grievance after June 1994 does not alter our conclusion.

Unreasonable Denial

The insurer argues that the Referee erred by awarding a penalty and related attorney fees for the insurer's allegedly unreasonable refusal to pay TTD benefits. The Referee reasoned that the insurer did not have a legitimate doubt as to its liability. We disagree.

Pursuant to ORS 656.262(10), claimant is entitled to a penalty if the carrier "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. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

No appellate forum has previously addressed the question of whether pursuing a grievance procedure to recover a terminated claimant's job satisfies the "willing to seek work" and "reasonable efforts" requirements of Dawkins. In other words, whether such constitutes "in the work force" has not been resolved. In light of the unusual circumstances in this case, we conclude that the insurer had a legitimate doubt about its liability. See LaDonna F. Burk, 44 Van Natta 781 (1992) (when the law is uncertain, a legitimate doubt may exist); Maria R. Porras, 42 Van Natta 2625 (1990) (penalty and attorney fee not appropriate when the carrier's reliance on a former rule was reasonable; at the time of the carrier's decision, no case had addressed the validity of a former rule). Therefore, we conclude that the insurer's denial was not unreasonable.

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

ORDER

The Referee's order dated September 19, 1994 is reversed in part and affirmed in part. That portion of the Referee's order awarding claimant a penalty of 25 percent of the unpaid temporary disability benefits due is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded a \$750 attorney fee, payable by the insurer.

Board Member Gunn concurring in part and dissenting in part.

I agree with the majority that claimant is entitled to temporary disability benefits. I disagree, however, with the majority's conclusion that the insurer's denial was not unreasonable. Accordingly, I dissent from that portion of the majority's decision.

Claimant was terminated for reasons unrelated to the compensable injury and he filed a grievance protesting his termination as wrongful. Claimant did not look for work with other employers because he was seeking reinstatement with the employer. Under those circumstances, it would have made no sense for claimant to look for another job when he knew he would quit and go back to work for the employer upon successful completion of the grievance proceedings.

In light of the fact that the insurer was aware that claimant had filed a grievance and was actively seeking reinstatement of his job, it was unreasonable for the insurer to conclude that claimant was "removed" from the work force. Nevertheless, the majority concludes that the insurer's actions were reasonable since no appellate forum has previously addressed this issue. In my view, the insurer did not need any appellate guidance. The insurer's position that filing a grievance and seeking reinstatement established that claimant had "withdrawn" from the work force is completely without merit. There is no doubt that claimant was still in the work force at the time he suffered a worsening of his right shoulder condition. The insurer did not have a legitimate doubt concerning its liability for the payment of temporary disability benefits and its refusal to make such payments was unreasonable.

For these reasons, I respectfully dissent from that portion of the decision which declines to assess a penalty for an unreasonable denial.

April 28, 1995

Cite as 47 Van Natta 779 (1995)

In the Matter of the Compensation of
SHERI R. ACREE, Claimant
WCB Case No. 94-11355
ORDER ON RECONSIDERATION
Coughlin, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On April 12, 1995, we withdrew our March 31, 1995 Order of Dismissal. We took this action to retain jurisdiction to consider the parties' revised proposed "Disputed Claim Settlement." Having received the parties' revised agreement, we proceed with our reconsideration.

The revised proposed settlement is designed to resolve all issues raised or raisable, in lieu of the Referee's order. Pursuant to the settlement, claimant agrees that the insurer's partial denial, as supplemented in the agreement, "is affirmed and shall forever remain in full force and effect." The agreement further provides that claimant's hearing request "shall be dismissed with prejudice and that the [settlement] amount shall be accepted in full settlement of all issues raised or raisable."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
FREDERICK D. CARTER, Claimant
WCB Case No. 93-06336
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Moscato, Byerly, et al., Defense Attorneys

Reviewed by Board Members Turner-Christian, Haynes, and Hall.

The self-insured employer requests review of those portions of Referee Hoguet's order that: (1) declined to consider Exhibits 43, 62, 64, 73, 77 and 79 for substantive purposes (evidence concerning claimant's third party claim); and (2) set aside its "back-up" denial of claimant's injury claims for left and right knee conditions. Claimant cross-requests review of that portion of the Referee's order that awarded claimant's counsel a \$2,200 assessed attorney fee. On review, the issues are evidence, compensability, and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed a claim, contending that he injured his left knee during the early morning of January 10, 1990 when he fell into a hole while walking in the dark across the employer's parking lot. When presented with claimant's injury claim for his left knee, the employer's safety officer (Ms. Floyd) recalled the following incident on the previous evening. While she was participating with claimant in an indoor team sport, claimant began limping to the extent that the other players stopped the game so that he could walk off the court and ice his knee. Ms. Floyd was uncertain which knee claimant had been favoring. (Ex. 73-7). While the claim was pending before the employer, Ms. Floyd provided this information to several of the employer's corporate officers. (Tr. 113-114).

Although the alleged work incident was unwitnessed, the injury claim was accepted. This acceptance was based upon claimant's statement that he fell into an open lightpost hole while walking across the parking lot to report for work. One of claimant's coworkers, Mr. Shropshire, who was nearby at the time of the purported injury, stated that he heard claimant call for help, and found him at the bottom of a hole. (Ex. 40a-9). Claimant later stated that had he stepped over a curb and into a three foot deep hole that "was excavated for a light." (Ex. 5a-3).

In approximately January 1992 claimant filed a third party negligence action. (Ex. 43). Claimant alleged that negligence on the part of one or all of the named defendants (i.e., the contractor, subcontractors and the real property owner) had been the cause of his fall and injuries. (Ex 43-3).

Claimant executed a "settlement agreement and release" on May 10, 1993. (Ex. 77). Pursuant to that settlement, claimant agreed to dismiss his third party action with prejudice, without monetary compensation and without admissions of liability from any party. (Ex. 77-1,2).

On May 14, 1993, the employer issued a "back-up" denial, revoking its acceptance of claimant's injury claim. (Ex. 78). Claimant requested a hearing, contesting the denial. Claimant and Mr. Shropshire testified consistent with their previous statements.

At hearing, the employer presented the following testimony in support of its denial: (1) the electrical subcontractor's project manager, Mr. Bertoch, provided photographs he had taken showing all the lightposts were in fact installed and constantly lit at the time of the alleged injury; and (2) an employee of the landscaping subcontractor, Mr. Grace, stated that there were no more excavated holes awaiting trees prior to claimant's alleged injury. (Tr. 91-93, 79-80).

In setting aside the employer's "back-up" denial, the Referee concluded that the denial was based upon information which the employer and its carrier knew, or could have easily ascertained, at the time of acceptance. Specifically, the Referee found that Ms. Floyd had actually witnessed claimant's alleged off-duty knee injury. Moreover, the Referee noted that Ms. Floyd communicated her reservations regarding the validity of claimant's injury claim to several company officers (i.e., Mr. O'Guri, craft supervisor; Mr. West, project manager; and Mr. Smoke, vice president of high technology operations). (Tr. 113-114).

Consequently, the Referee found that the employer's actual knowledge of claimant's alleged off-duty injury was attributable to the employer's carrier. See SAIF v. Abbott, 103 Or App 49 (1990). The Referee reasoned that the carrier was deemed to have considered that same evidence previously when it chose to accept the injury claim. Therefore, the Referee determined that the employer could not later revoke its acceptance based upon that prior knowledge.

Propriety of "Back-up" Denial

Once two years has passed from the date of accepting a worker's claim for compensation, the carrier may not retroactively deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. See ORS 656.262(6); Anthony G. Ford, 44 Van Natta 239 (1992). A "back-up" denial of a previously accepted condition will be upheld if the carrier can prove that the fraud, misrepresentation or other illegal activity alleged "could have reasonably affected" the carrier's original decision regarding the compensability of the claim.¹ Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987); Sarah E. Asher, 46 Van Natta 1104 (1994). If the carrier succeeds in proving its decision to accept the claim could have been reasonably affected, then the burden shifts to the claimant to prove by a preponderance of the evidence that the claim is nonetheless compensable. See Tony N. Bard, 45 Van Natta 2225 (1993).

Here, the employer does not dispute that its knowledge concerning a claim is imputed to its workers' compensation insurance carrier. See SAIF v. Abbott, *supra*. Rather, the employer contends that Ms. Floyd's observations were insufficient to defeat claimant's injury claim when it arose in January 1990 (e.g., Ms. Floyd was not certain which knee claimant had injured the night before his alleged injury). (App. Br. at 13). In any event, the employer acknowledges that it must prove the propriety of its "back-up" denial based on information which came to light after its decision to accept the claim. Consequently, the employer cannot establish the propriety of its "back-up" denial based upon any of Ms. Floyd's prior knowledge. See *id.*

The third party defendants conducted an investigation that uncovered information, which the employer asserts it had no prior knowledge of, concerning claimant's version of the circumstances surrounding his injury. The employer argues that it was this new information that persuaded claimant to drop his third party suit. (App. Br. at 12). Furthermore, the employer asserts that "it is only the new evidence from claimant's federal third-party claim, that shows the impossibility of claimant being injured on January 10, 1990." (App. Br. at 14).

The employer advances three independent sources of information that led to its decision to issue a retroactive denial: (1) claimant's voluntary dismissal of his third party claim; (2) Mr. Bertoch's statements to the defendant's attorneys investigating that third party action; and (3) Mr. Grace's statements made pursuant to that same investigation. (App. Br. at 13). Mr. Bertoch and Mr. Grace testified at hearing and confirmed that they made these earlier statements. The employer contends that it is the corroboration of Mr. Bertoch, Mr. Grace and claimant's dismissal of his third party action that finally "shows the impossibility of claimant being injured on January 10, 1990." (App Br. 14).

In response, claimant argues that the employer's denial was not based on any new information. Specifically, claimant asserts that, since Ms. Floyd "believed that claimant had not injured himself on the job on January 10th," the issue of "whether the employer knew on the date of the injury whether there was or was not a hole on the job site for claimant to fall in is irrelevant." (Resp. Br. 11). Claimant is not contesting that, at the time of acceptance, the employer was unaware that there were no excavated holes into which he could have fallen. Rather, claimant is arguing that, since Ms. Floyd's allegation that claimant was injured off-duty was known by the employer at the time it decided to accept his injury claim, the subsequent testimony of Mr. Bertoch and Mr. Grace cannot now form the basis for a "back-up" denial.

Inasmuch as neither claimant nor the defendants involved in the third party action made any substantive admissions, we do not find the dismissal of that matter to be probative, in and of itself, regarding the compensability of claimant's left knee condition. However, we are persuaded that the

¹ The dissent would apply a different standard. However, the authorities cited in the dissent have no application in the workers' compensation forum. Rather, the standard of materiality set forth in Ebbtide is the test for determining whether a "back-up" denial is appropriate.

employer did not have actual knowledge concerning the absence of open holes into which claimant could have fallen. Furthermore, we find that the employer's actual knowledge concerning the condition of its parking lot has probative value.

The information from Mr. Bertoch and Mr. Grace provided previously unknown grounds that could have reasonably affected the employer's decision to accept the claim. Ebbtide Enterprises v. Tucker, supra. In reaching this conclusion, we rely on the Supreme Court's discussion of the materiality standard:

"[The carrier] maintains that the Board and the Court of Appeals employed an inappropriate standard of materiality in reaching their conclusions. [The carrier] reads these opinions as imposing upon an insurer the burden of proving that it would have denied responsibility had the undisclosed information come to light before acceptance. Of course, so stringent a standard of materiality would be improper. . . . The Board required only a showing that the insurer's decision 'could reasonably have been affected' by knowledge of the prior injury. We agree that this is an appropriate measure of materiality for the purpose of justifying a backup denial." Ebbtide Enterprises v. Tucker, 303 Or at 464 (emphasis added).

The crux of Ebbtide's interpretation of "back-up" denials is the latitude afforded the measure of materiality. In other words, the employer must show that, had the observations of Mr. Bertoch and Mr. Grace been known, its decision to accept the claim could have been affected.

It can be argued that the employer could have conducted a more extensive initial investigation and thereby confirmed the existence of a hole in its parking lot.² However, the applicable standard for us to follow is not whether the employer's investigation was perfect, but whether the information which it now possesses "could have" affected its decision to accept the claim. Apparently, in deciding to accept claimant's injury claim, the employer chose to rely upon claimant's version of events as corroborated by his coworker, Mr. Shropshire. Consequently, we are persuaded that the new information provided by Mr. Bertoch and Mr. Grace, which indicated that there were no open holes into which claimant could have fallen, could have affected the employer's decision to accept the claim. Ebbtide Enterprises v. Tucker, supra.³

² The dissent subscribes to claimant's theory that the question of whether there was, in fact, a hole in the employer's parking lot is no longer material after the acceptance decision, because the employer bears the consequences of conducting an inadequate investigation. We disagree. As previously discussed, such a theory conflicts with the "materiality" standard we are required to apply pursuant to the Ebbtide standard. Moreover, where, as here, there is no evidence that the employer was aware that there was no hole in its parking lot when it accepted the claim, a factual determination that it was impossible for claimant to injure himself in the manner reported cannot be immaterial.

³ The dissent asserts that Ebbtide supports the application of a "reasonable investigation" standard. We disagree. As previously discussed, we interpret the holding of Ebbtide to be that a "back-up" denial is procedurally valid if a carrier establishes that its acceptance of a claim was based on fraud, misrepresentation or other illegal activity that "could have reasonably affected" its original decision to accept the claim. Consistent with that holding, the reference in Ebbtide to the carrier's investigation was merely a recitation of the Board's reasoning concerning its conclusion that information regarding a previously undisclosed "much older 1977 injury" could not reasonably have affected the carrier's decision to accept the claim because information concerning an "early 1982 injury" had not affected its acceptance decision.

Here, had the "post-acceptance" evidence been additional information regarding claimant's limping at the previous evening's event, such evidence would not be considered as reasonably likely to have affected the employer's decision to accept because the carrier already had similar information from Ms. Floyd at the time of its acceptance. Likewise, had this record established that the employer already had knowledge that its parking lot and light poles were fully intact at the time of claimant's alleged fall, the current "post-acceptance" evidence would not have satisfied the requisite Ebbtide standards. However, as we have explained above, in contrast to the Ebbtide Board's conclusion, the "post-acceptance" evidence was not cumulative to information that the employer had previously received at the time of its acceptance and that information reasonably could have affected the employer's acceptance decision. Consequently, in accordance with the Ebbtide standard, the employer's denial is justified.

Accordingly, we conclude that the employer has carried its burden of proving that the aforementioned information could have reasonably affected its decision to accept the claim. Ebbtide Enterprises v. Tucker, *supra*; Sarah E. Asher, *supra*. Therefore, we find that the employer's "back-up" denial is proper; and, thus, the burden shifts to claimant to prove the compensability of his injury claim for a left knee condition. Tony N. Bard, *supra*.

Compensability

In order to establish a compensable injury, claimant must prove, by medical evidence supported by objective findings, that his work activity was a material contributing cause of his disability or need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). We find that claimant has failed to prove by a preponderance of the evidence that he suffered an injurious incident on January 10, 1990. ORS 656.266.

Claimant relies upon his own testimony and that of Mr. Shropshire to establish his claim that he fell into a hole at the employer's construction site. Mr. Shropshire did not actually witness claimant's alleged injury. (Tr. 113). However, Mr. Shropshire's testimony is consistent with claimant's as they both assert that there was an excavated hole and it was dark in the parking lot. (Tr. 150).

The employer's witnesses present a different and irreconcilable version of the circumstances of January 10, 1990. Mr. Bertoch presented photographs demonstrating that there were no lightpost holes that claimant could have fallen into on January 10, 1990. (Exs. A-1 through A-8). Mr. Bertoch also testified that the installed lightposts were on 24 hours a day from mid-December 1989 until the construction project was completed. (Tr. 92). Additionally, Mr. Grace testified that there were no landscaping excavations into which claimant could have fallen after Fall 1989. (Tr. 79-80).

In the context of establishing compensability, we now consider Ms. Floyd's account of claimant's off-duty incident. We defer to the Referee's finding that Ms. Floyd was a credible and reliable witness. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Consequently, we find that claimant was limping the night before the alleged work incident. Such a history has not been provided to any of the physicians who offered an opinion regarding the cause of claimant's left knee condition.

Under these circumstances, with special consideration given to the extrinsic evidence (*e.g.*, Mr. Bertoch's dated photographs), we are not persuaded that claimant's disability and medical treatment is materially related to a fall in his employer's parking lot on January 10, 1994. Mark N. Wiedle, *supra*. Accordingly, we conclude that claimant has failed to prove the compensability of his left knee condition. ORS 656.005(7)(a); ORS 656.266; Tony N. Bard, *supra*. Inasmuch as claimant's right knee condition allegedly arose as a consequence of the left knee condition which we have concluded is not compensable, we uphold the employer's "back-up" denial of the left and right knee conditions.

Evidence

Lastly, we address the employer's assertion that the Referee erred in limiting the admissibility of Exhibits 43, 62, 64, 73, 77, and 79: comprising pleadings and evidence from claimant's third party negligence action. We have resolved the "back-up" denial issue based upon testimony from hearing and not those exhibits submitted by the employer. Consequently, we decline to disturb the Referee's evidentiary ruling. See generally, James D. Brusseau, II, 43 Van Natta 541 (1991).

Attorney Fees

Inasmuch as we have upheld the employer's "back-up" denial, claimant's counsel is not entitled to an assessed attorney fee.

ORDER

The Referee's order dated January 31, 1994 is reversed. The self-insured employer's "back-up" denial is reinstated and upheld. The Referee's attorney fee award is reversed.

Board Member Hall, dissenting.

Notwithstanding the employer-carrier's understandable concern that claimant misrepresented the mechanism of his injury, given the status of the claim (an accepted claim subject to a "back-up" denial), the question of fraud is secondary to the initial issue of whether the employer-carrier's "new" evidence is sufficient to allow it to move forward with a "back-up" denial. Simply stated, this is a case where we must be careful to be true to a rule of law, even if the result in this particular case (an apparently fraudulent claim) is undesirable. We must balance the duty of an employer-carrier to properly investigate a claim before acceptance,¹ stability of the compensation system, and the duty of the employer-carrier to produce new evidence in order to be entitled to a new hearing, with the potential that an apparently fraudulent claim will stand. As discussed below, I agree with the Referee that the employer's "back-up" denial was improper, because it was not based on evidence which the employer-carrier can demonstrate would have materially affected the original decision to accept the claim. Thus, because I believe that the majority errs, I respectfully dissent.

The enduring policy reason for restricting "back-up" denials is articulated in Bauman v. SAIF, 295 Or 788 (1983). There, the Court stated that allowing employers and insurers to vacillate between accepting and denying claims "would encourage degrees of instability in the workers' compensation system" not contemplated by ORS 656.262(6). 295 Or at 793. Absent a showing of fraud, misrepresentation, or other illegal activity, an employer/carrier may not deny a previously accepted claim.² 295 Or at 794. The Court explained:

"The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability. We need not list all the possible ramifications of such conduct but it is readily evident that problems involving lapsed memories, missing witnesses, missing medical reports, and host of other difficulties would arise from the delayed litigation of the compensability of the claim. * * * * [W]e hold that once a claim has been accepted the insurer or self-insured employer may not withdraw such acceptance." Id.

In Ebbtide Enterprises v. Tucker, 303 Or 459, 467 (1987), following Bauman, the Supreme Court affirmed the Court of Appeals' conclusion that evidence relied upon for the purpose of justifying a "back-up" denial must have a certain "materiality." To satisfy that requirement, the employer-carrier must show that its decision to accept the claim "could reasonably have been affected" by knowledge of that evidence. 303 Or at 464. It is critical to understand the role that due diligence played in the decisions of the Board and Courts in concluding that the evidence of alleged misrepresentation in Ebbtide was not material. Ultimately, the Ebbtide Supreme Court quoted from the Board and Court of Appeals orders, respectively, with approval:

"Our review of the record fails to persuade us that, had claimant informed EBI that her back problems originated with her 1977 industrial injury, rather than her more recent February 1982 injury, EBI's decision to accept the claim would have been any different. What claimant did consistently say to everyone, including the insurer's investigator and her doctor, rather graphically suggests at least the possibility that claimant's late 1982 problems originated with her early 1982 SAIF injury. If EBI did not follow this up with additional investigation, what basis is there for thinking it would have done anything differently had it known of the much older 1977 injury?

The Court of Appeals, reviewing the evidence *de novo*, affirmed, stating:

¹ In 1990, the time allowed for investigating a claim was increased from 60 to 90 days. See ORS 656.262(6).

² In 1990, the Workers' Compensation Act was amended to allow "back up" denials within two years of acceptance without a showing of fraud, misrepresentation, or other illegal activity. ORS 656.262(6); see Anthony G. Ford, 44 Van Natta 239 (1992). The present case, however, concerns a "back up" denial issued more than two years after acceptance, so the employer/carrier must prove fraud, misrepresentation, or other illegal activity.

'We agree with the Board's finding that the purported misrepresentation was not material. EBI knew of claimant's February, 1982, injury and that she ascribed most of her July back problems to that injury at the time when it accepted her claim in September. She had already been awarded additional permanent partial disability for the February injury. EBI's contention that its acceptance was due to a material misrepresentation is untenable, and its backup denial was impermissible.' 81 Or App at 112." 303 Or at 464 (emphasis added).

Because the Ebbtide carrier failed to investigate the claim before accepting it, claimant's alleged misrepresentation of a prior injury was not a material misrepresentation. Consequently, the Supreme Court agreed with the Board and the Court of Appeals, that the carrier could not successfully rely on a contention that its acceptance was based on a material misrepresentation and the "back-up" denial in Ebbtide was impermissible.

After the 1990 amendments to Chapter 656, the court held that a "back-up" denial under ORS 656.262(6) must be based on "later obtain[ed] evidence," not just a reevaluation of existing evidence. CNA Insurance Companies v. Magnuson, 119 Or App 282 (1993). The Magnuson court's analysis of ORS 656.262(6) is entirely consistent with the due diligence requirement articulated in Ebbtide. Evidence offered in support of a "back-up" denial simply does not qualify as later obtained evidence which could have materially affected the original acceptance, if it was available with the slightest diligence at the time of claim acceptance.

The Supreme Court has long been reluctant to permit a new trial based on newly discovered evidence. The earliest discussion of the relevant standard was in Lander v. Miles, 3 Or 40 (1868). There, the Court held that, in order to secure a new trial on the ground of newly discovered evidence: (1) the testimony must have been discovered since the former trial; (2) the testimony could not have been discovered at the time of that former trial; and (3) the testimony would not be cumulative.

In Lewis v. Nichols, 164 Or 555 (1948), the Court further explained that, on motion for new trial on grounds of newly discovered evidence, all persons of whom movant had either express or constructive knowledge cannot be deemed "newly discovered witnesses" after the trial.

In both Lander and Lewis the Court imposed a duty of diligent investigation, requiring the plaintiff to demonstrate that newly acquired testimony could not have been discovered at the time of the original trial. This duty is discussed as such in Newbern v. Exley Produce Exp., Inc., 208 Or 622 (1956), where, because "the slightest diligence" on plaintiff's part would have disclosed the new evidence, its belated discovery "certainly affords no grounds for a new trial." 208 Or at 631 (emphasis added). See Stubbs v. Mason, 252 Or 547, 551 (1969) (Where defendant did not "exhibit the degree of diligence necessary to undergird a motion for a new trial," the trial court did not abuse its discretion by denying defendant's motion for a new trial).

In the present case, the majority and dissent agree that testimony from Ms. Floyd (employer's safety officer) may not be relied upon to support the "back-up" denial, because that evidence came to light before the claim was accepted.³ Thus, the question is whether the information provided by Mr. Bertock and Mr. Grace qualifies as "later obtain[ed]" material evidence such that if the employer-carrier would be allowed to move forward with the "back-up" denial.⁴

Mr. Bertock was the electrical subcontractor's project manager for the jobsite where claimant alleges that he fell in an excavated hole. At the time of the alleged fall, the following circumstances existed: According to photographs provided by Mr. Bertock, all lightposts were installed. According to Mr. Grace, a landscaping employee, there were no excavated holes awaiting trees. The area where claimant claims to have fallen was already paved, with lightposts installed. Such was the situation,

³ Indeed, Ms. Floyd communicated her reservations about the validity of claimant's claim to corporate officers, before the claim was accepted. Because the employer apparently ignored the concerns of its safety officer (when it could have investigated with only slight diligence), it should be estopped from relying on those concerns as a basis for denying the previously accepted claim.

⁴ The majority and dissent also agree that claimant's dismissal of his third party lawsuit is not probative evidence in this case.

according to the employer's brief (Appellant's Brief p. 4), approximately forty-eight (48) days before the alleged fall. It is this information⁵ (about the status of the site), now provided by Mr. Bertock and Mr. Grace, which the employer-carrier offers as "new" (later obtained) evidence to prove fraud by claimant and justify its "back-up" denial. In other words, the employer-carrier asserts that it would not have accepted the claim had it known of the information (about the status of the site) now being provided by Mr. Bertock and Mr. Grace.

The present case is similar to Ebbtide. The slightest diligence (*i.e.*, investigation) would have revealed the then existing evidence concerning the status of the site. Had the employer-carrier conducted even a cursory examination of the parking lot where the alleged injury occurred, it would have inevitably noticed that there were no open holes into which claimant could have fallen. The information now being offered by Mr. Bertock and Mr. Grace (the substance of their testimony) could have been discovered at all times prior to the employer-carrier's decision to accept the claim. Regardless of when these particular witnesses and their testimony could have been discovered, the substance of the testimony (*i.e.*, the information that the lot was paved and there were no holes) could have been discovered with the slightest diligence before the claim was accepted. *See e.g.*, Smith v. Jacobsen, 224 Or 627, 638 (1960) (In the context of a personal injury suit, defendant's request for a new trial was denied since a "diligent search" for existing worker's compensation claims would have revealed the fact of plaintiff's prior injuries).

Under the Ebbtide diligence requirement, it cannot be said that the information provided by Mr. Bertock and Mr. Grace is material.⁶ As the Board correctly pointed out in Ebbtide: "If [the carrier] did not follow this up with additional investigation, what basis is there for thinking that it would have done anything differently had it known. . . ." (quoted in 303 Or at 364). In the instant case, the employer-carrier ignored the concerns of its safety officer, Mrs. Floyd, and ignored the open and obvious status of the parking lot. Since the employer-carrier has not produced evidence sufficient to establish that the decision to accept the claim would have been materially affected, I would conclude that the "back-up" denial was improper and the burden of proving compensability should not have reverted back to claimant. *See Tony N. Bard*, 45 Van Natta 2225 (1993).

⁵ It is, by the way, the information provided by the two witnesses that is at issue, not the witnesses themselves. They are only messengers.

⁶ Contrary to the majority's interpretation of my position, I do not propose a standard of materiality different from that articulated in Ebbtide. Instead, I would apply the Ebbtide standard, including the Court's implicit (if not explicit) diligence requirement. The caselaw cited above is offered to demonstrate the longstanding legal foundation upon which cases such as Ebbtide and Magnuson rest.

April 28, 1995

Cite as 47 Van Natta 786 (1995)

In the Matter of the Compensation of
LARRY E. FOURNIER, Claimant
 WCB Case No. 93-07028
 ORDER ON REVIEW
 Doble & Associates, Claimant Attorneys
 Moscato, Byerly, et al., Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian and Gunn.

Claimant requests review of Referee Garaventa's order which: (1) declined to grant claimant's motion for a continuance of the hearing for the introduction of rebuttal evidence; and (2) upheld the self-insured employer's denial of claimant's current low back condition. On review, the issues are the Referee's evidentiary ruling and compensability.

Compensability

We adopt and affirm the Referee's order with the exception of her comment that a pathological worsening of claimant's low back injury caused by claimant's off-the-job basketball injury is sufficient in itself to defeat compensability. Even assuming that the off-the-job incident pathologically worsened

claimant's back condition, claimant's current low back condition could still be compensable if: (1) claimant established that his original compensable injury was materially related to his current condition; and (2) the employer failed to prove that this incident was the major contributing cause of claimant's worsened condition. See Fernandez v. M & M Reforestation, 124 Or App 38 (1993); Roger D. Hart, 44 Van Natta 2189 (1992), aff'd Asplundh Tree Expert Company v. Hart, 132 Or App 494 (1995). However, we agree with the other reasons cited in the Referee's order that claimant's current low back condition is not materially related to his original compensable injury in 1980.

Evidentiary Ruling

Claimant moved for a continuance of the hearing to allow the introduction of rebuttal evidence from claimant's current attending physician, Dr. Brett. Claimant requested this action in order to respond to the depositions of examining physicians, Drs. Duff and Wilson. The Referee denied the motion, noting that under OAR 438-06-091 continuances are disfavored and that the parties are expected to present all their evidence at hearing. (Trs. 14, 15).

On review, claimant contends that, if we affirm the Referee's compensability determination, the Referee's evidentiary ruling should be reversed and the case remanded to the Referee for reopening of the record and submission of rebuttal evidence. We disagree.

On December 1, 1993, Drs. Wilson and Duff issued a report of their examination of claimant. They disagreed with Dr. Brett's conclusion that claimant's current low back injury was related to his original compensable 1980 injury. (Ex. 32). Instead, they opined that the major contributing cause of claimant's current low back condition was an off-the-job basketball incident.

On December 16, 1993, Drs. Duff and Wilson confirmed in a "check-the-box" report that claimant's 1980 injury was not materially related to his current condition and need for treatment. This report was submitted to the Hearings Division and claimant's counsel by the employer's counsel on December 27, 1993. (Ex. 33). On January 13, 1994, claimant apparently contacted the employer's counsel to demand cross-examination of both Dr. Wilson and Dr. Duff. (Tr. 5).

Dr. Wilson's deposition occurred on February 23, 1994. Dr. Wilson gave no indication that his prior opinion had changed. On February 25, 1993, claimant's attorney wrote the Referee, advising that he wished to obtain rebuttal evidence from Dr. Brett after the deposition of Dr. Duff, which was scheduled for March 18, 1994. (Ex. 35). The employer filed a copy of Dr. Wilson's deposition transcript with the Hearings Division on March 1, 1994, just two days prior to the March 3, 1994 hearing. Dr. Duff's deposition occurred as scheduled on March 18th.

A Referee "may continue a hearing ... [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence" OAR 438-06-091(3). OAR 438-06-091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within the Referee's discretion. See Ronald D. Hughes, 43 Van Natta 1911, 1912 (1991). Further, a referee is not bound by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve "substantial justice." ORS 656.283(7).

In this case, claimant contends that the Referee abused her discretion by violating his right to present final rebuttal evidence. We disagree.

Claimant could not reasonably be expected to produce rebuttal evidence in response to depositions of Drs. Wilson and Duff prior to the hearing. The transcript of Dr. Wilson's deposition was not submitted until two days prior to hearing and Dr. Duff's deposition did not occur until after the March 3, 1994 hearing. We also agree with claimant that he had the burden of proving that his current low back condition was materially related to the 1980 injury before the burden of proof shifted to the employer to prove that the off-the-job basketball injury was the major contributing cause of the worsened condition. See ORS 656.273(1); Fernandez v. M & M Reforestation, supra; Roger D. Hart, supra. Thus, claimant was a party bearing the burden of proof with respect to proving material causation.

However, Drs. Wilson and Duff submitted their initial report of December 1, 1993, and a supplemental report of December 16, 1993, well in advance of the March 3, 1994 hearing. Claimant did not offer an explanation as to why he did not seek a report from Dr. Brett rebutting their conclusions

prior to the scheduled hearing. See Gordon Kight, 46 Van Natta 1278 (1994), aff'd mem Kight v. Georgia-Pacific Corporation, 133 Or App 600 (1995) (no continuance because claimant did not establish that completion of the record could not have been accomplished with due diligence). Instead, he sought to cross-examine the aforementioned physicians pursuant to "pre" and "post" hearing depositions. Although Dr. Wilson and Dr. Duff may have subsequently refined their analyses in their respective depositions, neither doctor's basic conclusions changed as a result of their cross-examination.

Given these circumstances, we find that the Referee did not abuse her discretion by denying claimant's request for a continuance for the production of rebuttal evidence from Dr. Brett.

ORDER

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

Board Member Gunn dissenting.

The majority concludes that claimant's current low back condition is not compensable. It also finds that the Referee did not abuse her discretion in denying claimant's request for a continuance for the production of rebuttal evidence. Because I disagree with both of these decisions, I must respectfully dissent.

Dr. Brett, the attending physician, opined that claimant's compensable 1980 injury is the major contributing cause of his current low back condition. In concluding that claimant's current low back condition is not compensable, the Referee found Dr. Brett's opinion unpersuasive. The Referee and the Board (through its adoption of the Referee's reasoning) reject Dr. Brett's opinion because it is allegedly unexplained and not supported by the record. I disagree.

It is well-settled that we defer to the medical opinion of the attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAJE, 64 Or App 810 (1983). In this instance, I find no persuasive reason to do otherwise.

Relying on claimant's undisputed history of ongoing low back discomfort since the 1980 injury, Dr. Brett explained that the compensable industrial injury resulted in annular injury and weakening at both L4-5 and L5-S1. (Ex. 26). Even though there was some pathological worsening caused by claimant's basketball activities, Dr. Brett concluded that the original injury was the major factor in claimant's current condition.

This conclusion is supported by the examining physician, Dr. Duff, who agreed that the original injury had weakened a lumbar disc to the point where a minor event such as the basketball incident could bring about claimant's radicular symptoms. (Ex. 36-18). It is clear from Dr. Duff's testimony that the original 1980 injury, not the off-the-job basketball incident, is the major contributing cause of claimant's current condition.

In summary, Dr. Brett's opinion is adequately explained. It is also supported by claimant's credible history of ongoing low back discomfort, as well as by medical evidence elsewhere in the record. Accordingly, I would find that claimant's current condition is compensable based on the record as it now stands.

Alternatively, I would find that the Referee erred in not allowing claimant a continuance for the production of rebuttal evidence in response to the depositions of Drs. Duff and Wilson. The majority agrees that claimant was a party bearing the burden of proof with respect to proving material causation and has the right to present final rebuttal evidence pursuant to OAR 438-06-091(3). However, even though the majority agrees that claimant could not provide rebuttal evidence in response to the depositions of Drs. Duff and Wilson prior to the hearing, it still concludes that the Referee did not abuse her discretion in denying claimant's continuance request. The majority is wrong.

The administrative rule is clear. As the party with the burden of proving material causation, claimant has the right to present final rebuttal evidence. The Referee improperly denied claimant this right when she refused to allow him to rebut the depositions of Drs. Wilson and Duff. Therefore, the majority should have reversed the Referee's ruling and allowed claimant the right to fully present his case. Because it does not reverse the Referee's evidentiary ruling, I must also dissent from this portion of the majority's opinion as well.

In the Matter of the Compensation of
JOAN C. GILLANDER, Claimant
WCB Case No. 92-03284
ORDER DENYING RECONSIDERATION
Nancy F. A. Chapman, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Claimant requests reconsideration of our March 8, 1995 order which: (1) held that claimant had not established good cause for her failure to timely request a hearing from the SAIF Corporation's denial of her back injury claim; and (2) dismissed claimant's hearing request as untimely filed.

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). However, this authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987). For the reasons which follow, we deny claimant's motion for reconsideration.

In our initial order, we held that claimant's mistaken belief that her out-of-state claim had been accepted did not constitute "good cause" under ORS 656.319 (1)(a) for her untimely hearing request from SAIF's denial. Because she was collecting benefits under a temporary decision in her Washington claim when she received SAIF's denial, claimant asserted that she was not concerned about the Oregon denial. When the Washington claim was subsequently denied, claimant retained legal counsel and filed an untimely hearing request.

Relying on Bonnie J. Santangelo, 42 Van Natta 1979 (1990), we held that claimant's belief that her Washington claim had been accepted (based on her receipt of temporary benefits) did not constitute "good cause" for her untimely hearing request from SAIF's denial.

Claimant raises several arguments. First, she argues that we did not address that portion of the Referee's order which set aside SAIF's May 14, 1992 amended denial. Specifically, claimant contends that the second denial was timely appealed.

We have previously addressed a similar argument in Arthur D. Esgate, 44 Van Natta 875 (1992). In that case, an insurer denied the claimant's occupational disease claim for a right hand condition. That denial was not appealed and became final by operation of law. The claimant in Esgate later refiled his occupational disease claim and the insurer issued an "amended" denial containing appeal rights.

We held that the claimant was barred by claim preclusion from relitigating a claim for the same condition that was previously denied. We determined that the effect of the first denial was to finally determine that the claimant's right hand condition was not compensable. We further held that the claimant had to show that his current right hand condition denied by the "amended" denial had changed since the initial denial. Because the claimant's second claim was for the same condition that was previously denied, we held that the second claim was barred.

The present case involves a claim for an injury rather than an occupational disease. However, as in Esgate, we conclude that claimant would be barred by claim preclusion from asserting a second claim based on the same factual transaction as was the first denied claim. "Claim preclusion" bars a plaintiff who has prosecuted one action against a defendant through to a final judgment from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Rennie v. Freeway Transport, 294 Or 319, 323 (1982). Claim preclusion does not require actual litigation of an issue, but does require the opportunity to litigate, whether or not used. Drews v. EBI Companies, 310 Or 134 (1990).

Here, claimant had an opportunity to litigate the first denial. Because the claim denied by the "amended denial" in this case is based on the same factual transaction (the September 24, 1991 injury) as was the first denial, claimant is barred by claim preclusion from asserting that claim.

Claimant next argues that she did not file an Oregon claim against the employer. However, this contention was adequately addressed in our original order in which we held that an Oregon claim had been filed on claimant's behalf when SAIF received a form 827 from physicians treating claimant. See ORS 656.005(6). This document notified SAIF of a claim for benefits against the employer.

Next, claimant contends that receipt of time loss after SAIF's denial caused confusion beyond that caused by payment of interim compensation. We disagree and believe that this argument was adequately addressed in our initial order. In that order, we relied in part on our prior holding in Bonnie I. Santangelo, supra. In Santangelo, the claimant believed that one carrier had accepted her claim because it had begun paying interim compensation. Because she believed her claim with the carrier had been accepted, the claimant did not appeal a denial by the other carrier. We held that the claimant's receipt of interim compensation and her assumption that her claim had been accepted did not constitute good cause for not requesting a hearing on the other carrier's denial.

We are not persuaded that there is a material distinction between the present case and Santangelo. Here, claimant was receiving time loss based on a temporary decision in Washington. Therefore, she was not concerned when she received SAIF's denial, because she believed her Washington claim had been accepted. Similarly, in Santangelo, the claimant received interim compensation from one carrier after the other carrier had denied the claim. After reconsidering claimant's argument, we are not persuaded that the time loss received after SAIF's denial in this case caused any more confusion than receipt of interim compensation in Santangelo after another carrier had issued a claim denial.

Finally, claimant seeks clarification of the Board's policy in concluding that "good cause" did not exist in her case. Our "policy" remains as it has always been. In other words, according to ORS 656.319(1)(b), a hearing shall not be granted unless the request is filed within 180 days after notification of the 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. Based on the existing case precedents recited in our prior order which interpret ORS 656.319(1)(b), claimant did not establish good cause for failing to request a hearing within 60 days of notification of the denial.

Accordingly, for the foregoing reasons, claimant's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

April 28, 1995

Cite as 47 Van Natta 790 (1995)

In the Matter of the Compensation of
TREVER McFADDEN, Claimant
WCB Case No. 93-11698
ORDER ON REVIEW
Schneider, Hooten, et al., Claimant Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Mills' order that: (1) found that claimant's low back injury claim was not prematurely closed; (2) declined to set aside the Order on Reconsideration and remand the claim to the Department for a physical examination by the medical arbiter; and (3) affirmed the Order on Reconsideration that awarded no unscheduled permanent disability for the low back injury. On review, the issues are premature closure, remand, and extent of unscheduled disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and replacement. We do not adopt the findings of ultimate fact.

We replace the first sentence of the fourth paragraph and the fourth sentence of the fifth paragraph with the following. After the January 1992 low back injury, claimant had a little ongoing back pain which was not "all that bad," just "kind of sore." (Tr. 4, 5, 6). Claimant reported to Dr. Killian, treating physician, that his symptoms resolved with conservative treatment following the January 1992 injury. (Ex. 5). Claimant reported to Dr. Puziss, examining physician, that his pain resolved about a month after the January 1992 injury. (Ex. 7-1).

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the September 30, 1993 Order on Reconsideration, finding that claimant's condition was medically stationary when his claim was closed by a January 22, 1993 Notice of Closure, as amended April 12, 1993. We disagree.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. Schuening v. J.R. Simplot & Co., 84 Or App 622, 625 (1987). Claimant bears the burden of proving that he was not medically stationary at the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

In determining medically stationary status, OAR 436-30-035(1) provides that a "worker's condition shall be determined to be medically stationary when an attending physician or a preponderance of medical opinion declares the worker either 'medically stationary,' 'medically stable,' or uses other language meaning the same thing." Here, at the time of claim closure, there was no medical opinion indicating that claimant was medically stationary.

Claimant sustained two compensable back injuries while working for the employer. On January 30, 1992, claimant sustained a work-related low back strain while the employer was insured by Safeco Insurance Company (Safeco). On May 12, 1992, Safeco accepted this injury as a nondisabling low back strain. (Ex. 4). The injury was subsequently reclassified as disabling. (Ex. 10). It is this January 1992 injury that is the subject of the current litigation. In July 1992, claimant sustained a work-related thoracic strain. At that time, the employer was insured by Wausau Insurance Companies (Wausau). On January 20, 1993, Wausau accepted this injury as a nondisabling thoracic strain. (Ex. 8).

Following the January 1992 low back strain injury, claimant was examined and treated by physicians on two occasions. On February 14, 1992, claimant was seen by Dr. Anderson, M.D., who prescribed medication and physical therapy and released claimant to modified work for five to seven days. (Exs. 2, 3-1). On February 17, 1992, claimant was examined by Dr. Blauer, M.D., who prescribed different medication and referred claimant to physical therapy. (Ex. 3-2). Neither physician provided any opinion as to claimant's medically stationary status.

Following the July 1992 thoracic strain injury, claimant received medical treatment from Dr. Killian, M.D., Dr. Redwine, M.D., and Dr. Tolliver, D.O. (Exs. 5, 6, 6A, 6B,). Although Dr. Killian noted that, by claimant's history, his symptoms resolved following the previous injury with conservative treatment, neither Dr. Killian nor any of claimant's other treating physicians provided any opinion as to whether claimant was medically stationary regarding the January 1992 injury.

On October 8, 1992, Dr. Puziss, orthopedist, examined claimant on behalf of Wausau. (Ex. 7). Dr. Puziss noted that, based on claimant's history, claimant appeared to have "completely resolved his low back pains from his February [sic] 1992 injury[.]" (Ex. 7-3). Dr. Puziss' opinion focused on claimant's second work injury in 1992, finding that this was a new injury from which claimant was not yet medically stationary. Id. He provided no opinion as to whether claimant was medically stationary regarding the January 1992 injury.

The only other medical report in the record is a report from Dr. Martens, the medical arbiter appointed by the Director.¹ However, Dr. Martens gave no opinion as to claimant's medically stationary status.

Safeco argues that the reports of Drs. Killian and Puziss regarding claimant's history that his pain symptoms resolved following the January 1992 injury establish that claimant was medically stationary at the time Safeco closed the claim. We disagree. These statements do not constitute medical evidence that claimant was medically stationary regarding the January 1992 injury. The determination of claimant's medically stationary status is a medical question and the medical evidence in this record offers no opinion regarding that question. Harmon v. SAIF, *supra*; Reyna R. Rolban-Duenez, 46 Van Natta 865 (1994); Cindy A. Schrader, 46 Van Natta 175 (1994).

In other words, although "magic words" are not necessary, the record must be sufficient to conclude that the preponderance of the medical opinion finds claimant medically stationary or "uses other language meaning the same thing." ORS 656.005(17); OAR 436-30-035(1). After reviewing this record, we are not persuaded that passing references to claimant's history (that his symptoms have resolved) is sufficient evidence to satisfy that standard. This is particularly true since Dr. Puziss opined that claimant's condition was not medically stationary, albeit in regard to the later "thoracic" injury. Furthermore, Dr. Puziss did not opine that the January 1992 injury was medically stationary; he simply reported claimant's history that the symptoms had "resolved." Nor does the fact that claimant was able to return to his regular work following the January 1992 injury establish that his condition regarding that injury was medically stationary.

Accordingly, on this record, we find that claimant's January 1992 low back injury was not medically stationary at claim closure. Therefore, Safeco's Notice of Closure and the Order on Reconsideration are set aside as premature. Furthermore, our decision on the premature closure issue renders moot claimant's request for remand to the Director for a physical examination by a medical arbiter and his arguments regarding extent of permanent disability.

We have found that claimant's claim was prematurely closed. Inasmuch as our finding may result in increased temporary disability benefits, we conclude that claimant's counsel is entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); OAR 438-15-055; Dianne M. Bacon, 43 Van Natta 1930 (1991). Consequently, claimant's counsel is entitled to 25 percent of the increased temporary disability benefits created by our order, not to exceed \$3,800, payable directly to claimant's counsel.

ORDER

The Referee's order dated May 18, 1994 is reversed. The January 22, 1993 Notice of Closure, as amended April 12, 1993, and the September 30, 1993 Order on Reconsideration are set aside as premature. The claim is remanded to Safeco Insurance Company (Safeco) for further processing according to law. Claimant's attorney is awarded 25 percent of the increased temporary disability benefits created by the Board's order, not to exceed \$3,800, payable directly to claimant's attorney.

¹ When he requested reconsideration of Safeco's Notice of Closure, claimant requested a medical arbiter "examination." (Ex. 10-A). The Director appointed a medical arbiter, but directed him to conduct a record review. (Ex. 10C). Claimant argues that the Director does not have the authority to restrict the medical arbiter's review to a record review. Given both the fact that the medical arbiter did not address the premature closure issue (the preliminary issue in this case) and given our decision herein regarding that issue, we need not address claimant's arguments regarding the Director's authority, or any lack thereof, to restrict a medical arbiter's review to a record review.

In the Matter of the Compensation of
YEVGENIY GAYVORONSKIY, Applicant
WCB Case No. CV-94011
FINDINGS OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIM ACT)
Mary H. Williams, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Keith B. Kekaouha, special hearings officer, on March 3, 1995. Applicant, Yevgeniy Gayvoronskiy, was present and was not represented by counsel. Irwin Marcus, a citizen advocate, was present on applicant's behalf. A Russian interpreter, Peter Depeche of Passport to Languages, was also present. The Department of Justice Crime Victims' Compensation Fund ("Department") was represented by Mary Williams, Assistant Attorney General. The court reporter was Jan Nelson of Harris Reporting. Rebecca Ewing and Bill Koch, claims examiners for the Department, were present as witnesses for the Department.

Exhibits 1 through 35 were received into evidence and, following the receipt of testimony and closing argument, the record was closed on March 3, 1995.

Applicant has requested review by the Workers' Compensation Board of the Department's September 19, 1994 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on the lack of persuasive evidence that: (1) applicant was the victim of a compensable crime; (2) he had cooperated fully with law enforcement officials in the apprehension and prosecution of the assailant or that his failure to cooperate was for good cause; and (3) applicant's injury was not substantially attributable to his own wrongful act or substantial provocation of the assailant. See ORS 147.015(1), (3) & (5).

FINDINGS OF FACT

At about 12:30 a.m. on February 24, 1994, applicant completed his work shift as a production worker for a manufacturing firm. He caught a ride home with a co-worker, Viktor Vetkov, who lives in an apartment near applicant's apartment. Their apartments are about a 40-minute drive from their work place. During the drive home, applicant drank a few beers. They apparently stopped at a 7-11 store for a couple of minutes before continuing home. They arrived at the parking lot near their apartments, and applicant continued to drink more beers in the car.

After an undetermined period of time, Vetkov went home to his apartment. Applicant also headed to his own apartment, but he remembered leaving something in the car and returned to the parking lot to retrieve it. At the time, applicant was very intoxicated.

The events that followed are in dispute. Applicant reported to police that, when he returned to the parking lot, he was stabbed by someone. He reported that he did not know what happened, how the stabbing happened or who attacked him. Applicant could give no description of the assailant. (Ex. 18-3 & -4).

However, in written statements to the Department, applicant reported that a man asked him for money and, when applicant said he had no money, the man got mad and stabbed him. Applicant reported that he lost consciousness immediately and did not know how long he had been lying in the parking lot before he regained consciousness. (Exs. 22-2, 28-1).

It is undisputed that, after the stabbing, applicant went to Vetkov's apartment. Vetkov immediately called 911, and police and ambulance were dispatched to the apartment at about 3:30 a.m. When the ambulance crew arrived, applicant was diagnosed with a stab wound to the abdomen. He was oriented and obeyed commands. He was conscious while being transported to the hospital. His blood alcohol level was .132 at approximately 4 a.m. Applicant underwent abdominal surgery and was discharged on February 27, 1994. The District Attorney's office has been unable to locate any suspects.

In March 1994, applicant filed a request for crime victim's compensation with the Department. After investigating the claim, on July 13, 1994, the Department issued Findings of Fact, Conclusions and Order denying the claim for compensation. The Department concluded that, because of applicant's intoxication level and his conflicting statements regarding the circumstances surrounding the stabbing, applicant had failed to prove that: (1) he was the victim of a compensable crime; (2) he had cooperated fully with law enforcement officials; and (3) his injury was not substantially attributable to the applicant's wrongful act or substantial provocation by applicant.

Applicant requested reconsideration of the Department's order. By Order on Reconsideration dated September 19, 1994, the Department adhered to its denial of compensation, reasoning that applicant's version of what happened from the time Vetkov left him in the parking lot until he appeared at Vetkov's apartment with a stab wound, was inconsistent with ambulance, medical and police reports in the record.

Applicant requested a hearing contesting the Department's reconsideration order. At the March 3, 1995 hearing, applicant testified that, as he was returning to the car in the parking lot, a man called to him. Applicant said that he turned around to face the man, who then shouted something to him. Applicant was not sure if the man was demanding money. Applicant said he was then stabbed and recalled nothing more until he regained consciousness. He did not know how long he was lying on the ground before he regained consciousness and walked to Vetkov's apartment.

CONCLUSIONS OF LAW AND OPINION

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

The Department denied applicant's claim for three reasons. The first reason is the lack of sufficient evidence that applicant was the victim of a compensable crime. A "compensable crime" is defined by ORS 147.005(4):

"'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."

The Department contends that it had insufficient information from which to conclude that applicant was the victim of a compensable crime. Specifically, the Department found claimant's recollection of the events surrounding the stabbing to be unreliable. Based on applicant's timecard at work, the Department determined that applicant completed his work shift at 12:30 a.m. Further, based on the undisputed fact that applicant's apartment was about a 40-minute drive from work, the Department found that applicant would have arrived at the parking lot by 1:30 a.m. If, as applicant stated to the Department, he had been stabbed shortly thereafter, the Department reasoned that applicant would have had to be lying on the ground unconscious for approximately two hours. The Department also reasoned that, based on applicant's blood alcohol level of .132 at 4 a.m., and normal dissipation rates, applicant must have been consuming more alcohol than he admitted to the Department.

I find that the aforementioned inconsistencies can be explained by applicant's testimony that, after he arrived at the parking lot with Vetkov, he continued drinking in the parking lot for an undetermined period of time. His testimony indicates that applicant did not immediately walk home after arriving at the parking lot, but rather, remained there for a period of time after 1:30 a.m. His testimony also explains his elevated blood alcohol level.

I find that applicant has consistently reported that he was stabbed by a stranger without provocation. Although applicant reported to the Department that the stranger demanded money before stabbing him, his testimony at hearing indicated that he was not sure what the stranger was saying to him. In any event, I find that applicant's stabbing was an intentional, unprovoked act causing serious bodily injury, which would be punishable as a crime. Therefore, I conclude that claimant was the victim of a compensable crime.

The conclusion that applicant was the victim of a compensable crime does not entitle him to compensation, however. The law requires that, in order to receive crime victims compensation, the applicant must also show that "[he] has cooperated fully with law enforcement officials in the apprehension and prosecution of the assailant or the Department has found that the applicant's failure to cooperate was for good cause." ORS 147.015(3). Here, the Department's second reason for denying applicant's claim was its conclusion that applicant had not cooperated fully with law enforcement officials investigating the stabbing. On that basis, I must agree with the Department's denial of the claim.

The police reports in the record indicate that applicant said he did not know what happened, how it happened, or who attacked him. He also said he saw no one. (Ex. 18-4). Applicant gave no description of the assailant to police. (Ex. 18-3). However, in statements to the Department, applicant had more information. He reported that a man asked for money and, when applicant said he had none, the man became angry and stabbed him. (Exs. 22-2, 28-1). At hearing, applicant had still more information about his assailant. He recalled that the assailant was a man who was a head taller than applicant and much stronger. Although applicant noted that the parking lot was not lit at the time of the stabbing, it is apparent from his statements to the Department and his testimony at hearing that he could see his assailant well enough to describe him in some detail, and he knew more about how the stabbing occurred than he told police. Under these circumstances, I am unable to find that applicant fully cooperated with the police. I also do not find any basis for concluding there was good cause for applicant's failure to cooperate with police.

Accordingly, I must conclude that applicant is not entitled to crime victims compensation under the eligibility criteria set forth in ORS 147.015.¹

PROPOSED ORDER

I recommend that the July 13, 1994 Findings of Fact, Conclusions and Order of the Department of Justice Crime Victims Compensation Fund, as reconsidered September 19, 1994, be affirmed.

¹ Given my conclusion, it is unnecessary for me to address the Department's third reason for denying compensation, *i.e.*, that applicant failed to show that his injury was not substantially attributable to his own wrongful act or substantial provocation of the assailant.

May 1, 1995

Cite as 47 Van Natta 795 (1995)

In the Matter of the Compensation of
ROBERT G. EDWARDS, Claimant
 WCB Case No. 92-05991
 ORDER ON REVIEW
 Estell & Associates, Claimant Attorneys
 Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee McCullough's order that upheld the insurer's partial denial of claimant's claim for an L5-S1 disc condition, based on a conclusion that the claim is precluded by former adjudication. Claimant renews his contention that the insurer's claim processing was unreasonable. The insurer has moved the Board for an order dismissing claimant's request for review, based on claimant's failure to timely file his appellant's brief. On review, the issues are motion to dismiss, *res judicata*, and compensability (if the claim is not precluded). We affirm.

FINDINGS OF FACT

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

Claimant did not have an opportunity to litigate the L5-S1 disc herniation compensability issue in the prior proceeding, WCB Case No. 91-12120.

The prior judgment in this matter, in WCB Case No. 91-12120, which dismissed claimant's request for hearing for lack of jurisdiction, was not a final judgment "on the merits" for purposes of claim preclusion. See *Robert G. Edwards*, 44 Van Natta 2368 (1992).

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

The insurer has moved the Board for an order dismissing claimant's request for review, based on claimant's failure to timely file his appellant's brief. However, the filing of briefs is not

jurisdictional. OAR 438-11-020(1). Consequently, the insurer's motion to dismiss claimant's request for review on this basis is denied. See Bonnie A. Heisler, 39 Van Natta 812 (1987).

Claim Preclusion

A May 13, 1991 Determination Order closed claimant's claim for an April 27, 1990 low back strain and awarded temporary disability and 14 percent unscheduled permanent disability. Claimant requested reconsideration, contending that the claim was prematurely closed or, alternatively, requesting additional permanent disability. An Order on Reconsideration affirmed the Determination Order. Claimant requested a hearing.

A prior referee found that the Hearings Division lacked jurisdiction to address the premature closure and extent issues raised by claimant. On review, the Board affirmed the prior referee's order. Robert G. Edwards, 44 Van Natta 2368 (1992). The Board's order became final.

Meanwhile, claimant requested a hearing contesting the insurer's partial denial of claimant's L5-S1 disc condition. The present Referee held that the claim for an L5-S1 disc condition is precluded by the prior litigation. We disagree that claimant is precluded from contesting the insurer's partial denial of his L5-S1 disc condition. Nevertheless, on the merits of the claim, we find that the condition is not compensable.

The rule of claim preclusion is that, if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. See Restatement (Second) of Judgments at 17-19, 24 (1982); see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986). In addition, to have preclusive effect, the final judgment in the prior litigation must be a judgment on the merits of the claim.

"It is true, as a general proposition, that for a judgment to effect a preclusion of further litigation based on the same claim, it must be a final judgment 'on the merits.' Sibold v. Sibold, 217 Or 27, 32, 340 P2d 974 (1959); Swingle v. Medford Irr. Dist., 121 Or 221, 253 P 1051 (1927). The term 'on the merits' connotes a final definitive decision as to the substantive validity of plaintiff's cause of action, in contrast to a ruling based wholly upon a procedural aspect of the case. Thus, where a court dismisses a plaintiff's action on a matter of procedure -- e.g., improper venue, lack of jurisdiction, or nonjoinder of an essential party -- without ruling as to the substantive validity of plaintiff's claim for relief, that dismissal will not generally be *res judicata* so as to preclude subsequent action based on the same claim. See Restatement (Second) of Judgment section 20 [(1981)]."

Rennie v. Freeway Transport, 294 Or 319, 330-331 (1982) (emphasis added).

In Hellesvig v. Hellesvig, 294 Or 769, 776 (1983), the Court distinguished Rennie, *supra*, in the following manner:

"In Rennie we held that a prior judgment barred on *res judicata* grounds a plaintiff's assertion of a related claim in the subsequent proceeding, notwithstanding the fact that the prior judgment could have been based on a finding of a lack of subject matter jurisdiction, where the claim asserted nonetheless could have been finally adjudicated in the prior proceeding. 294 Or at 332-333. Here, in contrast, the trial court's holding in the prior proceeding that it did not have jurisdiction to adjudicate plaintiff's partition claim effectively prevented plaintiff from having the merits of his claim addressed and resolved there."

Therefore, the Hellesvig court held that the prior judgment, "being merely a procedural dismissal," did not bar the plaintiff's reassertion of the same claim in the separate and subsequent proceeding. *Id.*

In our view, the present case is more like Hellesvig than it is like Rennie, because the prior judgment dismissing claimant's hearing request for lack of jurisdiction effectively prevented claimant from having the merits of his claim addressed and resolved at that hearing. Thus, the prior referee's

order and the Board's order affirming that order did not constitute a judgment on the merits for purposes of claim preclusion.¹

Compensability

Claimant bears the burden of proving that his L5-S1 disc condition is compensably related to his April 27, 1990 lifting injury at work. See ORS 656.005(7)(a). Considering the passage of time since the injury and the number of possible explanations for claimant's current need for treatment, we conclude that the causation issue is a complex medical question which must be resolved by expert evidence. See Barnett v. SAIF, 122 Or App 279 (1993). In evaluating the medical evidence, we rely on those opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983).

The medical evidence concerning causation is provided by Dr. Mitchell, treating physician, Dr. Malos, consulting neurosurgeon, and Drs. Wilson, Coletti, Platt, and Dineen, examining physicians. Drs. Mitchell and Malos opined that claimant's current L5-S1 disc problem is related to the April 1990 work injury, based on claimant's history regarding his symptoms and the fact that claimant has a herniated disc, visible by MRI. Specifically, Drs. Mitchell and Malos relied on their understanding that claimant did not have low back problems prior to the May 1990 lifting incident, did have such problems since that incident, and had no intervening injury which might explain his symptoms and/or his disc condition. (See Exs. 29, 45, 55-1, 55A-3).

The treating doctors' history is incomplete. Claimant testified that he suffered two incidents involving his low back after the lifting incident at work and before the herniated disc at L5-S1 was discovered. On or about May 15, 1990, at home, claimant's nephew jumped on claimant's back from a couch and claimant experienced immediately increased low back pain. (See Tr. 32-35, 49-52). Claimant told his then current treating chiropractor the next day that the pain associated with this incident was so severe that he "thought it would bring him to his knees." (Ex. 2-1). Because claimant apparently neglected to tell his current treating and examining physicians about this incident, they were unable to evaluate its potential or actual causal contribution to claimant's current low back problems.

In addition, in June 1990, claimant was involved in a motor vehicle accident (MVA) which caused increased low back symptoms. (Ex. 2-2; Tr. 36-37, 53). Contemporaneous medical reports describe the MVA-related injury as an "aggravation" of the April 1990 work injury. (Ex. 10A). There is evidence, provided by Dr. Wilson, neurologist, indicating that the MVA may have caused claimant's L5-S1 disc condition. (Ex. 58-45-46).

Drs. Mitchell and Malos first examined claimant months after his April 1990 work injury, his May 1990 incident at home, and the June 1990 off-work MVA. Neither doctor indicated awareness of the May 1990 off-work incident. Although Dr. Mitchell reviewed the examining physicians' reports describing the June MVA, he stated, without discussion, that no cause other than the April 1990 work incident has ever been "proposed" for claimant's current low back problems. (Ex. 45). Dr. Malos agreed, without mentioning either off-work injury. (Ex. 55A-3). Under these circumstances, we cannot

¹ "To entitle a party successfully to invoke the plea of *res judicata* the decision of a prior suit or action between the same parties must have been rendered upon the merits of the controversy: [citations omitted.]

"The judgment is upon the merits when it amounts to a declaration of the law as to the respective rights and duties of the parties, based on the ultimate facts or state of facts disclosed by the pleadings, and evidence upon which the right of recovery depends, irrespective of formal, technical, or dilatory objections or contentions : 5 Words & Phrases, 4494."

Crowe v. Abraham, 86 Or 99, 103 (1917).

See Pruitt v. Muldrick, 39 Or 353, 358 (1901) (quoting Mr. Justice Field in Hughes v. United States, 71 U.S. (4 Wall.) 232); Hughes v. Walker, 14 Or 480, 483 (1887) (Where the county court never considered the merits of the controversy, or rendered any judgment affecting the same, but simply dismissed the plaintiff's action, the judgment is not a bar).

say that the opinions of Drs. Mitchell and Malos are well-reasoned or based on accurate and complete histories. Accordingly, we decline to rely on those opinions. See Somers v. SAIF, supra; Weiland v. SAIF, supra. There is no other medical evidence relating claimant's L5-S1 disc condition to his work injury². Accordingly, we conclude that claimant has not carried his burden of proof.

ORDER

The Referee's order dated July 8, 1994 is affirmed.

² Drs. Wilson, Coletti, Platt, and Dinneen opined that claimant's current low back complaints are not related to his disc condition, based on examination inconsistencies. (Exs. 25, 46, 58-37). Moreover, claimant told Dr. Wilson, neurologist, that the MVA did not affect his low back. (Exs. 25-2-6, 46-3, 58-43, 58-52-55), but contemporaneous reports from Dr. DeShaw, treating chiropractor, indicate that it did (Exs. 2-2, 10A).

May 1, 1995

Cite as 47 Van Natta 798 (1995)

In the Matter of the Compensation
YEVGENIY GAYVORONSKIY, Applicant
WCB Case No. CV-94011
ORDER ON RECONSIDERATION (CRIME VICTIM ACT)
Mary H. Williams, Assistant Attorney General

On March 31, 1995, Special Hearings Officer Keith Kekauoha issued Findings of Fact, Conclusions and Proposed Order which affirmed the Department of Justice Crime Victims Compensation Fund's Order on Reconsideration dated September 19, 1994 that denied applicant's claim for crime victims compensation. On our own motion, we have reviewed this matter, and although we agree with the proposed order's affirmance of the denial of compensation, we modify its findings and conclusions as follows.

FINDINGS OF FACT

At about 12:30 a.m. on February 24, 1994, applicant completed his work shift as a production worker for a manufacturing firm. He caught a ride home with a co-worker, Viktor Vetkov, who lives in an apartment near applicant's apartment. Their apartments are about a 40-minute drive from their work place. During the drive home, applicant drank a few beers. They apparently stopped at a 7-11 store for a couple of minutes before continuing home. They arrived at the parking lot near their apartments, and applicant continued to drink more beers in the car.

After an undetermined period of time, Vetkov went home to his apartment. Applicant also headed to his own apartment, but he remembered leaving something in the car and returned to the parking lot to retrieve it. At the time, applicant was very intoxicated.

The events that followed are in dispute. Applicant reported to police that, when he returned to the parking lot, he was stabbed by someone. He reported that he did not know what happened, how the stabbing happened or who attacked him. Applicant could give no description of the assailant. (Ex. 18-3 & 4).

However, in written statements to the Department, applicant reported that a man asked him for money and, when applicant said he had no money, the man got mad and stabbed him. Applicant reported that he lost consciousness immediately and did not know how long he had been lying in the parking lot before he regained consciousness. (Exs. 22-2, 28-1).

It is undisputed that, after the stabbing, applicant went to Vetkov's apartment. Vetkov immediately called 911, and police and ambulance were dispatched to the apartment at about 3:30 a.m. When the ambulance crew arrived, applicant was diagnosed with a stab wound to the abdomen. He was oriented and obeyed commands. He was conscious while being transported to the hospital. His blood alcohol level was .132 at approximately 4 a.m. Applicant underwent abdominal surgery and was discharged on February 27, 1994. The District Attorney's office has been unable to locate any suspects.

In March 1994, applicant filed a request for crime victim's compensation with the Department. After investigating the claim, on July 13, 1994, the Department issued Findings of Fact, Conclusions and Order denying the claim for compensation. The Department concluded that, because of applicant's intoxication level and his conflicting statements regarding the circumstances surrounding the stabbing, applicant had failed to prove that: (1) he was the victim of a compensable crime; (2) he had cooperated fully with law enforcement officials; and (3) his injury was not substantially attributable to the applicant's wrongful act or substantial provocation by applicant.

Applicant requested reconsideration of the Department's order. By Order on Reconsideration dated September 19, 1994, the Department adhered to its denial of compensation, reasoning that applicant's version of what happened from the time Vetkov left him in the parking lot until he appeared at Vetkov's apartment with a stab wound, was inconsistent with ambulance, medical and police reports in the record.

Applicant requested a hearing contesting the Department's reconsideration order. At the March 3, 1995 hearing before Special Hearings Officer Kekauoha, applicant testified that, as he was returning to the car in the parking lot, a man called to him. Applicant said that he turned around to face the man, who then shouted something to him. Applicant was not sure if the man was demanding money. Applicant said he was then stabbed and recalled nothing more until he regained consciousness. He did not know how long he was lying on the ground before he regained consciousness and walked to Vetkov's apartment.

CONCLUSIONS OF LAW AND OPINION

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

By proposed order dated March 31, 1995, Special Hearings Officer Kekauoha affirmed the Department's Order on Reconsideration. Contrary to the Department's reasoning, however, the Special Hearings Officer found sufficient evidence to prove that applicant was the victim of a compensable crime. Nevertheless, because he found that applicant had not fully cooperated with police in the investigation of the stabbing, the Special Hearings Officer concluded that applicant was not entitled to compensation under the eligibility requirement in ORS 147.015(3).

We disagree with the Special Hearings Officer's finding that applicant has established he was the victim of a compensable crime. A "compensable crime" is defined by ORS 147.005(4):

"'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."

The Department contended that it had insufficient information from which to conclude that applicant was the victim of a compensable crime. Specifically, the Department found claimant's recollection of the events surrounding the stabbing to be unreliable. Based on applicant's timecard at work, the Department determined that applicant completed his work shift at 12:30 a.m. Further, based on the undisputed fact that applicant's apartment was about a 40-minute drive from work, the Department found that applicant would have arrived at the parking lot by 1:30 a.m. If, as applicant stated to the Department, he had been stabbed shortly thereafter, the Department reasoned that applicant would have had to be lying on the ground unconscious for approximately two hours. The Department also reasoned that, based on applicant's blood alcohol level of .132 at 4 a.m., and normal dissipation rates, applicant must have been consuming more alcohol than he admitted to the Department.

The Special Hearings Officer found that the aforementioned inconsistencies were adequately explained by applicant's testimony that, after he arrived at the parking lot with Vetkov, he continued drinking in the parking lot for an undetermined period of time. Applicant testified that he did not immediately walk home after arriving at the parking lot, but rather, remained there for a period of time after 1:30 a.m.

We find, however, that applicant's testimony is unreliable. In this regard, we agree with the Department that there are inconsistencies in applicant's various reports concerning the events surrounding the stabbing. Although applicant testified at hearing that he remained in the parking lot after work and continued drinking before he and Mr. Vetkov walked to their respective apartments, there is no prior record that this information was provided to the police or the Department.

Furthermore, when applicant reported the stabbing to police, he said that he did not know what happened, how it happened, or who attacked him. He also said he saw no one. (Ex. 18-4). Applicant gave no description of the assailant to police. (Ex. 18-3). However, in statements to the Department, applicant had more information. He reported that a man asked for money and, when applicant said he had none, the man became angry and stabbed him. (Exs. 22-2, 28-1). At hearing, applicant had still more information about his assailant. He recalled that the assailant was a man who was a head taller than applicant and much stronger. Although applicant noted that the parking lot was not lit at the time of the stabbing, it is apparent from his statements to the Department and his testimony at hearing that he could see his assailant well enough to describe him in some detail, and he knew more about how the stabbing occurred than he told police.

Finally, applicant reported to the Department that he immediately lost consciousness after the stabbing. However, hospital emergency room notes show that applicant denied any loss of consciousness. (Ex. 32-2).

We recognize that applicant primarily speaks Russian and does not have a good command of English, which may explain the inconsistencies in applicant's reports to police and the Department. However, applicant's responses to the Department's inquiries were written in Russian and translated by the Department, and an interpreter was provided at hearing. In addition, at the time of hearing, applicant was in receipt of the entire documentary record, including the police and Department reports. Yet, he did not contest the information provided in those reports. Therefore, we are inclined to believe that the police and Department reports provide true and accurate accounts of applicant's statements to police and the Department.

Given the inconsistencies noted above, we view applicant's testimony with caution, particularly given the absence of any corroborating evidence. Mr. Vetkov, for example, was apparently the last person to see applicant prior to the stabbing. He could have corroborated applicant's testimony that applicant had continued drinking in the parking lot after arriving there at or about 1:30 a.m., and that both he and the applicant went to their apartments sometime later. Yet, Mr. Vetkov was not called to testify. Accordingly, we decline to rely on applicant's uncorroborated, unreliable testimony, and conclude that there is insufficient information in the record to find that applicant was the victim of a compensable crime.

Based on the aforementioned inconsistencies between applicant's statements to police, the Department and at hearing, we also do not find that applicant fully cooperated with police. In addition, we find no basis for concluding there was good cause for applicant's failure to cooperate with police.

Accordingly, we conclude that applicant is not entitled to crime victims compensation under the eligibility criteria set forth in ORS 147.015.

IT IS SO ORDERED.

Board Member Hall dissenting.

The majority concludes there is insufficient information to find that applicant was the victim of a compensable crime and that he fully cooperated with police. I disagree and, therefore, dissent.

From this record, it is evident that applicant is an immigrant with very poor English language skills. The majority relies upon inconsistencies in the record between applicant's statements to police and those to the Department and at hearing (*i.e.*, the time frame and varying degree of details concerning the assault) to conclude that applicant was not the victim of a crime. Regardless of inconsistencies, applicant was stabbed in the stomach and has consistently stated to police, to the Department, and to the hearings officer that he was stabbed by an assailant unknown to applicant and without provocation. Applicant's history, in that regard, stands unrefuted. Where is there any evidence that applicant was other than a victim of a crime? The majority erroneously translates inconsistencies in history into a conclusion that applicant's stabbing was not even the result of a crime.

As the record reflects, applicant was questioned by police soon after the stabbing and before he was transported to the emergency room, and while he was heavily intoxicated. When questioned, he had a stab wound in the abdomen. Under those circumstances, should we be surprised if applicant had little useful information to give to police? Nevertheless, he did answer all of their questions. There is no evidence in this record that applicant failed or refused to fully cooperate with authorities. The police report certainly does not reflect any statement by the police that they felt applicant was uncooperative. It appears that the police interview consisted of a few specific questions to which applicant responded. On this record, applicant has carried his burden of fully cooperating with authorities.

Since the day of the stabbing, applicant has recalled more details regarding the events surrounding the assault. The majority penalizes applicant, concluding that the varying degree of details somehow demonstrates a failure to cooperate with police. However, I would find that the details are consistent with applicant's statements to the police that he was stabbed by a stranger without provocation. Given the traumatic circumstances at the time the police questioned applicant, I would find that applicant fully cooperated by answering their questions. Again, there is no evidence that applicant refused to answer their questions or that he was anything other than a victim of a crime. Based on this record, applicant has carried his burden of proof. For these reasons, I would reverse the Department's denial of crime victims compensation.

May 1, 1995

Cite as 47 Van Natta 801 (1995)

In the Matter of the Compensation of
RON M. MATTIOLI, Claimant
WCB Case No. 94-05445
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Hall, Turner-Christian and Haynes.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's denial of claimant's claim for a right index finger injury; and (2) declined to award a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant has worked for the employer since October 1993. On February 1, 1994, claimant forgot his lunch. He decided to remain on the employer's premises and have a sandwich from the vending machine located in the employer's cafeteria. While trying to remove a sandwich from the vending machine, claimant's finger got caught in the machine. His finger was injured and he sought treatment at the end of the work day.

Claimant is not paid for his lunch hour. He clocks out for the lunch hour and clocks back in after his lunch hour has ended. He is free to leave the premises during the lunch hour.

SAIF denied compensability of the claim on March 31, 1994.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's injury did not arise out of the course and scope of his employment. The Referee further concluded that there was not a sufficient relationship between claimant's injury and his employment. We disagree.

ORS 656.005(7)(a) provides that a "compensable injury" is an injury arising out of and in the course of employment requiring medical services or resulting in disability or death[.] "In the course of employment" concerns the time, place, and circumstances of the injury; "arising out of employment" tests the causal connection between the injury and the employment. Norpac Foods v. Gilmore, 318 Or 363, 366 (1994). In assessing whether there is a sufficient causal link between a claimant's injury and employment, part of the inquiry is whether what occurred was part of the anticipated risk of employment. Henderson v. S.D. Deacon Corp., 127 Or App 333, 338 (1994).

Here, we conclude that it was anticipated that claimant and other employees would use both the employer's lunchroom and the vending machines provided by the employer. We find that claimant's injury arose in the course of employment, as it occurred during lunch hour on the employer's premises, and claimant was injured by a vending machine provided by the employer. Furthermore, the fact that claimant was injured in an unusual manner does not mean that the injury did not arise out of his employment. Claimant was not violating any policy of the employer by using the vending machine on his lunch break. To the contrary, the employer provided both the lunchroom and the machine, with the reasonable expectation that the facility would be used by its workers at noon. Therefore, an injury resulting from that machine should be considered no different than an injury resulting from a slip and fall on the lunchroom floor.

Finally, we agree with claimant that this case is also controlled by Clark v. U.S. Plywood, 288 Or 255, 263 (1980). In Clark, a worker was killed during his lunch break while attempting to retrieve his lunch from the top of a hot glue press. The Court held that lunch time injuries are normally compensable if they occur on the premises and arise from premises' hazards such as building collapse, tripping on a hole in the floor or falling on slippery steps. The Court also stated that conduct which an employer expressly authorizes and which leads to the injury of an employee should be compensated whether it occurs in a directly related work activity or in conduct incidental to the employment. Id. at 267.

In the present case, we find that claimant's injury occurred on the premises and arose from a premise hazard. Furthermore, although the injury may not have been a "directly related work activity," the Clark Court also recognized that conduct incidental to the employment, such as lunch hour injuries, can be compensable. Under the circumstances, we conclude that claimant's injury arose out of and in the course of employment. Furthermore, because that injury required medical services and resulted in disability, the injury is compensable. ORS 656.005(7)(a). Accordingly, we reverse that portion of the Referee's order.

Penalties and Attorney Fees

Claimant contends that SAIF's denial is unreasonable. However, claimant has provided no reasoning to support his contention. Furthermore, after considering the fact that claimant was on an unpaid lunch break and that he apparently informed SAIF's claim examiner that the injury was his "own" mistake on his "own" time, (see Ex. 6), we conclude that SAIF's denial was not unreasonable. Therefore, we do not find a basis for an award of a penalty and a related attorney fee.

Claimant is entitled to an assessed attorney fee for his counsel's services at hearing and on review concerning the issue of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is \$3,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 31, 1994 is reversed in part and affirmed in part. The SAIF Corporation's denial of March 31, 1994 is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of \$3,000, to be paid by SAIF. The remainder of the Referee's order is affirmed.

Board Member Haynes dissenting.

Because I find that claimant's injury did not occur in the course and scope of his employment, I respectfully submit my dissent in this case. First, I note that, in addition to relying on Norpac, Inc. v. Gilmore, supra, the Referee also analyzed this case under the factors set forth in Mellis v. McKeown, Hanna, Griswold, 74 Or App 571, rev den, 300 Or App 249 (1985). I agree with her analysis that the only factors weighing in favor of compensability are: (1) that the activity (i.e., claimant's use of the lunchroom) was anticipated by the parties; and (2) the injury occurred on the employer's premises. Accordingly, the factors concerning: (1) benefit to the employer (which, if any, was minimal); (2) whether the employee was paid for the activity (claimant was not paid for his lunch hour), and (3) whether the risk was an "ordinary risk of, and incidental to, the employment" (claimant worked repacking merchandise, therefore, a finger injured in a vending machine was not an ordinary risk of, or incidental to, his employment), all weigh against compensability.

Furthermore, I do not find that the Gilmore or Clark cases cited by the majority support compensability. Gilmore stresses that there must be a causal connection between the injury and the employment. Here, I do not find a connection between claimant's lunchtime vending machine injury and his employment as a packaging person. Additionally, the Clark case states that lunch time injuries will normally be compensable if they arise from "premises' hazards" such as a building collapse, a hole in the floor or slippery steps. In the present case, the contents of the offending machine may well be considered a hazard; however, I do not find that the machine itself (absent any jagged glass doors or live electrical wires) constitutes a "hazard." The Court has provided examples of hazards including a hot glue press and the collapse of a building, etc., but has not seen fit to include a vending machine on that list.

Finally, I note that the Form 801 describes claimant's accident as occurring because the "sandwich was stuck and (claimant) reached in the machine and banged his finger inside." (Ex. 5). Additionally, claimant apparently informed a claims examiner that he did not want to make a workers' compensation claim for the injury as "it was his own stupid mistake on his own time." (Ex. 6).

I conclude that claimant's initial reaction was correct. This claim should have been made to claimant's personal insurance company. The result of the majority's decision in this case is that virtually any injury on an employer-owned lunch premise will be compensable. Accordingly, I find it unlikely that employers will enthusiastically continue to provide such amenities for their employees. For the aforementioned reasons, I respectfully dissent from the majority's opinion.

May 1, 1995

Cite as 47 Van Natta 803 (1995)

In the Matter of the Compensation of
JON C. MEILING, Claimant
WCB Case No. 94-07033
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Thye's order that declined to award a penalty-related attorney fee under ORS 656.382(1) for the SAIF Corporation's alleged failure to comply with OAR 436-10-070. On review, the issue is attorney fees.

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

On review, claimant seeks an attorney fee under ORS 656.382(1) arguing that SAIF unreasonably resisted the payment of compensation by failing to follow the procedures set out in OAR 436-10-070. The Referee concluded that, even if SAIF failed to follow the procedures set forth in OAR 436-10-070, SAIF's actions did not amount to unreasonable resistance to the payment of compensation because SAIF accepted claimant's surgery claim within the 90 days allowed by statute. We agree.

Claimant sustained a compensable crush injury to his right foot in October 1986. On April 14, 1994, Dr. Berselli, claimant's attending physician requested authorization from SAIF for right foot surgery. SAIF received the surgery request on April 18, 1994. SAIF arranged for Dr. Woll to examine claimant in order to determine whether the proposed surgery was reasonable and necessary and related to claimant's accepted injury. There is no evidence in the record that SAIF notified Dr. Berselli of this consultation. Dr. Woll examined claimant on May 31, 1994 and reported to SAIF that the industrial injury was the major cause of claimant's current condition and that the proposed surgery was appropriate.

On July 11, 1994, within 90 days of its receipt of the surgery claim, SAIF notified the Board and claimant's attending physician that it was recommending that claimant's claim (which was in the Board's "own motion" jurisdiction) be reopened for surgery. On July 15, 1994, the Board issued an order authorizing reopening of the claim to provide temporary total disability beginning the date of hospitalization.

OAR 436-10-070 sets out a procedure whereby an insurer may require an independent consultation with a physician of its choice, when elective surgery is recommended by an attending or consulting physician. Under the rule, the insurer must notify the physician who provided notice of intent to perform surgery within 7 days whether or not a consultation is desired. If a consultation is desired, it must be completed within 28 days. The insurer is required to notify the surgeon of the consultant's findings within 7 days of the consultation. If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the attending physician, the insurer may request director review.

Here, SAIF did consult with Dr. Woll concerning the surgery proposed by Dr. Berselli. However, SAIF apparently did not follow the procedure set out in OAR 436-10-070. Because the surgery claim was accepted within 90 days, we agree with the Referee that SAIF's apparent failure to comply with the notice requirements in OAR 436-10-070 did not constitute unreasonable resistance to the payment of compensation.

Such a conclusion does not render the aforementioned rule meaningless as claimant asserts. First, had the insurer neglected to timely accept or deny the surgery claim, any violation of the administrative rule would also have been considered in evaluating the reasonableness of the insurer's conduct. Moreover, ORS 656.745 and OAR 436-10-130(6) authorize civil penalties assessable by the Director against insurers who fail to follow medical services rules. OAR 436-10-130(6) provides:

"Insurers who violate these rules shall be subject to the penalties in ORS 656.745 of not more than \$2,000 for each violation or \$10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation. If the director finds any insurer in violation of OAR * * * 436-10-070 * * * civil penalties may be imposed."

ORDER

The Referee's order dated October 3, 1994 is affirmed.

May 1, 1995

Cite as 47 Van Natta 804 (1995)

In the Matter of the Compensation of
BOBBY G. MOOSE, Claimant
 WCB Case No. 94-07296
 ORDER ON REVIEW
 Willner & Heiling, Claimant Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Hoguet's order which declined to award a penalty or attorney fee for the insurer's allegedly unreasonable claim processing. On review, the issues are claim processing, penalties and attorney fees.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated October 7, 1994 is affirmed.

Board Member Hall specially concurring.

The issue in this case is whether it was unreasonable for the insurer's claims examiner to approach claimant, whom she thought to be unrepresented, with a "lowball" settlement offer. The Board affirms the Referee's finding that there is no basis for a penalty or attorney fee on the evidence in this record. While I agree, on this record, that claimant has not proven that the insurer's settlement offer was unreasonable, I write separately to raise concerns about settlement offers.

This claim was in open status in May 1994 when the insurer approved surgery for claimant's compensable L4-5 disc herniation. On June 1, 1994, a new claims examiner took over responsibility for claimant's file. Claimant's present attorney sent the insurer's claims department a letter on June 6, 1994, advising that he was now representing claimant. The insurer received the letter on June 8, 1994.

On June 13, 1994, the claims examiner sent claimant a letter offering to settle the claim for \$12,000. The claims examiner did not copy claimant's counsel and testified that she was unaware of claimant's representation when she sent the letter. She was aware, however, that surgery had been authorized. The Referee determined the claims examiner to be a credible witness.

ORS 656.331(1)(b) prohibits an insurer or self-insured employer from contacting a worker without giving prior or simultaneous written notice to the worker's attorney if the contact "affects the denial, reduction or termination of the worker's benefits." (emphasis supplied). Although the claims examiner's letter does not explicitly state that the settlement offer was for a claim disposition agreement, there is no evidence of a bona fide dispute regarding the compensability of claimant's current condition. See ORS 656.289(4). Thus, it is safe to assume that the settlement offer was for a CDA.

Inasmuch as a CDA does concern the release of benefits apart from medical services, the claims examiners contact with claimant did "affect" the "termination" of the worker's benefits. Therefore, I would find that the claims examiner's conduct violated ORS 656.331, even though she testified that she was unaware of claimant's representation. Because it is clear that the insurer had notice that claimant was represented when the claims examiner sent her June 13, 1994 settlement offer, I agree with claimant that the claims examiner should be charged with at least constructive knowledge of claimant's representation by counsel. Cf. Nix v. SAIE, 80 Or App 656 (1986), rev den 303 Or 158 (1987) (employer's knowledge imputed to insurer).

The record indicates that all benefits have been paid to claimant. While ORS 656.382(1) would provide the basis for the award of an attorney fee for unreasonable resistance to the payment of compensation, I find insufficient evidence in this record that the insurer's settlement offer was unreasonable.

Claimant's counsel asserts that claimant's claim has a value of \$200,000 and that the insurer's "lowball" offer of \$12,000 was patently unreasonable. Given that claimant has undergone multiple surgeries and had requested vocational assistance, there is probably merit in counsel's assertion. However, we must decide this case based on the record not subjective impressions or assertions. Because the record lacks evidence as to the value of the claim, there is insufficient evidentiary basis to conclude that the settlement offer was unreasonable. Accordingly, under the particular circumstances of this claim, I am unable to conclude that the insurer unreasonably resisted the payment of compensation. Under the appropriate circumstances, however, the Board does have the legal authority to assess an attorney fee under ORS 656.382(1) for an unreasonable CDA settlement offer.

In the Matter of the Compensation of
DOUGLAS B. ROBBINS, Claimant
WCB Case No. 92-13962
ORDER ON REVIEW
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of that portion of Referee Hoguet's order which denied claimant's request to reclassify his nasal condition claim from nondisabling to disabling. The self-employed employer cross-requests review of that portion of the Referee's order which set aside its denial of claimant's current rhinitis condition. On review, the issues are reclassification and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except his ultimate finding of fact that claimant's perennial rhinitis condition had essentially remained unchanged since October 1987. In addition, we find that claimant's accepted nasal condition is nasal vestibulitis. Claimant's current nasal condition has been diagnosed as allergic rhinitis.

CONCLUSIONS OF LAW AND OPINION

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

Subsequent to the Referee's order, we disavowed our decision in Robert E. Wolford, 45 Van Natta 435 (1993) in Donald G. Stacy, 45 Van Natta 2360 (1993), aff'd mem Stacy v. Corrections Division, 131 Or App 610 (1994). In Stacy, we held that for purposes of ORS 656.273(4)(b) and 656.277, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought. Stacy, 45 Van Natta at 2361. In this case, the "date of injury" is the date claimant first sought medical treatment. Therefore, the one year time limit for requesting reclassification began November 12, 1987. We otherwise agree with the Referee's conclusion that claimant failed to challenge his claim classification within one year from his date of injury.

Compensability of Claimant's Current Condition

The Referee relied on the opinion of Dr. Baker, allergist, to conclude that claimant's compensable condition had not changed and continued to be the cause of his current condition. The employer relies on the opinions of Drs. Long, Milligan, and Morton to contend that claimant's current nasal condition is not compensably related to his accepted condition. We find that claimant's current nasal condition is different than his accepted nasal condition and that his current condition is no longer related to his accepted condition.

Claimant worked approximately six weeks in September and October 1987 as a temporary employee for the employer. During his job assignment, at OECO, as an electronics technician, claimant was exposed to various chemicals. On November 12, 1987, claimant sought treatment for nasal problems, including bleeding ulcers in each nostril. Dr. Long diagnosed nasal vestibulitis. On December 18, 1987, Dr. Long noted that claimant's nasal vestibulitis was healing well. (Ex. E7-2). Claimant, however, subsequently developed nasal congestion, particularly in the right nostril. In April 1989, Dr. Long reported that claimant had nasal restriction due to allergic rhinitis and mildly deviated nasal septum. He could not relate claimant's current problem to the chemical exposure in 1987. He recommended allergy testing. (Exs. E7-6, E12). However, claimant canceled the allergy testing.

Dr. Milligan, an otolaryngologist who had previously treated claimant, first saw claimant for his nasal complaints in July 1988. At that time, Dr. Milligan felt that claimant's complaints were due primarily to an inflamed or enlarged turbinate. Dr. Milligan opined that claimant's chemical/MEK exposure in 1987 was not a material contributing cause of his present complaints, because of the nature of the exposure and because claimant had not been exposed to the chemical for over three years. He explained that, in 1987, claimant incurred either a reaction to the chemical irritant or a possible chemical burn. However, noting that the membranes in the nose are very resilient and recover in a timely fashion once the chemical irritant is removed, Dr. Milligan further stated that if claimant's current

problem was due to the 1987 chemical exposure, then he would have expected a bilateral problem. Since claimant's current problem was right-sided, Dr. Milligan opined that some other irritant may be causing claimant's current problems. (Ex. E18).

Dr. Baker, allergist, first saw claimant on September 23, 1991. He opined that claimant now had a chronic reaction with onset of chronic nasal problems after exposure to MEK. (Exs. E19). Dr. Baker, however, subsequently opined that, until allergy testing ruled out an allergic component to his nasal congestion, based on claimant's history, his problems began in 1987 when he was exposed to chemicals. (Ex. E29).

Dr. Morton examined claimant on October 11, 1991 and diagnosed chronic allergic rhinitis with a history of recurrent sinusitis, very unlikely to have been caused by claimant's degree and duration of MEK exposure. (Exs. E20, 21). Dr. Morton opined that claimant's MEK exposure did not cause his nasal ulcerations in 1987 or his recurrent sinusitis since then. (Ex. E22). Drs. Summers, Baker, and Milligan concurred with Dr. Morton's opinion. (Exs. E26, E27, E28).

When there is a conflict in the medical evidence, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Although claimant considers Dr. Baker his treating physician, we do not give his opinion the usual deference given to the treating physician. Dr. Baker first saw claimant four years after his work exposure. In contrast, Dr. Milligan had treated claimant before his work exposure and also treated claimant from July 1988 until November 1991 for his claimant's nasal condition. Therefore, Dr. Milligan was in a better position to compare claimant's accepted condition with his current condition. See Roff v. Georgia Pacific Corporation, 80 Or App 78 (1986). Dr. Baker also fails to explain why claimant's current nasal problem is only a right-sided problem whereas nasal problem in 1987 was bilateral. Finally, because Dr. Baker's subsequent opinion is contrary to his concurrence with Dr. Morton's opinion and because he offered no explanation for his changed opinion, we do not find his changed opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987).

The preponderance of the persuasive medical opinion establishes that claimant sustained a chemical irritant reaction in 1987 and that claimant's current allergic rhinitis/sinusitis condition is unrelated to his accepted nasal condition. Consequently, claimant has failed to establish that his compensable nasal vestibulitis is or remains the major contributing cause of his current rhinitis/sinusitis condition. ORS 656.005(7)(a)(B); Dietz v. Ramuda, 130 Or App 397 (1994) (the relative contribution of each cause, including the precipitating cause, must be evaluated to determine which is the major cause). Accordingly, the employer's October 26, 1992 denial is reinstated and upheld.

ORDER

The Referee's order dated August 2, 1994 is affirmed in part and reversed in part. That portion of the order setting aside the employer's October 26, 1992 denial is reversed. The October 26, 1992 denial is reinstated and upheld in its entirety. The remainder of the Referee's order is affirmed.

May 1, 1995

Cite as 47 Van Natta 807 (1995)

In the Matter of the Compensation of
RONALD A. SMITH, Claimant
 WCB Case No. 94-01121
 ORDER ON REVIEW
 Francesconi & Busch, Claimant Attorneys
 Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of that portion of Referee Davis' order that set aside its denial of claimant's face and head injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The relevant facts, as found by the Referee and which we have adopted, are as follows. Claimant worked as a bus driver. During a bus stop on Halloween 1993, a passenger named Daryl Barber attempted to board the bus; Barber carried the front end of a baby stroller containing his three-week-old daughter. Claimant told Barber that he could not board the bus with an open stroller and to get off the bus and fold it. When Barber continued to board the bus, claimant put out his hand in front of the stroller and stopped its progress up the aisle. Claimant again told Barber to exit the bus and fold up the stroller. Claimant also reached for a pair of nunchakus he was carrying on the bus and unfastened his seatbelt.

Barber turned away from claimant as if to get off the bus. However, Barber then turned around and hit claimant in the face with his fist. Claimant rose from his seat and a conflict ensued between the two men, during which claimant swung a pair of nunchakus at Barber and struck him. Eventually, the men were pulled apart and Barber exited the bus.

Claimant pinned another passenger who had attempted to break up the fight and held him until police arrived. Claimant also was verbally abusive to police officers who attempted to interview him regarding the incident.

In determining whether claimant's injury from the altercation with Barber arose out of and was in the course of his employment, the Referee applied ORS 656.005(7)(b)(A). That statute provides that "compensable injury" does not include injury "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." The Referee concluded that, although claimant was not the initiator of the physical confrontation, he did participate in the fight following the initial blow by Barber. However, the Referee found that claimant acted in self-defense and, therefore, claimant was not an "active participant" under the statute. Further concluding that the fight was connected to the job assignment and not a deviation from customary duties, the Referee concluded that the claim was compensable.

On review, the insurer asserts that the Referee erred in finding the claim compensable. In particular, the insurer contends that claimant should not prevail under ORS 656.005(7)(b)(A) because he was an "active participant."¹ We agree.

An "active participant" under the statute is one who voluntarily assumes an active or aggressive role in the altercation or has an opportunity to withdraw from the encounter and does not do so. Irvington Transfer v. Jasenosky, 116 Or App 635, 640 (1992). Here, even before Barber hit claimant, claimant brought out his nunchakus and unfastened his seatbelt. After being hit, claimant used the nunchakus to hit Barber. Although claimant characterized the nunchakus as a type used only for "practice," there was testimony by police officers, who viewed claimant's nunchakus, that they were capable of causing serious injury. (Tr. 139-40, 157).

We find that claimant voluntarily assumed an active and aggressive role in the altercation with Barber. In particular, claimant's actions in obtaining the nunchakus and unfastening his seatbelt show that he was prepared to actively participate in any conflict. Furthermore, by swinging the nunchakus, we find proof that claimant was using the nunchakus to strike Barber, rather than ward off Barber's blows or push Barber away from him. Based on these facts, we find that claimant's actions were intended to assault and injure Barber and, thus, went beyond self-defense. Hence, we conclude that he was an "active participant."

¹ We find no merit to claimant's argument that the insurer is prohibited on review from asserting a defense under ORS 656.005(7)(b)(A) because its denial relied on the ground that claimant's injury was not in the course and scope of his employment without specifically citing to the statute. During opening statements, the insurer's attorney argued that claimant was an active participant and thus, by statute, his injuries were outside the course and scope of his employment and not compensable. (Tr. 11-13). There was no objection from claimant's attorney. Thus, even assuming that the scope of the insurer's denial did not include a defense under ORS 656.005(7)(b)(A), we conclude that, by implicit agreement, the parties agreed to litigate the issue and that the Referee properly considered it. See, e.g., Judith M. Morley, 46 Van Natta 882, 883 (1994) (issue of compensability held to be properly considered by the Referee even though not stated in the denial because the parties implicitly agreed to litigate the issue).

We consider the remaining elements to be satisfied in the statute. Claimant's job assignment was to drive a public transit bus. In performing this assignment, there was testimony from his employer's station manager Robert Davie that, when confronted by an unruly passenger, bus operators are to contact the dispatcher for assistance rather than personally handling any such situation. (Tr. 241). Mr. Davie also testified that open strollers were not permitted on the buses, but that operators are also told to reasonably accommodate passengers by allowing them to board the bus and then collapse the stroller. (Id. at 247-48).

We agree with the Referee that claimant's initial actions in attempting to prevent Barber from boarding with the open stroller were connected with his job assignment in that he was following company policy. However, following Barber's refusal to comply with folding the stroller, claimant did not contact dispatch; instead, he physically stopped the stroller, reached for his nunchakus and unfastened his seatbelt. At this point, we consider claimant's conduct to have no connection with his job assignment. We also find a lack of connection between claimant's job assignment and his actions in using the nunchakus against Barber. Therefore, we find that the fight was not connected with claimant's job assignment.

Finally, the record is clear that claimant's customary duties did not include actively participating in fights with bus passengers. Thus, we also find claimant's conduct to be a deviation from his customary duties.

Based on this reasoning, we conclude that the claim is not compensable. ORS 656.005(7)(b)(A).

ORDER

The Referee's order dated September 29, 1994 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

May 1, 1995

Cite as 47 Van Natta 809 (1995)

In the Matter of the Compensation of
KATHLEEN L. WILLIAMS, Claimant
WCB Case Nos. 94-08465 & 94-07255
ORDER ON REVIEW

Welch, Bruun, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of those portions of Referee Hoguet's order that: (1) set aside its denial of claimant's low back injury claim; and (2) set aside claimant's right middle finger injury claim. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

In January 1994, claimant also told Ken Campbell's immediate supervisor, Tim Scott, about the lifting/delivery incident in December 1993. She did not tell her own immediate supervisor about the incident.

We do not adopt the last sentence of the third full paragraph on page 3 or the third full paragraph under ultimate findings of fact on page 4.

CONCLUSIONS OF LAW AND OPINION

We briefly recite the relevant facts. In 1990, claimant experienced a compensable injury to her low back with the same employer. This injury resulted in disc surgery and residual low back and left leg symptoms that wax and wane with activity and for which claimant takes medication.

On December 26, 1993, claimant, an automobile dealer credit officer, hand-carried about 30 to 50 pounds of credit applications, contracts and insurance forms from her fifth floor office to her car in order to deliver them to automobile dealers. Claimant immediately noticed low back tightness and, within the next few days, began to experience pain in the right hip, buttock and leg into the knee, for which she sought treatment. Claimant was initially diagnosed with sacroilitis vs. bursitis, with the possibility of degenerative joint disease. She was treated conservatively. (Exs. 99, 102, 103, 104, 105 and 107).

On March 23, 1994, claimant fell on the sidewalk on her way to work, dislocating her right middle finger. (Exs. 110, 111, 112 and 113). On March 31, 1994, claimant filed a Form 801 for her right hand and right back injuries. (Ex. 115). Claimant attributed her fall to her right leg giving out as a result of the back injury. Id.

On June 13, 1994, the employer denied the right hand [finger] injury claim on the basis that claimant's condition and disability did not arise out of and in the course and scope of her employment. (Ex. 127). On July 1, 1994, the employer denied claimant's right leg and back claim on the basis that the medical evidence did not establish compensability and that the claim was filed untimely. (Ex. 131).

Timeliness of Low Back Injury Claim

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

Compensability of Low Back Injury

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

Compensability of Right Middle Finger Injury

Claimant does not contend that her right finger injury arose out of and in the course of employment. Rather, she contends that her compensable low back injury resulted in her right leg giving way, which caused her to fall and dislocate her finger. Because claimant alleges that her finger injury resulted from the compensable back condition, rather than the original industrial accident itself, in order to prove compensability of the finger claim, claimant must establish that her compensable low back condition was the major contributing cause of her right finger dislocation. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Because of the passage of time between claimant's low back injury and her fall, we find that the causation question is medically complex. Therefore, we require expert medical opinion to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

After our review of the record, we find no medical opinion which establishes that claimant's low back and right leg conditions were the major contributing cause of claimant's fall.

Claimant relies on the opinion of the employer's medical examiner, orthopedist Dr. Dineen. However, although Dr. Dineen opined that claimant's right hand injury was "indirectly" related to claimant's low back injury, we do not interpret his report to express the opinion that the major contributing cause of claimant's hand injury was her low back and right leg condition. (See Ex. 132). Moreover, we do not find his opinion persuasive, because he relies on claimant's history as the basis for his causation opinion. There is no medical evidence documenting a causal connection between claimant's right leg condition and the 1993 fall. Moreover, Dr. Dineen offers no medical analysis of the relationship between claimant's low back condition and claimant's attribution of her fall to a "pinched nerve" in her right leg, a diagnosis which is not supported by the medical record. (See Exs. 99, 102, 103, 105, 107). Consequently, we conclude that claimant failed to carry her burden to prove the compensability of her right finger condition.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, the Referee concluded that a reasonable attorney fee for claimant's counsel's services at hearing for prevailing against the two denials was \$2,200. As we have reversed on the issue of the compensability of the right middle finger claim, we reduce the award for prevailing at hearing to \$1,500. In reducing the Referee's attorney fee award, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that counsel's efforts might have gone uncompensated.

In addition, claimant's attorney is entitled to an assessed fee for services on review for defending the compensability of the low back and right leg injury claim. ORS 656.382(2). After considering the same factors as set forth above, 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 employer. In reaching this conclusion, we have particularly considered the time devoted to the issue of the compensability of the low back and right leg (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 30, 1994 is reversed in part and affirmed in part. That portion of the order that set aside the employer's denial of claimant's right hand (middle finger) injury claim is reversed. The denial is reinstated and upheld. The Referee's \$2,200 attorney fee award for prevailing at hearing is modified to \$1,500, payable to claimant's attorney by the employer. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded \$1,000, payable by the self-insured employer.

May 3, 1995

Cite as 47 Van Natta 811 (1995)

In the Matter of the Compensation
CAROL L. ATHEARN, Claimant
WCB Case No. 95-00791
ORDER OF DISMISSAL
Aller & Morrison, Claimant Attorneys
Lundeen, et al., Defense Attorneys

The Board is in receipt of claimant's April 5, 1995 letter to Referee Galton, as well as her March 6, 1995 letter to the Workers' Compensation Division. Inasmuch as both letters either directly or indirectly refer to Referee Galton's February 10, 1995 Order of Dismissal, we have interpreted claimant's recent submission as a request for Board review of the Referee's order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because we conclude that the request is untimely, the request for review is dismissed.

FINDINGS OF FACT

On January 17, 1995, claimant, through her then-attorney, requested a hearing from the insurer's October 5, 1994 denial. Thereafter, a hearing was scheduled for April 11, 1995.

On February 8, 1995, claimant's attorney submitted a letter to the Referee announcing that claimant was withdrawing her appeal of the insurer's denial. On February 10, 1995, in response to the announcement, the Referee dismissed claimant's hearing request. The order included notice of when (within 30 days) and where (with the Workers' Compensation Board) a request for review of the Referee's order should be filed.

On March 8, 1995, claimant, pro se, mailed, by certified mail, a March 6, 1995 letter to the Workers' Compensation Division. (She also mailed copies of her letter to the employer, its insurer, and their attorney.) Claimant requested that the Division order the insurer to provide reimbursement for the purchase of a hot tub spa.

On March 31, 1995, the Director dismissed claimant's request for Director review. In light of the Referee's February 10, 1995 order dismissing claimant's hearing request from the insurer's denial of the hot tub, the Director determined that exclusive jurisdiction over the dispute rested with the Board.

On April 5, 1995, claimant, pro se, sent a letter to the Referee, which was received by the Board's Portland Hearings Division on April 6, 1995. Submitting a copy of her March 6, 1995 letter to the Workers' Compensation Division, claimant acknowledged that she had directed her appeal to the "wrong [workers' compensation] department." Nevertheless, asserting that she was actively pursuing a review of the Referee's February 10, 1995 dismissal order when she mailed her March 6, 1995 letter to the Division, claimant sought the opportunity to present her case to the appropriate forum.

On April 13, 1995, the Board acknowledged claimant's April 5, 1995 letter as a request for review of the Referee's February 10, 1995 order. Copies of the acknowledgment were mailed to the employer, its insurer, and their attorney.

CONCLUSION OF LAW

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

Filing means the physical delivery of a thing to any permanently staffed office of the Board or the date of mailing. OAR 438-05-046(1)(a). If filing of a request for Board review of a referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id.

Here, the 30th day after the Referee's February 10, 1995 order was March 12, 1995, a Sunday. Therefore, the final day to perfect a timely appeal was Monday, March 13, 1995. See Anita L. Clifton, 43 Van Natta 1921 (1991).

Claimant asserts that her March 6, 1995 letter to the Workers' Compensation Division (Medical Review Unit) constitutes a request for Board review of the Referee's order. Inasmuch as the letter pertains to the insurer's denial of claimant's hot tub spa and does not refer to the Referee's decision, we are not inclined to interpret the letter as an appeal of the Referee's February 10, 1995 dismissal order. Nonetheless, even if we interpreted claimant's letter in such a manner, we would still conclude that the request for review was not timely filed with the Board.

Claimant's March 6, 1995 letter was mailed, by certified mail, to the Workers' Compensation Division (Medical Review Unit) on March 8, 1995, within 30 days of the Referee's February 10, 1995 dismissal order. However, the letter was neither mailed to nor received by the Board until April 6, 1995, when the Portland Hearings Division received it along with claimant's April 5, 1995 letter to the Referee.

Since the Workers' Compensation Division (Medical Review Unit) is not a "permanently staffed office of the Board," the Board's first receipt of claimant's request for review of the Referee's February 10, 1995 order did not occur until April 6, 1995. OAR 438-05-046(1)(a). Inasmuch as April 6, 1995 is more than 30 days from the Referee's February 10, 1995 order, the request must be dismissed as untimely filed. See John R. Johanson, 46 Van Natta 946 (1994) (Filing of request for Board review of a referee's order with the Medical Review Unit of the Workers' Compensation Division does not constitute timely filing with the Board.)

We are mindful that claimant has requested review without benefit of legal representation. We further acknowledge claimant's assertion that she has received misleading information from her prior counsel and Workers' Compensation Division personnel concerning her objections to the insurer's denial. Finally, we realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Nevertheless, instructions for requesting Board review were clearly stated in the Referee's order. In any event, we are not free to relax or ignore a jurisdictional requirement. Alfred F. Puglisi, 39 Van Natta 310 (1987).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEOTA J. DOOLITTLE, Claimant
WCB Case No. 94-03703
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Hall, Turner-Christian and Haynes.

Claimant requests review of that portion of Referee Herman's order that affirmed that portion of an Order on Reconsideration awarding claimant 17 percent (54.4 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The only issue on review is adaptability. Claimant asserts that the Referee erred in concluding that the Dictionary of Occupational Titles (DOT) code that most closely describes claimant's at-injury job is Pet and Pet Supplies Salesperson (retail trade) (DOT 277.357-042), which requires a physical capacity to perform light work. We agree.

Adaptability is based on a comparison of the highest prior strength demands of the worker's jobs during the ten years preceding the time of determination with the worker's maximum residual functional capacity at the time of determination. Former OAR 436-35-310(1) (WCD Admin. Order No. 93-052) (Temp.). In the ten years preceding the time of determination, claimant's most physically demanding job was her job at injury. Therefore, we compare the strength demands of that job with claimant's residual functional capacity to determine her adaptability.

First, we must determine the DOT code for claimant's at-injury job. Although more than one DOT code may arguably describe that job, we must select the title that most accurately describes claimant's work, and that does not ignore significant elements of that work. See William L. Knox, 45 Van Natta 854 (1993) (Board concludes that the claimant's work was "very heavy", where "significant elements" of the claimant's job at injury included work as a material handler, and where the claimant's lifting and handling activities were more than an incidental part of the claimant's job at injury).

Here, claimant's job at injury was working for a retail pet shop. The shop sold fish and birds, and related accessories, as well as cat, dog and bird food, and dog kennels. Claimant's job duties varied. She waited on customers and rang up sales. She also cleaned fish tanks and bird cages. Between customers, she restocked shelves and aisles with merchandise; she also lifted and carried fish tanks, dog kennels, and pet food sacks. She also cleaned the store, which required vacuuming and dusting.

At hearing, claimant testified that she carried 40- to 60-pound fish tanks on a monthly basis (Tr. 10-13); lifted 15- to 40-pound bird cages on a weekly to daily basis (Tr. 13-14); lifted 5- to 40-pound sacks of cat and dog food on a daily basis (Tr. 14-16); lifted 35- to 40-pound dog kennels every few months (Tr. 16); lifted 50- to 80-pound sacks of bird seed on a weekly or bi-weekly basis (Tr. 16-17, 23); and, with assistance, lifted fish tanks and stands that weighed over 200 pounds on a very infrequent basis. (Tr. 21-22). The employer testified that claimant was not required to do some of this lifting, but did not deny that she did it from time to time. (Tr. 30).

Claimant asserts her at-injury strength should have been classified "medium." The "medium" DOT code to which she refers us is Pet Shop Attendant (retail trade) (DOT 410.674-010), which includes work tasks such as feeding and watering animals, cleaning and disinfecting cages, and transferring animals between quarters.¹ The employer urges us to affirm the Referee's conclusion that Pet and Pet Supplies Salesperson (retail trade), a light strength position, most accurately describes claimant's at-injury job. That work tasks described under that code include: selling pets and pet accessories, equipment, food and remedies; feeding and providing water for pets; and cleaning cages and tanks.

¹ Claimant also refers us to several heavy strength DOT codes. Because she does not argue that her at-injury job required heavy strength, we do not consider those codes in analyzing this case.

Both DOT codes apply, in part, to claimant's at-injury job. However, after reviewing the entire record, we are convinced that the DOT code for Pet Shop Attendant (retail trade) more accurately describes claimant's at-injury job.

Particularly, we note that a significant portion of claimant's work involved lifting heavy equipment and stock. We find that this activity was more than an incidental part of claimant's work. See William L. Knox, *supra*. Further, we find that, although several of the work duties of Pet and Pet Supplies Salesperson DOT code apply to claimant, we find that code inapplicable to this case, because it assumes that the salesperson's duties require only light strength. On this record, we find that claimant's at-injury job required more than light strength on a relatively routine basis. In making this finding, we have relied on claimant's essentially un rebutted testimony concerning her lifting and cleaning responsibilities. Accordingly, although claimant's at-injury job involved some work in the "light" category, we conclude that the medium strength DOT code for Pet Shop Attendant (retail trade) most accurately describes that job.

Accordingly, we modify that portion of the Referee's decision affirming the Order on Reconsideration that awarded claimant 17 percent unscheduled permanent disability. Instead, because claimant's at-injury job required medium strength, and she is presently capable of light strength work, her adaptability value is 3. Former OAR 436-35-310(2) (WCD Admin. Ord. No. 93-052) (Temp.). Consequently, she is entitled to total of 29 percent unscheduled permanent disability. Former OAR 436-35-280 (WCD Admin. Ord. No. 93-052) (Temp.).

ORDER

The Referee's order dated July 22, 1994 is modified. In addition to the disability awarded by Order on Reconsideration, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability, giving her a total unscheduled award of 29 percent (92.8 degrees). Claimant's counsel is awarded an approved attorney fee of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, provided the total of fees approved by the Board does not exceed \$3,800.

Board Member Haynes dissenting.

The majority concludes that, by virtue of claimant's occasional medium strength lifting activities at her at-injury job, the medium strength DOT code for Pet Shop Attendant (retail trade) most accurately describes that job. Because I believe that majority has misconstrued the record and the law, I dissent.

Although more than one DOT code may apply to a worker, the Board must determine which title is most applicable. See OAR 436-35-270(3)(g); William D. Knox, 45 Van Natta 854 (1993). The strength requirement of that DOT code governs claimant's adaptability analysis. I believe that the Referee correctly determined that the DOT code for Salesperson, Pet and Pet Supplies (retail trade), a light strength position, is most applicable to claimant.

The record reveals that claimant worked for a pet supply shop; her primary duties were retail sales, cleaning fish tanks, bird cages and the shop itself. Between customers, she restocked merchandise. She also carried 40- to 60-pound fish tanks on a monthly basis (Tr. 10-13); lifted 15- to 40-pound bird cages on a weekly to daily basis (Tr. 13-14); lifted 5- to 40-pound sacks of cat and dog food on a daily basis (Tr. 14-16); lifted 35- to 40-pound dog kennels every few months (Tr. 16); lifted 50- to 80-pound sacks of bird seed on a weekly or bi-weekly basis (Tr. 16-17, 23); and, with assistance, lifted fish tanks and stands that weighed over 200 pounds on a very infrequent basis. (Tr. 21-22).

DOT 277.357-042, the code for Salesperson, Pet and Pet Supplies (retail trade), states:

"Sells pets and pet accessories, equipment, food, and remedies: Advises customer on care, training, feeding, living habits, and characteristics of pets, such as dogs, cats, birds, fish, and hamsters. Explains use of equipment, such as aquarium pumps and filters. Feeds and provides water for pets. Performs other duties as described under SALESPERSON (retail trade; wholesale tr.) Master Title. May clean cages and tanks. *

* * *

The master title states, in part, "Places new merchandise on display."

DOT 410.674-010, the code for Pet Shop Attendant (retail trade), states:

"Performs any combination of the following duties to attend to animals * * * on farms and in facilities, such as kennels, pounds, hospitals, and laboratories: Feeds and waters animals according to schedules. Cleans and disinfects cages, pens, and yards and sterilizes laboratory equipment and surgical instruments. Examines animals for signs of illness and treats them according to instructions. Transfers animals between quarters. Adjusts controls to regulate temperature and humidity of animals' quarters. Records information according to instructions, such as genealogy, diet, weight, medications, food intake, and license number. Anesthetizes, inoculates, shares, bathes, clips, and grooms animals. Repairs cages, pens, or fenced yards. May kill or skin animals, such as fox and rabbit, and pack pelts in crates. * * *"

The DOT code for Salesperson, Pet and Pet Supplies (retail trade) quite closely matches claimant's work duties, the majority of which involved the sale of birds and fish and pet supplies and restocking of merchandise. Although the DOT code does not include all of claimant's lifting activities, the record reveals that most of claimant's work activities fall within the pet and pet supplies job description.

The Pet Shop Attendant (retail trade) DOT code is less applicable to claimant, in that its primary focus is on the intensive care and treatment of animals that require medium strength to maneuver. Claimant's at-injury job involved primarily retail sales of small pets (birds and fish) and animal care products, rather than care of animals requiring medium strength. Consequently, I find that the pet shop attendant job description less representative of claimant's at-injury job.

The majority concludes that, because a "significant portion of claimant's work involved lifting heavy equipment and stock," and because that "activity was more than an incidental part of claimant's work," the Pet Shop Attendant (retail trade) DOT code most accurately describes claimant's at-injury job. In so concluding, the majority runs afoul of OAR 436-35-270(3)(g). That rule defines light work as "[l]ifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds." OAR 436-35-270(3)(g)(B) (emphasis added). "Frequent" means one-third to two-thirds of the time, whereas "occasional" means up to one-third of the time. OAR 436-35-270(3)(g).

The record establishes that claimant lifted more than 10 to 20 pounds; however, at most, she did so occasionally; there is no persuasive evidence that claimant lifted any objects frequently. For that reason alone, I would find that her work required only light strength.

Further, under the rule, medium work requires lifting of up to 50 pounds with "frequent lifting and carrying of objects weighing up to 25 pounds." OAR 436-35-270(3)(g)(C). The record establishes that claimant occasionally -- up to one-third of the time -- lifted objects up to (or even more than) 50 pounds. However, as stated previously, there is no persuasive evidence that claimant frequently -- one-third to two-thirds of the time -- lifted any objects, much less those weighing up to 25 pounds. Accordingly, under the rule, there is no basis for concluding that claimant's at-injury job required medium strength.

In reaching these conclusions, I recognize that the rule does not address the exact scenario presented by this case; viz., work that involves infrequent lifting of heavy objects (and rare lifting of very heavy objects) accompanied by occasional lifting of light- to medium-weight objects. However, aside from the maximum weight lifted, to qualify as a medium strength endeavor under the rule, the work must involve frequent lifting and carrying of objects weighing up to 25 pounds. Because the record does not reflect that level of activity on claimant's part, I would hold that she has failed to establish that her at-injury work required medium strength. Accordingly, I would adopt and affirm the Referee's conclusions that, notwithstanding claimant's infrequent to occasional heavy lifting responsibilities, on the whole, her at-injury work required only light strength and that the most applicable DOT code is Salesperson, Pet and Pet Supplies (retail trade). Because the majority concludes otherwise, I dissent.

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

Reviewed by Board Members Haynes and Gunn.

Albany Retirement Center, Inc. (Albany) requests review of that portion of Referee Thye's order that dismissed its request for hearing. Claimant cross-requests review of that portion of the Referee's order that declined to award his attorney a fee pursuant to ORS 656.382(2). On review, the issues are the propriety of the dismissal order and attorney fees. We remand.

FINDINGS OF FACT

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

At the time of the July 30, 1992 hearing before Referee Lipton, there was an announcement made over the loudspeaker system notifying people to evacuate the building. (Tr. 72; 184). Despite the announcement, the hearing proceeded and Referee Lipton granted a motion by claimant and the SAIF Corporation to dismiss Albany's hearing request. Ms. Proctor, an assistant manager at Albany was present in the hearing room. At the beginning of the hearing, Ms. Proctor had identified herself as an employee of Albany. (Tr. 189).

CONCLUSIONS OF LAW AND OPINION

Because the procedural history of this case is lengthy, we recount the pertinent facts. Claimant, an Albany employee, alleged a compensable injury in August 1991. SAIF denied the claim on the ground that it did not insure Albany at the time of the injury. A Proposed and Final Order of the Department found Albany to be a noncomplying employer. The Department referred the claim to SAIF for processing under ORS 656.054. SAIF first denied and then later accepted the claim.

In a letter written by John A. Sleutel, president of the corporation, Albany requested a hearing challenging SAIF's acceptance of the claim. A hearing was scheduled for July 30, 1992 before Referee Lipton. Prior to the date of hearing, claimant filed a motion to dismiss Albany's hearing request on the grounds that Albany (a corporation) was not represented by an attorney as required by ORS 9.320. A copy of the motion was not sent to Albany; however, Referee Lipton mailed a copy of claimant's motion to Albany on July 21, 1992.

When the July 30, 1992 hearing convened, claimant, his attorney and SAIF's attorney were present. In addition, Ms. Proctor, an assistant manager employed by Albany was present in the hearing room. Although Referee Lipton was aware that an employee of Albany was present in the hearing room, he did not have the impression that Ms. Proctor was there to represent the interests of Albany or John Sleutel. During the hearing, there was an announcement over the loudspeaker informing people to evacuate the building.

In spite of the evacuation announcement, the hearing continued. Claimant, joined by SAIF, moved to dismiss Albany's request for hearing. Finding that neither Mr. Sleutel nor counsel representing the interests of Albany had appeared at the hearing, the Referee granted the motion. In an August 10, 1992 letter, Mr. Sleutel, on behalf of Albany, objected to the dismissal of his hearing request. In the letter, Sleutel asserted that another representative of Albany was present at the hearing. The Board treated Sleutel's letter as a request for Board review.

On Board review, we interpreted Albany's letter objecting to the dismissal of its hearing request as a motion for postponement. On this basis, we remanded the case to Referee Lipton to determine whether Albany failed to appear at the hearing, and, if so, whether such a failure was justified. Donald L. Grant, 44 Van Natta 1855, on recon 44 Van Natta 2117 (1992).

In response to our order, Referee Lipton sent a letter to the parties asking whether they wished to convene a hearing. Only claimant responded to Referee Lipton's order. Claimant indicated that he did not desire a hearing.

Thereafter, reasoning that there was an unjustified failure to appear at the prior hearing, Referee Lipton again issued an order dismissing Albany's hearing request. Albany moved for reconsideration of Referee Lipton's dismissal order, contending that it had never received the Referee's letter asking the parties if they wished a hearing. After addressing Albany's motion, Referee Lipton denied the motion for reconsideration and Albany requested Board review.¹

On review of Referee Lipton's dismissal order, we found that the record was insufficiently developed for us to resolve the issue of whether Albany failed to appear at the initial hearing and, if so, whether the failure was justified. Consequently, we remanded a second time for further proceedings. Donald L. Grant, 45 Van Natta 1523 (1993).

Because Referee Lipton was called as a witness in the proceedings on remand, this case was assigned to the present Referee. After a hearing, the Referee concluded that Albany, a corporation, did not "appear" at the July 30, 1992 hearing before Referee Lipton because Albany was not represented by an attorney.² The Referee further found that the failure to appear was unjustified because claimant's motion to dismiss put Albany on notice prior to the hearing that it must be represented by an attorney. Alternatively, the Referee found that Ms. Proctor did not appear at the hearing as a representative of Albany because she "appeared only as a witness, and not as a representative" of Albany. We disagree with the Referee's analysis.

Pursuant to ORS 9.320, any action, suit, or proceeding may be prosecuted or defended by a party in person, or by attorney, except that the state or a corporation appears by attorney in all cases, unless otherwise provided by law. Under OAR 438-06-071(2), "[u]njustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the referee shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

We conclude that Albany attended the scheduled hearing through its representative, Ms. Proctor. On remand, Referee Lipton testified that there was a woman in the hearing room who identified herself as an employee of Albany. Ms. Proctor testified that if Referee Lipton had asked whether anyone in the room was present on behalf of Albany, she would have stated that she was there on behalf of John Sleutel to testify. We accept this un rebutted testimony and find that Ms. Proctor attended the scheduled hearing as a representative for Albany.

In reaching this decision, we disagree with the Referee's conclusion that, as a corporation, Albany could only "appear" for purposes of OAR 438-06-071(2) by means of an attorney. In accordance with ORS 9.320, Albany could only "appear" to "prosecute" its hearing request via an attorney. Nevertheless, the Board's rule is designed for situations where a party or its representative unjustifiably fails to attend a scheduled hearing. Here, Albany (through Ms. Proctor) had "attended" the hearing, though she was not statutorily authorized to proceed with its prosecution of objections to claimant's claim and SAIF's acceptance. Nonetheless, such a lack of statutory authority does not transform Ms. Proctor's attendance at the hearing, on behalf of Albany, into a failure to "appear" for Albany under OAR 438-06-071(2).

¹ Albany did not respond to Referee Lipton's letter, although a copy of the letter was apparently sent to Albany's address. Albany's apparent lack of response to Referee Lipton's letter did not constitute a waiver of its right to pursue a hearing. For a waiver to occur, a party must have intentionally relinquished a known right. See Drews v. EBI Companies, 310 Or 134 (1990); Wright Schuchart Harbor v. Johnson, 133 Or App 680 (1995). To establish waiver, there must be a clear, unequivocal and decisive act of the party showing such a purpose. Waterway Terminals v. P.S. Lord, 242 Or 1 (1965). We are not persuaded that Albany took any action which clearly, unequivocally and decisively relinquished its right to a hearing.

² The Referee also concluded that the employer did not have "standing" to appear without an attorney. We disagree. To begin, as a noncomplying employer, Albany is a party to this proceeding. Astleford v. SAIF, 319 Or 225 (1994). Albany also has a pecuniary interest in this litigation. In other words, through enactment of ORS 656.054(1), the legislature has recognized that noncomplying employers have interests which should be represented in proceedings such as this. Thus, we conclude that Albany has "standing." See Trojan Concrete v. Tallant, 107 Or App 429, rev den 312 Or 151 (1991).

Alternatively, even were we to conclude that Albany failed to "attend" the hearing for purposes of OAR 438-06-071(2), we would find that such failure was justified under the circumstances of this case. In this regard, we disagree with the Referee's conclusion that Albany had notice, prior to the date of hearing that, as a corporation, it had to be represented by an attorney. The only such "notice" Albany arguably had prior to the July 30, 1992 hearing, was from a motion of the opposing party, received fewer than 10 days before the date of hearing. See OAR 438-06-045 (Unless otherwise ordered by the referee, the responding party shall be allowed 10 days after filing of a motion to file a written response). It could be argued that claimant's motion should have at least caused Albany to question whether or not it needed an attorney. However, given the nature of the document (a motion from an adverse party) and given the short time period between receipt of the motion and the scheduled hearing, we are not persuaded that Albany was placed on notice that it must be represented by an attorney at the scheduled hearing. Consequently, we hold that, even if Albany failed to appear at the hearing, such a failure was justified. To deny Albany a hearing for failure to retain an attorney representative, when it received no prior notice of the necessity to do so, would not be consistent with our notion of substantial justice.

Having found that Albany appeared at the hearing, we now address whether a continuance should have been granted to allow Albany to secure legal counsel since it could not proceed unrepresented. OAR 438-06-091(4) allows a continuance for "any reason that would justify postponement of a scheduled hearing." OAR 438-06-091 provides that a scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement.

Because the language of OAR 438-06-091 is permissive, the authority to continue a hearing rests within a referee's discretion. OAR 438-06-091; Sue Bellucci, 41 Van Natta 1890 (1989); see Randy L. Kling, 38 Van Natta 1046 (1986). Based on the following reasoning, we conclude that it was an abuse of discretion not to grant a continuance.

First, as previously discussed, the record establishes that Albany was unaware that it had to be represented by an attorney at a workers' compensation proceeding. Albany's only notice, prior to hearing, that it needed to be represented by an attorney, was claimant's motion which was received less than 10 days prior to the hearing and was a pleading of an adverse party. Moreover, Referee Lipton acknowledged that he would likely have granted a continuance if an unrepresented party appeared before him who had not been advised, other than by another party's motion, that he must be represented by an attorney. (Tr. 193). Considering such circumstances, including the confusion surrounding the evacuation announcement at the hearing, we find that it was an abuse of discretion for the Referee not to find extraordinary circumstances beyond Albany's control to justify a continuance of the hearing. OAR 438-06-081; 438-06-091(4).

SAIF cites Dani R. Cave, 44 Van Natta 130 (1992), in support of its argument that a postponement or continuance should not have been allowed.

In Cave, the NCE requested Board review of the Referee's order setting aside the denial. The NCE contended that the referee abused her discretion by refusing to postpone the hearing to enable it to retain legal counsel. The NCE further argued that it reasonably believed that it would be represented by SAIF at the hearing.

We held that since the NCE had been specifically informed by SAIF, approximately two months before the hearing that SAIF did not represent it, the NCE's argument was not a sufficient basis for postponing the hearing. We also held that, assuming the NCE was prejudiced by lack of counsel at the initial hearing, the referee cured any prejudice by continuing the hearing to allow the NCE to present rebuttal medical evidence, further testimony and depose claimant's physicians (by which time the NCE had secured legal representation and did not object to the initial hearing). Considering the circumstances in Cave, we declined to remand for additional evidence taking.

We find Cave distinguishable. To begin, there is no indication that the NCE in Cave was a corporation. Thus, it is not apparent that ORS 9.320 was applicable. (In fact, since the NCE was allowed to proceed with an attorney, it is likely that the statute was not applicable). In other words, here, unlike in Cave, the NCE could not proceed without an attorney and was not aware of that requirement prior to the hearing. Moreover, there was no issue in Cave as to whether the NCE "appeared" or whether it was permissible for the employer to proceed with a hearing on the merits without representation. In any event, in Cave, the referee continued the hearing, thereby allowing the NCE to obtain counsel. That is the same ultimate result which should have occurred in this case.

We recognize that Albany could not have proceeded with the hearing because it was a corporation which was not represented by an attorney. Nevertheless, the question before us is not whether Albany could proceed with a hearing on July 30, 1992. Rather, it is whether or not Albany appeared at the hearing, and if so, whether extraordinary circumstances existed to justify a continuance of the hearing to allow Albany an opportunity to secure legal representation. Based on the foregoing reasoning, we have answered both of those questions in the affirmative.

In summary, we conclude that Albany appeared at the hearing through Ms. Proctor. In addition, based on the extraordinary circumstances previously described, we conclude that a continuance of the hearing should have been granted to permit Albany to retain legal representation for a hearing concerning the merits of SAIF's claim acceptance.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, the record has never been developed concerning Albany's objections to SAIF's acceptance of claimant's injury claim. Because we conclude that such a hearing should have been granted, we remand to Referee Thye to hold a hearing regarding the issues raised by Albany's hearing request, which may be conducted in any manner that will achieve substantial justice. Because of our disposition of this case, we do not address claimant's request for an attorney fee pursuant to ORS 656.382(2). That issue should likewise be addressed by the Referee on remand.

Accordingly, the Referee's order dated July 5, 1994 is vacated. This matter is remanded to Referee Thye for further proceedings consistent with this order.

IT IS SO ORDERED.

May 3, 1995

Cite as 47 Van Natta 819 (1995)

In the Matter of the Compensation of
RITA O. ISHMAEL, Claimant
WCB Case No. 93-13135
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Referee Poland's order which set aside its denial of claimant's injury/occupational disease claim for bilateral plantar fasciitis. Claimant cross-requests review of that portion of the order which upheld SAIF's denial of her injury/occupational disease claim for bilateral bone spurs. On review, the issue is compensability.

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

Plantar Fasciitis

Finding the medical opinion of a consulting orthopedic surgeon, Dr. Cohen, to be the most persuasive, the Referee concluded that claimant had sustained her burden of proving that her bilateral plantar fasciitis condition was compensable as an occupational disease. On review, SAIF makes several contentions in support of its argument that the Referee erred. We are not persuaded.

SAIF notes that Dr. Cohen used the phrases "a major contributing cause" and "a major contributing factor" in describing the contribution of claimant's employment in the employer's wig and beauty supply shop to the development of her bilateral plantar fasciitis condition. (Exs. 18, 21). Citing Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985) (work conditions must be the, as opposed to a, major contributing cause of an occupational disease), SAIF asserts that it is unclear whether Dr. Cohen is opining that claimant's employment is one of several causes of claimant's condition or whether it is the major contributing cause of claimant's condition. Therefore, SAIF contends that Dr. Cohen's opinion cannot satisfy claimant's burden of proving that her employment is the major contributing cause of the development or worsening of her bilateral foot condition. See ORS 656.802(2).

However, as SAIF notes, Dr. Cohen also stated in his deposition that claimant's employment was the major contributing cause of claimant's bilateral foot condition. (Ex. 19-5, 10). After fully considering several potential casual factors, such as obesity, flat feet, and bone spurs, Dr. Cohen directly related claimant's symptoms to prolonged standing at work which stretched and pulled her feet outward, which then irritated the muscles near the plantar fascia and caused spasms and pain. (Ex. 19-15, 16).

Viewing the medical evidence from Dr. Cohen as a whole, including this testimony, we are persuaded that he believes to a degree of medical probability that claimant's employment is the major contributing cause of claimant's bilateral foot condition. We, therefore, agree with the Referee that Dr. Cohen's medical opinion satisfies claimant's burden of proving medical causation.

SAIF argues, however, that Dr. Cohen had an incorrect history of how much prolonged standing claimant did and that his medical opinion is, therefore, flawed. SAIF asserts that claimant actually stood no more than two or two and one-half hours, as the employers testified, rather than the period of four to six hours which Dr. Cohen assumed.

The Referee found claimant's testimony regarding the amount of standing in her job to be more reliable than that of her employer's. In particular, the Referee found that claimant testified in a straightforward and credible manner and had presented herself in a straightforward manner at all medical examinations. The Referee also noted that the employer did not have the opportunity to observe claimant throughout the entire work day.

To the extent that the Referee's credibility finding is based on observation of claimant's demeanor and manner of testifying, we defer to that finding. See International Paper Co. v. McElroy, 101 Or App 61 (1990) (when credibility finding is made on the basis of demeanor, deference is given to the referee's determination). Moreover, based on our de novo review of the substance of claimant's testimony, we agree for the reasons cited by the Referee that claimant is a credible witness. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285, 734 P2d 1 (1987). Accordingly, we find that Dr. Cohen's medical history is accurate and in accordance with claimant's credible testimony that she stood for prolonged periods from four to six hours.

SAIF also asserts that Dr. Cohen's medical opinion does not establish more than a symptomatic worsening of claimant's plantar fasciitis. Therefore, it argues that claimant failed to sustain her burden of proving that her employment was the major contributing cause of a worsening of her underlying, preexisting condition

SAIF analogizes this case to Stephen M. Petricevic, 45 Van Natta 2372 (1993). There, we held that the claimant failed to prove he sustained a compensable occupational disease for plantar fasciitis when the medical evidence indicated the claimant had experienced a symptomatic worsening of his plantar fasciitis condition, but did not establish that the symptoms of the condition were the disease.

We find Petricevic distinguishable. Unlike Petricevic, the medical evidence in this case from Dr. Cohen establishes that the symptoms of plantar fasciitis are the disease. Dr. Cohen testified that plantar fasciitis was "essentially a symptomatic diagnosis." (Ex. 19-14). SAIF concedes that Dr. Cohen testified that this condition was made manifest only by symptoms of pain and spasm. (Ex. 19-15). Inasmuch as we find that Dr. Cohen's testimony confirms that the symptoms of plantar fasciitis are the disease, a symptomatic flare-up is all that is necessary for there to be a compensable occupational disease claim, provided the medical evidence demonstrates that claimant's employment is the major contributing cause of the symptomatic worsening. See Georgia Pacific v. Warren, 103 Or App 275 (1990); Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990). For the reasons previously noted, we find that Dr. Cohen's medical opinion establishes major causation.

Finally, we agree with the Referee that Dr. Cohen's medical opinion is more persuasive than that of a consulting orthopedist, Dr. Achterman, who opined that claimant's employment was not the major contributing cause of the plantar fasciitis condition, and an examining physician, Dr. Fuller, who concluded that the plantar fasciitis was unrelated to claimant's employment. We agree with the Referee that Dr. Fuller did not sufficiently consider the fact that claimant's symptoms occurred in association with claimant's prolonged standing at work. (Ex. 20). Moreover, we do not find Dr. Achterman's

opinion to be as thoroughly explained as Dr. Cohen's. (Exs. 11, 13, 14, 15). Thus, we do not find it to be as persuasive. See Somers v SAIF, 77 Or App 259, 263 (1986) (greatest weight given to better reasoned medical opinions).

Bone Spurs

The Referee found that claimant had failed to prove that her bilateral bone spurs were compensable as an occupational disease. The Referee reasoned that there was no medical evidence which established that claimant's employment contributed to the development of this condition or caused a pathological worsening of the spurring.

On review, claimant contends that the Referee erred, arguing that Dr. Cohen confirmed that her employment caused a pathological worsening of her bone spurs. Claimant's contention is not persuasive.

As support for her position, claimant cites Dr. Cohen's statement that her long periods of standing at work "probably also aggravated the pre-existing calcaneal spurs of the right and left feet." (Ex. 18). However, we do not find that this statement establishes a pathological worsening, since it is unclear whether Dr. Cohen is referring to a symptomatic, as opposed to a pathological, worsening of the bilateral bone spur condition.

Claimant also notes the following testimony from Dr. Cohen:

"But there is no doubt that something takes place in order to get a spur. Something has to occur. And that something is the pull of the plantar fascia on the heel, like a Spanish windlass--over a long period of time, years, you can develop a spur in the process of pulling. And that means standing, perhaps weight, playing some part, though we're are not sure about weight." (Ex. 19-17, 18 emphasis supplied).

Claimant's contention notwithstanding, we do not interpret the preceding testimony as confirmation that claimant's employment pathologically worsened the bone spur condition. Instead, we find that Dr. Cohen was stating that claimant's employment played a role in the development of that condition. However, claimant concedes, and Dr. Cohen elsewhere opined, that claimant's employment was not the major contributing cause of the development of that condition. (Exs. 17-3, 19-5). Accordingly, because Dr. Cohen does not confirm that claimant's employment was the major contributing cause of a pathological worsening of the underlying bone spur condition, we agree with the Referee's finding that this condition is not compensable.

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

ORDER

The Referee's order dated November 4, 1994 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,000, payable by SAIF.

In the Matter of the Compensation of
MARY A. KELLEY, Claimant
WCB Case Nos. 94-03785 & 93-10990
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
VavRosky, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Kemper Insurance Company (Kemper) requests review of Referee Bethlahmy's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition; and (2) upheld United Pacific Insurance's (United) denial of claimant's occupational disease 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 exceptions, correction, and supplementation. We do not adopt the findings of fact contained in the third sentence of the first paragraph and the last sentence of the sixth paragraph.

Claimant began working at Reese Cleaners, Kemper's insured, on May 17, 1993. (Ex. 17).

On September 12, 1992, claimant compensably injured her right shoulder while working for United's insured. On October 6, 1992, United accepted the claim for a right shoulder strain. (Ex. 4). In September and October 1992, while receiving treatment for this compensable right shoulder injury, claimant reported occasional hand symptoms of numbness in both hands, her right hand feeling "sleepy," and paresthesia in both hands. (Exs. 1, 5-1, 6-1). On December 19, 1992, during an IME for the right shoulder injury, claimant reported that, about once a day her right hand "falls asleep," primarily at night. (Ex. 9-3). Claimant received no treatment for these hand symptoms.

Claimant's problems with her hands worsened after she began working at Kemper's insured on May 17, 1993. She first sought medical treatment for her bilateral hand complaints on June 9, 1993. (Ex. 16). On July 15, 1993, Dr. Thayer, claimant's treating physician, released her from work effective June 9, 1993, due to hand pain. (Ex. 18).

Prior to June 9, 1993, claimant was not disabled by and received no treatment for her hand symptoms. (Exs. 1, 5, 6, 9, 32, Tr. 36).

Claimant filed a claim with Kemper for the bilateral CTS condition in July 1993. (Exs. 16, 17, 18, 19, 21). On or about December 28, 1993, claimant filed a claim with United for this condition. (Ex. 31).

CONCLUSIONS OF LAW AND OPINION

Compensability

Applying the last injurious exposure rule, the Referee found that claimant had established the compensability of the bilateral CTS condition and that Kemper was responsible for that condition. We agree.

Kemper argues that claimant cannot use the last injurious exposure rule to establish the compensability of her claim because she did not join all of the former carriers that Kemper disclaimed against in its disclaimer of responsibility and claim denial. (Exs. 21, 29, 33). We disagree.

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 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. ORS 656.308(2) also 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 Kemper and United issued disclaimers of responsibility, naming each other, in addition to other carriers, as the potentially responsible party. (Exs. 29, 30, 33). Claimant filed claims against Kemper and United, but did not join the various other carriers identified in Kemper's and United's disclaimers. At hearing, both Kemper and United disputed that they were responsible for claimant's bilateral CTS condition.

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 does not preclude the claimant from asserting compensability against the first carrier. Id. We concluded that ORS 656.308(2) addresses responsibility for a claim and does not pertain to compensability. 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 for occupational diseases set out in ORS 656.807. Wilson, supra, 45 Van Natta at 2363 n.1. 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. Furthermore, we have held that this reasoning applies whether or not the carrier properly complied with ORS 656.308(2). Marilyn K. McMasters, 46 Van Natta 800 (1994); Troy L. Stafford, 46 Van Natta 2299 (1994).

An occupational disease claim is considered "void" unless filed within one year from the later date of the following: (1) the date the worker first discovers the disease; (2) the date the worker becomes disabled from the disease; or (3) the date the worker is informed by a physician that he or she is suffering from an occupational disease. ORS 656.807(1); Bohemia, Inc. v. McKillop, 112 Or App 261 (1992).

Here, claimant first became disabled from CTS as of June 9, 1993, and filed a claim against Kemper for that condition in July 1993. (Exs. 16, 17, 18, 19, 21). See Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992) (physician's report requesting medical treatment for a specified condition constitutes a claim). In addition, on or about December 28, 1993, United received notice of claimant's claim for her bilateral CTS condition. (Ex. 31). Therefore, claimant complied with the filing requirements of ORS 656.807(1) and timely filed claims for the occupational disease against both Kemper and United. Accordingly, applying the reasoning of Jon F. Wilson, supra, and Marilyn K. McMasters, supra, to this case, we conclude that claimant's failure to join all named potentially responsible carriers within the 60-day time limit of ORS 656.308(2) does not bar her from proving the compensability of her occupational disease claim against Kemper¹ (or United). Troy L. Stafford, supra.

In reaching this conclusion, we acknowledge that Kemper relies on Kevin G. Eller, 45 Van Natta 1, aff'd mem 123 Or App 123 (1993), in support of its argument that claimant cannot use the last injurious exposure rule to establish compensability of her claim but instead must prove that her work at Kemper's insured was the "major contributing cause of a worsening of the preexisting noncompensable disease." (Appellant's Brief, page 4). In Eller, a later employer both denied compensability of the claimant's CTS and notified the claimant that it was disclaiming responsibility on the basis that an earlier employment was the major contributing cause of the CTS. Because the claimant did not file a claim against the earlier employer, we analyzed the claimant's prior carpal tunnel symptoms while

¹ Actually, this case presents a twist on the facts in Jon F. Wilson, supra. In Wilson, the carrier against whom the claimant had not filed a claim within the time limits provided under ORS 656.308(2) following a disclaimer by another carrier, argued that the claimant was precluded from establishing a compensable occupational disease claim against it. For the reasons discussed above, we rejected that argument. Here, claimant initially filed an occupational disease claim with Kemper. It was that claim that resulted in Kemper's denial and disclaimer of responsibility. Claimant also filed a claim against United, one of the insurers that Kemper disclaimed against. Kemper argues that, because claimant did not file a claim against all of the potentially responsible carriers that it disclaimed against, she may not use the last injurious exposure rule to establish the compensability of the occupational disease claim. Thus, here, it is not one of the carriers that was not joined in this dispute that is arguing that claimant may not establish compensability against it. Instead, Kemper, the carrier against whom claimant initially filed her claim, is making that argument. These facts present an even less compelling argument than the one rejected in Wilson. For the reasons discussed above, we reject Kemper's argument. Because claimant timely filed a occupational disease claim against Kemper, she may prove compensability of that claim against Kemper. One means of proving compensability is with the last injurious exposure rule.

working for the earlier employer as a preexisting condition and required the claimant to prove that his work activities at the second employer were the major contributing cause of a worsening of the preexisting CTS.

We find Eller inapposite. There is no evidence that the claimant in Eller invoked the last injurious exposure rule to establish compensability of his occupational disease, as claimant has done in the present case. Therefore, Eller does not support Kemper's argument that claimant cannot use the last injurious exposure rule to prove compensability of her occupational disease under the circumstances of the present case.

In addition, to the extent that Eller may be read to support Kemper's argument, such a reading is not consistent with the court's recent decision in Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994). In Bennett, the claimant had filed occupational disease claims for hearing loss against two employers and later entered into a DCS with the first employer. The court reasoned 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 responsible employer remains in the case. Id. at 77. The court held that if the claimant could 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, he could rely on the last injurious exposure rule to prove the compensability of the claim against the later employer by showing that employment conditions there could have caused the condition. Id. at 78.

It stands to reason that, if employment conditions while in the employ of an insured with whom a claimant has entered into a DCS can be considered in applying the last injurious exposure rule to prove compensability of a claim, employment conditions while in the employ of an insured who has not been joined in the case may be considered to prove compensability. See also Silveira v. Larch Enterprises, 133 Or App 297, 302-03 (1995) (the court held that "for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws."). Given the reasoning in the above line of cases, we find that claimant may use the last injurious exposure rule to prove compensability of her occupational disease claim.

We proceed to the merits of the compensability of claimant's bilateral CTS condition. The Referee correctly analyzed claimant's bilateral CTS condition as an occupational disease claim. ORS 656.802(1)(c). Claimant must show that her work activities are the major cause of the disease or worsening of a preexisting disease, which must be established by objective findings. ORS 656.802(2). However, under the "rule of proof" prong of the last injurious exposure rule, claimant need not prove that employment with any one employer was the major contributing cause of the disease; it is sufficient to show that the disease was in major part caused by employment-related exposure. Runft v. SAIF, 303 Or 493, 499 (1987); Inkley v. Forest Fiber Products, 288 Or 337 (1980); Bennett v. Liberty Northwest Ins. Corp., supra. We agree with the Referee that claimant has met her burden of proof.

The causation of a disease is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967). Three physicians rendered opinions as to the compensability of claimant's bilateral CTS condition.

Dr. Nolan, a surgeon who examined claimant on behalf of Kemper, noted that claimant had subjective and objective signs of advanced bilateral CTS. (Ex. 20-2). He stated that claimant gave no history of a specific injury, but rather reported a history of problems that began after working a short time at Kemper's insured. He opined that the CTS preexisted claimant's employment at Kemper's insured, noting that significant CTS to the degree from which claimant suffers takes many months or years to develop. Id. He stated that, without a history of an acute injury, advanced CTS does not occur over the short period of time that claimant worked at Kemper's insured. On that basis, Dr. Nolan opined that claimant's work at Kemper's insured was not the major contributing cause of her bilateral CTS. Id. Instead, he opined that it was "due to either one of her many previous hand intensive occupations or to idiopathic factors." (Ex. 20-3). He did not elaborate on the alleged idiopathic factors. Finally, he opined that claimant's work at Kemper's insured did not pathologically change claimant's underlying CTS. (Ex. 28).

Dr. Thayer, treating physician, disagreed with Dr. Nolan's opinion and stated that claimant's work at Kemper's insured worsened her preexisting condition. (Ex. 22). After being provided with claimant's work history, including her work at Kemper's insured, Dr. Thayer opined that claimant's

work history of repetitive hand movement type jobs is the major contributing cause of her bilateral CTS, noting that the major cause of claimant's seeking medical treatment was her work at Kemper's insured. (Ex. 26).

Dr. Thayer referred claimant to Dr. Podemski, neurologist, who conducted nerve stimulation studies and diagnosed advanced bilateral CTS based on those studies and claimant's symptoms. (Ex. 19). Dr. Podemski opined that, due to the advanced nature of the CTS, it was probable that the condition preexisted claimant's employment at Kemper's insured. (Ex. 27). Assuming that was the case, Dr. Podemski stated that he could not say that her work activities at Kemper's insured contributed to a worsening of the underlying condition. He stated that, at best, the work at Kemper's insured caused an increase in symptoms. On the other hand, he opined that, assuming that the CTS did not preexist claimant's work at Kemper's insured, he could not say that that work was the major contributing cause of the CTS. Id.

We generally give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons not to give greater weight to the opinion of Dr. Thayer, who began treating claimant in June 1993, when claimant first sought treatment for her hand symptoms. Furthermore, contrary to Kemper's contentions, we find that Dr. Thayer had an accurate history of claimant's hand intensive work history, including her work at Kemper's insured. (Ex. 26-3).

In addition, Dr. Thayer addressed the contribution of claimant's work history on the CTS condition, concluding that these hand intensive work activities, which included her work at Kemper's insured, were the major contributing cause of the bilateral CTS. On the other hand, both Drs. Nolan and Podemski focused on whether the work activities at Kemper's insured were the actual major contributing cause of the CTS condition. Based on Dr. Thayer's opinion, we find that claimant has established that her work activities are the major contributing cause of the bilateral CTS. Such a showing is sufficient for purposes of the last injurious exposure rule. Runft v. SAIF, supra; Inkley v. Forest Fiber Products, supra; Bennett v. Liberty Northwest Ins. Corp., supra. Accordingly, claimant has established the compensability of her claim.

Responsibility

The Referee applied the last injurious exposure rule in determining that Kemper was responsible for claimant's bilateral CTS. We adopt the Referee's reasoning and conclusions regarding the responsibility issue with the following supplementation.

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 an accepted claim with United for right shoulder strain. (Ex. 4). Although claimant reported occasional hand symptoms during her treatment in 1992 for the right shoulder strain, there is no medical evidence that the right shoulder strain is related to the bilateral CTS condition. In addition, claimant first sought treatment for and was diagnosed with bilateral CTS in June/July 1993. There is no evidence that the bilateral CTS was accepted or processed with the right shoulder strain claim. Therefore, we conclude that the bilateral CTS is not the "same condition" as the accepted right shoulder strain injury and that ORS 656.308(1) is not applicable. Bennett v. Liberty Northwest Ins. Corp., supra, at 128 Or App 75 n.1 (1994). Where ORS 656.308(1) is not applicable, the last injurious exposure rule applies to assign responsibility. SAIF v. Yokum, 132 Or App 18 (1994); Jerald T. Kilby, 46 Van Natta 2487 (1994); Fred A. Nutter, 44 Van Natta 854 (1992).

Regarding assignment of responsibility, the last injurious exposure rule provides that where, as here, a worker proves that an occupational disease is caused by work conditions that existed where more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Tivis E. Hay, 46 Van Natta 1002 (1994). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date on which the claimant first became disabled as a result of the compensable condition, or if the claimant did not become disabled, the date on which he or she first sought medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986). //

Here, claimant was first disabled and first sought treatment for her bilateral CTS condition in June 1993, while Kemper was on the risk. Accordingly, we find the "onset of disability" of claimant's bilateral CTS condition occurred while Kemper was on the risk.

Consequently, responsibility for claimant's occupational disease is initially assigned to Kemper. See Boise Cascade Corp. v. Starbuck, *supra*. Because it timely disclaimed responsibility under ORS 656.308 (2), Kemper can shift responsibility to United (or another prior unjoined insurer) by showing that claimant's work exposure while United (or another prior unjoined insurer) was on the risk was the sole cause of claimant's bilateral CTS condition, or that it was impossible for conditions while Kemper was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, *mod* 73 Or App 223, *rev den* 299 Or 203 (1985).

As discussed above, the persuasive medical evidence establishes that claimant's work activities, including those at Kemper's insured, caused her bilateral CTS condition. Accordingly, on this record, we conclude that Kemper has not established the necessary prerequisite to shift responsibility to United or any other prior insurer. Therefore, responsibility for claimant's bilateral CTS condition remains with Kemper.

Attorney Fees on Review

Claimant is entitled to an assessed attorney fee for prevailing over Kemper's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,300, to be paid by Kemper. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 4, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,300, to be paid by Kemper Insurance Company.

May 3, 1995

Cite as 47 Van Natta 826 (1995)

In the Matter of the Compensation of
ELMER F. KNAUSS, Claimant
 WCB Case No. 94-02325
 ORDER ON REVIEW
 Emmons, Kropp, et al., Claimant Attorneys
 Michael Fetrow (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Referee Myzak's order that increased claimant's unscheduled permanent disability award from 5 percent (16 degrees), as awarded by Determination Order and Order on Reconsideration, to 49 percent (156.8 degrees) for his cardiovascular condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the following supplementation. Claimant suffered a myocardial infarction while working for SAIF's insured in May 1991. At the time of his infarction, an arteriogram showed claimant's triple vessel coronary artery disease (CAD).

On May 24, 1991, SAIF denied claimant's "cardiovascular condition." A referee set aside SAIF's denial of claimant's "cardiovascular condition" in an August 25, 1992 Opinion and Order.

On September 29, 1992, SAIF issued a partial denial of claimant's "preexisting condition of heart disease."

Claimant became medically stationary on October 13, 1992.

An April 12, 1993 Order on Review affirmed the August 1992 referee's order. SAIF subsequently appealed the Board's order.

A Determination Order dated May 27, 1993 awarded claimant 5 percent unscheduled permanent disability. A February 17, 1994 Order on Reconsideration affirmed the Determination Order. Claimant requested a hearing from the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established entitlement to 44 percent unscheduled permanent disability for his cardiovascular condition. We agree, and we adopt the Referee's "Opinion and Conclusions of Law," with the following supplementation.

On review, SAIF first contends that the Referee erred in concluding that claimant's coronary artery disease (CAD) was compensable. SAIF argues that it accepted only a myocardial infarction, and claimant's current impairment is not related to that compensable condition. We disagree with SAIF's reasoning.

We find the facts of this case to be similar to King v. Building Supply Discount, 133 Or App 179 (1995). In King, the claimant filed a claim for a heart attack. The carrier issued a written denial which denied not only the heart attack claim, but also the claimant's preexisting CAD. At hearing, the referee found that the heart attack was compensable and the denial was set aside "in its entirety," and remanded to the carrier for processing. The referee's order was not appealed. Later, the carrier issued a denial of the CAD. The court held that the carrier was precluded by the prior referee's order from contesting the compensability of the CAD. While noting that no claim had been previously made for the CAD, the court found that the carrier specifically denied the disease, and thus, framed the issue for litigation before the prior referee. The court reasoned that, had the carrier's denial been upheld and the claimant later sought compensation for that denied condition, a denial of that future claim would have been upheld. Inasmuch as the referee's order had set aside the denial in its entirety, the court concluded that the referee's order had the effect of ordering the acceptance of the CAD. Id.

In the present case, claimant was previously diagnosed with CAD, and in 1991, he suffered a myocardial infarction. SAIF denied claimant's "cardiovascular condition," and the denial was set aside by a prior referee who remanded the claim to SAIF for acceptance and processing according to law. We subsequently affirmed that prior referee's order.

Under the circumstances, we agree with the Referee that compensability of claimant's cardiovascular condition has been litigated. The Referee found, and we agree, that the persuasive medical evidence establishes that the CAD and heart attack are not separable. (Ex. 8, 18-A). Furthermore, the prior referee relied on the opinion of claimant's treating doctor, Dr. Drips, who noted evidence of CAD at the time of claimant's May 1991 infarction. (Ex. 4).

Consistent with King, we conclude that, although no specific claim had been made by claimant for his CAD, claimant's "cardiovascular condition," which included his CAD, was specifically denied by SAIF. Therefore, the prior referee's order setting aside SAIF's denial of claimant's cardiovascular condition and ordering SAIF to accept and process that condition, had the effect of ordering the acceptance of claimant's CAD. Accordingly, because our subsequent order affirmed the prior referee's order, SAIF is precluded from relitigating the compensability of that condition.

In reaching our conclusion regarding compensability, we acknowledge SAIF's argument that the Board order which affirmed the prior referee's order has been appealed to the Court of Appeals. Such a fact distinguishes the present case from King, supra, which involved an unappealed order that had become final by operation of law. However, we have previously held that, for reasons of administrative efficiency, an order may be given precedential effect, even though adjudication of the initial claim is not final due to an appeal. Michael S. Barlow, 46 Van Natta 1627 (1994).

In Barlow, the claimant argued that he was not precluded from litigating compensability of his low back claim as an occupational disease, even though the compensability of the condition had been previously litigated as an accidental injury. The claimant contended that claim preclusion did not apply because the prior referee's order which decided compensability under an accidental injury theory had been appealed to the Board. We rejected the claimant's argument and reasoned that, for purposes of administrative efficiency, it was appropriate for a subsequent referee to give precedential effect to the prior referee's order, notwithstanding the fact that the first order had been appealed.

Similarly, in the present case, we conclude that it was appropriate for the Referee to give precedential effect to the prior referee and Board order which set aside SAIF's denial of claimant's

cardiovascular condition. We find that, for the reasons expressed in Barlow, administrative efficiency is best served by such an approach. To take an alternative approach (i.e., giving no effect to prior litigation of the same claim, or deferring a decision on the subsequent order during the entire pendency of the prior order) could encourage further and potentially unnecessary litigation, as well as result in inconsistent rulings and additional delays in the resolution of disputes.

Consequently, we agree with the Referee that claimant's CAD condition is compensable.

Finally, on review, SAIF argues that, with respect to the issue of permanent disability, claimant waived the issues of social and adaptability factors. SAIF contends that, because there were no social or vocational values awarded by Determination Order or the Order on Reconsideration, and claimant raised only the issue of impairment at the time of hearing, claimant therefore "waived" the issues of social and adaptability factors. Consequently, SAIF argues that the Referee should not have addressed those factors in rating the extent of claimant's permanent disability. We disagree.

At hearing, the Referee asked claimant's counsel to identify the issues. Claimant's counsel responded:

Claimant's counsel: "Appeal from the Reconsideration Order of February 14, 1994, the issue being unscheduled permanent disability. As we discussed the factors that were limited to an issue is whether (claimant) is a class one or a class three under the cardiovascular ratings of the disability rating guides."

Referee: "And for the record with the affected body part being the heart?"

Claimant's counsel: "The heart, yes."

Referee: "Would you agree with that statement of the issue?"

SAIF's counsel: "Yes, I do."

Referee: "For the record, did you have any cross issues?"

SAIF's counsel: "No."

Waiver has been defined as "the intentional relinquishment of a known right." Drews v. EBI Companies, 310 Or 134, 150 (1990). Here, we are unable to find that claimant intentionally relinquished his right to litigate the issues of social and adaptability values. We agree that, at hearing, claimant stated that the issue being litigated was "unscheduled permanent disability," in particular, whether claimant "is a Class I or a Class III under the cardiovascular ratings of the disability rating guide." Notwithstanding the remarks of claimant's counsel, however, we are unwilling to find that, on this record, claimant specifically and intentionally relinquished his right to litigate the issues of social and adaptability values. In other words, we are not persuaded that claimant was not contesting the Evaluation Section's decision concerning social and adaptability factors when he was appealing the reconsideration order on the issue of permanent partial disability. Accordingly, after considering the circumstances of this case, we do not find that claimant "waived" his right to contest the social and adaptability values used in rating his permanent disability.

SAIF does not contest the specific calculation of claimant's permanent disability (assuming that we found that claimant had not waived the social and adaptability issues). Consequently, we adopt and affirm the Referee's order regarding claimant's unscheduled permanent disability award.

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$900, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 7, 1994, as reconsidered October 7, 1994, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$900, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
STANLEY MEYERS, Claimant
WCB Case No. 90-09863
ORDER ON REMAND
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Meyers v. Darigold, Inc.*, 123 Or App 217 (1993). The court reversed our order, *Stanley Meyers*, 43 Van Natta 2643 (1991), that held that the Hearings Division lacked jurisdiction under ORS 656.327 to consider a medical treatment dispute regarding the appropriateness of chiropractic treatment in excess of two visits per month. Concluding that the Hearings Division has jurisdiction of this dispute, the court has remanded for reconsideration.

FINDINGS OF FACT

Claimant, a warehouseman, compensably injured his low back and left hip on September 17, 1986, when he was struck by a forklift being driven by a co-worker. The diagnosis was lumbar strain with myofascitis, and left hip strain. Claimant was released from work and treated conservatively. His claim was closed by Notice of Closure on December 15, 1986 with an award of temporary disability benefits only.

In January 1987, claimant sought treatment for left hip pain. He was diagnosed with a strain of the left sacroiliac joint, released from work and treated conservatively. X-rays revealed mild degenerative changes in the lumbar spine. His claim was reopened and closed by Notice of Closure on June 1, 1987, with an additional temporary disability award. No permanent disability was awarded. The June 1987 closure notice was the last award or arrangement of compensation.

Claimant continued working at his regular job and, in January 1989, he sought treatment with Dr. Ho for recurrent low back pain. He did not follow up with treatment for his pain. In September 1989, claimant returned to Dr. Ho with recurrent low back pain. Dr. Ho treated with electrical stimulation, manipulation and trigger point injections. Claimant's condition improved, though he continued to have residual discomfort in his low back.

In February 1990, claimant began treating with Dr. Kennedy, a chiropractor, for low back and left hip pain which worsened with activity. Claimant treated with Dr. Kennedy once or twice per week.

By letter dated April 24, 1990, the insurer partially denied claimant's chiropractic treatment in excess of the administrative guideline for such treatments, *i.e.*, two visits per month.¹ On June 1, 1990, the insurer issued a letter denying claimant's aggravation claim on the basis that there was no material worsening of his condition. Claimant requested a hearing on both denial letters and also sought the assessment of penalties and attorney fees for the insurer's allegedly unreasonable denials.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside both the medical services and aggravation denials, and assessed a penalty for unreasonable claim processing. On Board review, we vacated, for lack of jurisdiction, that portion of the Referee's order that set aside the insurer's medical services denial. *Stanley Meyers, supra*. We reasoned that the Director had exclusive jurisdiction over the issue of the reasonableness and necessity of medical treatment pursuant to ORS 656.327, and that the medical treatment dispute was not a matter concerning a claim over which the Hearings Division had jurisdiction. *Id.* In addition, we reversed the Referee's assessment of a penalty and attorney fee, finding that the insurer's failure to seek Director review was not unreasonable. *Id.*

¹ The administrative guideline in effect at the time of the disputed treatment, *former* OAR 436-10-040(2)(a), provided, in pertinent part:

"Frequency and extent of treatment shall not be more than the nature of the injury or process of a recovery requires.... The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter." WCD Admin. Order 1-1990.

On the aggravation issue, we reversed the Referee's order and reinstated and upheld the aggravation denial. Id. We reasoned that, although claimant experienced a symptomatic worsening of his compensable condition, he did not prove his earning capacity was diminished below what it was at the time his claim was last closed. Id.

The Court of Appeals reversed our order. On the medical services issue, the court determined that the Director acquires exclusive jurisdiction over a medical treatment dispute under ORS 656.327 only if a party or the Director "wishes" Director review and gives the appropriate notice. Meyers v. Darigold, Inc., supra, 123 Or App at 221-22. Because no such "wish" was filed with the Director in this case, the court held that jurisdiction of this medical treatment dispute remained with the Board. Id.

On the aggravation issue, the court held that, inasmuch as claimant's aggravation claim was limited to medical services, he was not required to prove diminished earning capacity in order to establish his claim. Id. at 223. The court instructed us to determine, on remand, whether claimant's need for medical services was the result of the compensable injury. Id. at 224.

Medical Services

Inasmuch as we have jurisdiction over the issue of the reasonableness and necessity of the disputed medical treatment, we now address the merits of that dispute.

The medical treatment in dispute here was chiropractic treatments in excess of two visits per month, which Dr. Kennedy provided from February 1990 through June 1990. It is claimant's burden to prove that the disputed medical treatment was required for the nature of his injury or the process of his recovery. See ORS 656.245(1)(a); former OAR 436-10-040(1)(a); Robert P. Holloway, Sr., 45 Van Natta 2036 (1993).

The insurer's denial was based on the opinion of examining physicians, Drs. Fechtel (chiropractor) and Kiest (orthopedist), who opined that chiropractic treatments in excess of two visits per month were "contraindicated." They found no significant orthopedic or neurologic pathology and, instead, found the pain was focal to the muscles of the lumbo-pelvic region. They opined that the pain is "maintained by [claimant's] sedentary lifestyle, increase in weight over the last several years, and secondary deconditioning." They recommended an aggressive exercise rehabilitation program for the lumbar spine and gluteal muscles. (Ex. 23-6). Dr. Ho, claimant's former treating orthopedist, concurred with the opinion of Drs. Fechtel and Kiest. (Ex. 26).

Dr. Kennedy, the treating chiropractor, disagreed with Drs. Fechtel and Kiest's recommendation for no more than two chiropractic treatments per month. Dr. Kennedy opined that claimant's level of pain had decreased with chiropractic treatment and that his sharp, stabbing pains were not as severe. He indicated that, as claimant's work week progressed, his back pain worsened so that he had trouble working and sleeping. Dr. Kennedy explained that claimant's need for further treatment is due in part to Dr. Ho's injection treatments which he felt prolonged claimant's condition. He believed there was still room for further improvement with chiropractic treatment and that claimant was not yet ready for only two treatments per month. (Ex. 27).

Dr. Lindstrom, examining physician, opined that claimant has left sacroiliac joint pain which has improved with chiropractic treatment. He believed that claimant would benefit from continued chiropractic treatment one to two times per week for the next two months. (Ex. 29).

Claimant testified that he sought chiropractic treatment with Dr. Kennedy because Dr. Ho's treatments were not working. Since treating with Dr. Kennedy, claimant has had no stabbing pains and he sleeps better.

Based on our review of the record, we conclude that claimant has sustained his burden of proving that chiropractic treatments in excess of the administrative guideline were required for the recovery from his compensable low back and left hip strain. In this regard, we rely on the well-reasoned opinion of claimant's current treating chiropractor, Dr. Kennedy, who opined that claimant's level of pain has decreased with chiropractic treatment. His opinion is corroborated by claimant's testimony at hearing. (See tr. 15). Dr. Kennedy also opined that claimant has required treatment on a weekly basis because of worsening pain during the work week which made it difficult for him to work

and sleep. Based on Dr. Kennedy's opinion, we find that weekly chiropractic treatments were necessary to enable claimant to continue his regular employment. See West v. SAIF, 74 Or App 317 (1985). Finally, as claimant's treating physician, Dr. Kennedy was in the best position to evaluate claimant's progress with chiropractic treatment, and we find no persuasive reason not to defer to his opinion. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Drs. Fechtel and Kiest, on the other hand, saw claimant once and did not offer a persuasive explanation for their opinion. They attributed claimant's pain to secondary factors, such as his weight gain and deconditioning, but they also recognized that the compensable injury initiated the pain condition. Drs. Fechtel and Kiest did not address evidence that claimant's level of pain has decreased with weekly chiropractic treatment, nor did they respond to evidence that weekly treatment has been necessary to enable claimant to work at his regular job. (Ex. 23-6). Although Dr. Ho, claimant's former treating physician, concurred with Dr. Fechtel and Kiest's opinion, his concurrence is not explained, and we therefore do not give it great weight. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Moreover, because Dr. Ho had not seen claimant since February 1990, he was not able to evaluate first-hand claimant's progress with chiropractic treatment, which began in February 1990. (Ex. 26).

Based on our finding that weekly chiropractic treatments were required for the process of claimant's recovery from the compensable injury, we shall set aside the insurer's medical services denial dated April 24, 1990. However, because the insurer was in receipt of Drs. Fechtel and Kiest's report at the time of its medical services denial, we find that the insurer had a legitimate doubt about the appropriateness of chiropractic treatments in excess of the treatment guideline. Therefore, the denial was not unreasonable. See Brown v. Argonaut Ins. Co., 93 Or App 588, 591 (1988). Accordingly, a penalty and attorney fee for allegedly unreasonable claim processing is not warranted.

Aggravation

On the aggravation issue, the court held that, inasmuch as claimant was seeking only medical services under his aggravation claim, he was not required to prove that he was less able to work as a result of his allegedly worsened condition. The court instructed us to address the question of whether claimant's need for medical services was the result of the compensable injury.

At the time of the last award of compensation in June 1987, claimant had no impairment of function, and he did not receive a permanent disability award for the compensable injury. (Exs. 13, 14). In January 1989, however, claimant returned to Dr. Ho with recurrent low back discomfort. Dr. Ho reported that claimant's condition was "worse" and diagnosed "a recurrence of low back strain of occupational origin." (Ex. 15). Dr. Ho opined that claimant's symptoms represented a flare-up of the slight residual symptoms claimant had in May 1987. (Ex. 16).

Dr. Ho initially treated with electrical stimulation and manipulation, and wrote that claimant's "overall condition remains stationary with the present episodes representing repetition of a pattern toward recurrence directly proportional to the degree of mechanical stress to which he is subjected at work." (Ex. 17-2). Claimant improved to a limited extent. Due to persisting discomfort, however, Dr. Ho began trigger point injection treatments in September 1989 and declared that claimant was not medically stationary. (Exs. 19, 20). Dissatisfied with Dr. Ho's treatments, claimant transferred his care to Dr. Kennedy in February 1990. (Ex. 22).

In April 1990, Drs. Kiest and Fechtel examined claimant and opined that he remained medically stationary since the June 1987 claim closure. (Ex. 23-6). Dr. Ho concurred. (Ex. 26). Dr. Kennedy disagreed, stating that claimant was not yet medically stationary due to persistent back pain. (Ex. 27).

Although Dr. Ho was claimant's treating physician from March 1987 through February 1990, his opinion regarding claimant's medically stationary status was contradictory. He stated that claimant was not medically stationary, then concurred, without explanation, with Drs. Kiest and Fechtel's opinion that claimant remained medically stationary since 1987. We therefore decline to rely on Dr. Ho's opinion. Dr. Kennedy's opinion, on the other hand, is most consistent with the medical record, including Dr. Ho's reports, which shows that claimant experienced at least a temporary symptomatic worsening since the June 1987 claim closure. For this reason, we find that Dr. Kennedy's opinion is better reasoned than that of Drs. Kiest and Fechtel. Accordingly, we rely on Dr. Kennedy's opinion to find that claimant's compensable back condition had worsened since the last award of compensation.

We also find that the compensable injury was a material contributing cause of the worsened condition and need for treatment. See Jocelyn v. Wampler Werth Farms, 132 Or App 165, 173 (1994) (A worsening of a compensable condition, not caused in major part by an off-the-job injury, is compensable under ORS 656.273(1) if the compensable injury is a material contributing cause of the worsening.) In this regard, even Drs. Kiest and Fechtel conceded there was a causal connection between claimant's need for treatment and the original injury "through a deconditioning mechanism." (Ex. 23-6). Further, inasmuch as claimant has not been awarded permanent disability for the compensable injury, he need not prove that his symptomatic worsening was more than waxing and waning of symptoms contemplated by a previous permanent disability award. See ORS 656.273(8). Therefore, we conclude that claimant has established a compensable aggravation claim for treatment of his low back condition beginning in January 1989.² Accordingly, the insurer's June 1, 1990 denial shall be set aside.

We find, however, that the insurer had a legitimate doubt about its liability for an aggravation claim under the facts of this case. At the time of the insurer's denial, there were Board cases holding that a worker must prove diminished earning capacity in order to prevail on an aggravation claim involving an unscheduled condition. E.g., Edward D. Lucas, 41 Van Natta 2272, 2274-75 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Hence, in the absence of evidence of claimant's diminished earning capacity, the insurer's aggravation denial was not unreasonable and does not warrant the assessment of a penalty and attorney fee.

Claimant's attorney is entitled to an assessed fee for services before the Board on remand. ORS 656.388(1).³ 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 on remand 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 Supplemental Response 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, the Referee's order dated August 3, 1990 is reversed in part and affirmed in part. That portion of the Referee's order which assessed a penalty and related attorney fee for the insurer's allegedly unreasonable claim processing is reversed. The remainder of the order is affirmed. For services on remand, claimant's counsel is awarded an assessed fee of \$1,000, payable by the insurer.

IT IS SO ORDERED.

² Because claimant is asserting an "aggravation" claim for medical services only, were we reviewing this case on a clean slate, we would analyze the claim as one for medical services under ORS 656.245, rather than a claim for aggravation under ORS 656.273. However, because the court has framed the issue as aggravation, we have applied the analysis applicable to aggravation claims, with one exception: In accordance with the court's specific holding, we have not imposed the requirement that claimant prove diminished earning capacity as a result of his worsened condition.

³ The court has already awarded attorney fees for claimant's counsel's "pre-remand" services.

In the Matter of the Compensation of
BILL R. OFFILL, Claimant
WCB Case No. 94-01628
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Hall.

The insurer requests review of that portion of Referee McCullough's order that increased claimant's unscheduled permanent disability award for a low back injury from 9 percent (28.8 degrees), as awarded by Order on Reconsideration, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was previously awarded 25 percent unscheduled permanent disability due to low back and neck conditions caused by a compensable injury that occurred in November 1986. In March 1993, claimant suffered the low back injury which gave rise to the presently disputed permanent disability award. The parties agree that claimant's permanent disability award under the disability standards amounts to 18 percent. However, the insurer contends that this award should be reduced in light of claimant's 25 percent permanent disability award for the 1986 injury.

Asserting that claimant's previous award included nearly identical values for social/vocational factors¹, the insurer argues that claimant should not be entitled to further compensation for those same social/vocational factors. Accordingly, the insurer requests that we reduce claimant's 18 percent unscheduled permanent disability award by those same factors (representing loss of earning capacity) as calculated under the 1993 award.

Claimant does not dispute the insurer's assertion that his prior award included a value for social/vocational factors. Rather, based upon his contention that he made a full recovery from his previous injury, claimant argues that the amount of his prior award is irrelevant. (Resp. Br. at 3).

Because claimant previously was awarded 25 percent unscheduled permanent disability for his low back and neck, we consider such an award in arriving at the appropriate permanent disability for the current injury. See ORS 656.214(5); OAR 436-35-007(3)(b); Patrick D. Whitney, 45 Van Natta 1670 (1993). This determination requires a comparison of the current extent of disability under the standards with the prior permanent disability award to decide if the current award reflects any preexisting disability for which the claimant received benefits. OAR 436-35-007(3)(b); Patrick D. Whitney, supra; Mary A. Vogelaar, 42 Van Natta 2846, 2848 (1990). If the preexisting disability is included in the current award, the award is reduced by an amount that represents the previously compensated loss of earning capacity. Id.

Although an injured worker is entitled to that unscheduled permanent disability which results from a compensable injury, the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, supra; OAR 436-35-007(3)(b).

The Referee found that claimant was restricted from heavy labor following the 1986 injury. The Referee further determined that this restriction was the sole basis for claimant's award of 25 percent unscheduled permanent disability. Based on this evidence, the Referee concluded that claimant's 1986

¹ The insurer contends (without contradiction) that claimant's social/vocational factors for the 1986 injury were calculated as 13, whereas they are figured as 12 under the 1993 award.

low back injury was no longer disabling at the time of his 1993 injury (*i.e.*, claimant made a full recovery from the impaired condition rated for disability in the 1986 claim). Thus, the Referee concluded that claimant's current extent of disability in his low back was completely attributable to the 1993 injury. We disagree.

Following the 1986 injury, Dr. Tiley restricted claimant from heavy work. (Ex. B-1). There is no indication that the "heavy labor" restriction was ever removed. However, at the time of the March 1993 injury, claimant was again performing heavy work. Subsequent to the 1993 injury, claimant's treating physician, Dr. Lax (neurological surgeon), permanently restricted claimant from heavy labor. (Ex. 3C).

Despite being restricted from heavy work following the 1986 injury, claimant was again performing heavy work at the time of his 1993 injury. Inasmuch as there is no evidence that the earlier restriction against performing heavy labor had been removed, we find that claimant's current restriction from heavy work was previously considered and compensated by the 1986 permanent disability award. See Alberta M. Lakey, 43 Van Natta 30 (1991).

As mentioned, the insurer does not dispute the calculation of claimant's permanent disability award at 18 percent. Nevertheless, it seeks a 12 percent offset for allegedly duplicative lost earning capacity for social/vocational factors as an inclusive value of the 25 percent award of unscheduled permanent disability for the 1986 injury.

We agree that the insurer is entitled to offset the permanent disability award for claimant's 1986 injury, but we refrain from applying the mechanical formula it proposes. See Alberta M. Lakey, *supra*. Inasmuch as the heavy work restriction stemming from his 1986 injury had not been removed at the time of his 1993 injury, we find that the reimposition of the restriction by Dr. Lax does not reflect a loss of earning capacity solely attributable to the 1993 injury.

In particular, upon examination of claimant shortly after the March 1993 injury, Dr. Lax noted that claimant had a history of intermittent low back problems for several years. (Ex. 2). He also noted that claimant's current low back condition was not as symptomatic as it had been on past occasions. (*e.g.*, no radiation of pain into the lower legs and feet). *Id.*

Based on the aforementioned medical evidence, and after considering claimant's prior 25 percent unscheduled permanent disability award, we find that one-half of the 18 percent award under the disability standards represents a loss of earning capacity which existed at the time of the 1993 injury. Alberta M. Lakey, *supra*. Therefore, to avoid doubly compensating claimant for the same loss of earning capacity, we reduce claimant's current disability award of 18 percent to 9 percent. In other words, under the disability standards, this 9 percent award represents permanent disability which was not present prior to the 1993 injury.

The 1994 Order on Reconsideration reduced the Determination Order award from 12 percent to 9 percent unscheduled permanent disability. Inasmuch as we have also calculated claimant's unscheduled permanent disability as 9 percent, the February 8, 1994 Order on Reconsideration is reinstated and affirmed. See Mary A. Vogelaar, *supra*; ORS 656.214(5); see also OAR 436-35-007(3)(b).

Finally, in claimant's respondent's brief, he raises the issue of whether OAR 436-35-007(3)(b) is valid in light of ORS 656.222. As discussed below, we conclude that OAR 436-35-007(3)(b) is not inconsistent with ORS 656.222.

In City of Portland v. Duckett, 104 Or App 318 (1990), *rev den* 311 Or 187 (1991), the court expressly stated that ORS 656.222 applies only to offsetting subsequent awards for scheduled disability (emphasis in original). Inasmuch as OAR 436-35-007(3)(b) provides that a worker is not entitled to be doubly compensated for a permanent loss of earning capacity in an unscheduled body part, we discern no conflict with ORS 656.222.

Moreover, the Director has authority to promulgate rules necessary to administer the Workers' Compensation statutes. ORS 656.726(3). Specifically, ORS 656.214(5) provides that the relevant factors for determining "permanent loss of earning capacity" are to be provided by the Director pursuant to 656.726(3)(f). Inasmuch as the Director's rules, including the prohibition against double compensation in OAR 436-35-007(3)(b), are consistent with the Workers' Compensation Act, and the authority granted the Director by the Act, we are bound by those rules. See Eileen N. Ferguson, 44 Van Natta 1811 (1992), *aff'd* 127 Or App 478 (1994)(citing Miller v. Employment Division, 290 Or 285 (1980); Charles M. Anderson, 43 Van Natta 463 (1991)).

ORDER

The Referee's order dated June 1, 1994 is reversed. The Order on Reconsideration award of 9 percent (28.8 degrees) unscheduled permanent disability is reinstated and affirmed.

Board Member Hall dissenting.

The majority finds that claimant currently has 18 percent unscheduled permanent disability, but concludes that all but 9 percent of that permanent disability was previously compensated under the 1986 injury claim. Because I believe that all of claimant's current unscheduled permanent disability is due to the 1993 injury, I dissent.

Contrary to the majority's assertion, ORS 656.214(5) does not authorize an automatic offset for a prior permanent disability award. Rather, the statute provides, in pertinent part, that "the criteria for rating of [unscheduled permanent] disability shall be the permanent loss of earning capacity due to the compensable injury." (Emphasis added). The plain meaning of the statute excludes consideration of lost earning capacity resulting from a source other than the subject compensable injury. If, however, the identified disability is, in fact, due fully to the compensable injury, then the claimant is entitled to be fully compensated for that disability. Simply stated, a claimant is entitled to full compensation for that disability which is proven to be caused by the compensable injury.

Consequently, if a worker receives a permanent partial disability award for one injury and subsequently recovers fully from that disability before sustaining a second injury, then the claimant is entitled to the full measure of disability caused by that second injury. There is no authority for an offset based on the prior award if the claimant fully recovered from the first injury before sustaining the second injury. In such a case, claimant's post-second injury disability would be due to the second compensable injury.

In the present case, although claimant received an award of 25 percent unscheduled permanent disability for the November 1986 injury to his neck and back, the record shows that claimant fully recovered from the disabling effects of that injury and was performing heavy work when he was injured again in March 1993. The majority makes much of the fact that the medical restriction against claimant performing heavy work was not expressly removed prior to the 1993 injury. That is immaterial, however, because claimant was, in fact, performing heavy work, thereby demonstrating that he had sufficiently recovered from the 1986 injury to perform such work. Thus, I would find as did the Referee, that claimant fully recovered from the effects of his 1986 injury before suffering the 1993 injury and, thus, all of claimant's current permanent partial disability resulted from the 1993 compensable injury. See Kenny I. Miller, 47 Van Natta 439, 441 (1995) (Member Hall dissenting). Under the express terms of ORS 656.214(5), therefore, claimant is entitled to receive, without any offset, the full 18 percent unscheduled permanent disability award for the 1993 injury.

Awarding claimant full permanent partial disability benefits for the disabling effects of his current injury, notwithstanding any prior awards for a previous injury, furthers the objectives of encouraging workers to recover from their injuries and return to work. See ORS 656.012(2)(c). As the Supreme Court explained in Green v. State Ind. Acc. Com., 197 Or 160 (1953):

"Compensation for permanent partial disability is awarded not only for the purpose of compensating in a measure for the injury suffered by a workman, but also to assist him in readjusting himself so as to be able to again follow a gainful occupation. The law contemplates that the injured workman may, and perhaps will, again become employed in industry in some capacity. It would indeed be unjust if, while gainfully employed, the workman suffered another accident proximately resulting in additional permanent partial disability, he were denied any compensation therefor. We do not believe the legislature intended any such harsh result. The Workmen's Compensation Law must always be given a liberal interpretation. It is just a coincidence that plaintiff's second injury involved the same part of his body as that injured in the first accident, and that fact can have no bearing upon plaintiff's right to compensation for the permanent injury actually suffered as the result of the second accident." Id. at 169.

By depriving claimant of the full benefits for his permanent disability due to the 1993 injury, the majority is penalizing him for recovering from his 1986 injury and returning to heavy work. I believe this result is harsh and inconsistent with the objectives of the Workers' Compensation Law. Therefore, I dissent.

May 3, 1995

Cite as 47 Van Natta 836 (1995)

In the Matter of the Compensation of
EUGENE J. SENGER, Claimant
WCB Case Nos. 93-11345 & 93-09233
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Brown's order that set aside its denial of claimant's occupational disease claim for degenerative disc disease. Claimant contends that SAIF may not raise a "claim preclusion" defense for the first time on review. On review, the issues are the effect of prior litigation and/or stipulated agreements, and compensability. We reverse.

FINDINGS OF FACT

In 1974, claimant suffered a low back injury while employed by another employer. His claim was accepted. Claimant also has a long history of low back degenerative disc disease.

Claimant worked for SAIF's insured from 1980 until December 14, 1992.

In 1989, claimant filed low back claims with the earlier employer and SAIF's insured. Both claims were denied. A May 8, 1991 Disputed Claim Settlement (DCS) settled the compensability/responsibility dispute and extinguished claimant's rights to seek benefits under those claims. (Ex. 30).

Claimant filed a claim for a January 8, 1992 low back injury, which SAIF denied. Claimant requested a hearing. Referee Baker issued a November 19, 1992 Opinion and Order, which directed SAIF to accept the injury claim. He also noted that claimant's longstanding degenerative condition was not compensable by virtue of the 1991 DCS and concluded that the record did not establish that claimant's work activities since the May 8, 1991 DCS had worsened claimant's noncompensable degenerative condition. (Ex. 37-5).

On November 30, 1992, SAIF issued a partial denial of claimant's back treatment after April 10, 1992. (Ex. 38). On December 1, 1992, SAIF accepted a "lumbar strain from January 8, 1992 to April 10, 1992." (Ex. 39-1).

On December 14, 1992, claimant experienced low back symptoms while reading meters at work. He filed a claim and sought treatment. SAIF accepted a December 14, 1992 lumbar strain by an April 22, 1993 stipulation. The stipulation provided that the November 30, 1992 partial denial would remain in effect and claimant's request for hearing from that denial would be dismissed with prejudice. (Ex. 46).

On May 6, 1993, SAIF issued a partial denial of claimant's back treatment after January 7, 1993 under the December 1992 claim. (Ex. 47). Claimant requested a hearing. Referee McWilliams issued a November 5, 1993 Opinion and Order which set aside the May 6, 1993 partial denial with respect to treatment provided before February 4, 1993 and upheld the denial with respect to treatment provided after that date. (Ex. 61).

On September 7, 1993, claimant filed an occupational disease claim, alleging that his work activities were the major contributing cause of his degenerative and strain conditions. (Ex. 54). SAIF denied the claim on September 21, 1993. (Ex. 57). Claimant requested a hearing and the matter was submitted to the present Referee on the record.

FINDINGS OF ULTIMATE FACT

By virtue of the parties' May 8, 1991 DCS, claimant's low back degenerative condition was not related to his employment with SAIF's insured as of that date.

By virtue of the parties' April 22, 1993 stipulation, claimant's low back condition was compensably related to the January 8, 1992 lumbar strain until April 10, 1992 (the date of SAIF's unappealed partial denial), but not thereafter.

By virtue of Referee McWilliams' unappealed November 5, 1993 Opinion and Order, claimant's low back degenerative and strain conditions were not related to the accepted December 1992 injury from February 4, 1993 through August 12, 1993 (the date the hearing was held before Referee McWilliams).

CONCLUSIONS OF LAW AND OPINION

The Referee found that the opinion of Dr. Kitchel, treating physician, persuasively established that claimant's 12-year work exposure with SAIF's insured was the major cause of his current degenerative disc condition. In addition, finding that claimant's work activity between September 30, 1992 and December 14, 1992 could have worsened that condition,¹ the Referee concluded that claimant had established the compensability of his occupational disease claim. We disagree.

Claimant bears the burden of proving that his employment activities or exposures were the major contributing cause of his degenerative disc condition or its worsening. ORS 656.802(2). We agree with the Referee that there is medical evidence implicating claimant's 12-year work exposure with SAIF's insured as causally significant.² However, in light of the parties' two agreements and Referee McWilliams' November 1993 order, that does not end the inquiry.

As a matter of law, by virtue of the parties' May 8, 1991 DCS, their April 22, 1993 stipulation, and the November 1993 order, claimant's pre-May 8, 1991 and February 4, 1993 through August 12, 1993 work exposures and his January 8, 1992 strain injury do not compensably contribute to his current condition. See Gilkey v. SAIF, 113 Or App 314, rev den 314 Or 573 (1992) (Where the parties have agreed that there is no relationship between an injury and a condition, they are bound by that agreement³). Thus, the question becomes whether claimant's work activities or exposures, other than those subject to prior agreement (or excluded by Referee McWilliams' final order), are the major contributing cause of claimant's degenerative disc condition or its worsening. Although there is evidence relating claimant's degenerative condition to his 12-year work exposure there is no evidence indicating that claimant's work exposure since May 8, 1991, not including January 8, 1992 or February 4, 1993 through August 12, 1993, is the major contributing cause of that condition or its worsening. Consequently, claimant's occupational disease claim must fail.

ORDER

The Referee's order dated October 3, 1994 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

¹ In this regard, the Referee relied on Bennett v. Liberty Northwest Insurance Corporation, 128 Or App 71 (1992). In Bennett, the claimant relied on the last injurious exposure rule to prove that work activities with one of several employers "could have" caused his condition. Here, claimant concedes that the 1991 DCS resolved his occupational disease claim for "pre-DCS" work exposures with SAIF's insured. Under these circumstances, the last injurious exposure rule of proof does not apply. See Lola M. Springer, 46 Van Natta 1672, on recon 46 Van Natta 2213 (1994).

² Dr. Kitchel, treating physician, opined that claimant's work injuries and work activities (during his 12 year employment with SAIF's insured) were the major contributing cause of claimant's worsened degenerative disc disease. (Exs. 53-11, 53-19-22, 60, 63).

³ We acknowledge claimant's contention that SAIF may not argue that claimant's occupational disease claim is barred by "claim preclusion," because that defense was not raised at hearing. We construe claimant's argument as an assertion that SAIF waived a defense by failing to raise it before the parties submitted the matter to the Referee on the record. We find evidence of no such waiver. Moreover, there is no "claim preclusion" issue in this case. Instead, as discussed herein, by the terms of the parties' agreements, claimant may not contend that the work exposures subject to those agreements compensably contribute to his current condition. See Gilkey v. SAIF, supra.

In the Matter of the Compensation of
ALEC E. SNYDER, Claimant
WCB Case No. 93-15291
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian and Gunn.

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

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his finding that the August 1993 injury was the major contributing cause of his disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

On review, the parties agree that, inasmuch as claimant had a preexisting low back condition which combined with the August 1993 work incident (in which claimant stepped into a hole) to cause his subsequent disability and need for treatment, ORS 656.005(7)(a)(B) applies in this case. Hence, the dispositive issue is whether the August 1993 work incident was the major contributing cause of his disability and need for treatment.

Relying on the Court of Appeals' decision in U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), the Referee reasoned that, since claimant's preexisting low back condition was asymptomatic for two years prior to the August 1993 incident, the August 1993 incident was the major contributing cause of his subsequent disability and need for treatment. The insurer argues that the Referee erred in his analysis of the medical evidence. We agree.

Given the multiple potential causes for claimant's resultant condition, we find that the application of the "major contributing cause" standard to the facts of this case presents a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 281 (1993). The medical evidence in this case is divided between Dr. Kuller, who supports compensability, and Dr. McGirr, who does not.

Both doctors agree that claimant has a prior history of lumbar disc herniation and surgeries (in March 1991) which resulted in arthritic changes and scar tissue that preexisted the August 1993 incident. Neurosurgeon Dr. McGirr, who reviewed claimant's medical records and saw claimant on at least three occasions following the August 1993 incident, opined that the August 1993 incident, while playing a role in his persistent low back pain, was not the major contributing factor in his low back problems. He opined that the more significant contribution was made by the previous injuries and degeneration which predisposed claimant to the lumbar strain. (Ex. 47).

Orthopedic surgeon Dr. Kuller, who reviewed claimant's medical records only, opined that, while claimant's previous surgeries were a predisposing factor in his subsequent need for treatment, the August 1993 incident was the major contributing cause. She observed that claimant was able to perform heavy manual work for about a year prior to the August 1993 incident and did not seek treatment for back pain during that time period. She reasoned that "in the absence of his fall at work in [August] 1993 he would not likely have needed to seek medical treatment for his back as his back was not [previously] symptomatic despite heavy manual labor." (Ex. 46).

The Referee noted that, similar to the facts in Burtis, claimant's preexisting condition was asymptomatic for years prior to the work incident. Reasoning that Dr. McGirr's opinion was contrary to the law as set forth in Burtis, the Referee relied on Dr. Kuller's opinion and concluded that claimant had met his burden of proof under ORS 656.005(7)(a)(B). We disagree with that analysis.

In Burtis, *supra*, the claimant experienced a compensable cervical strain injury, which was superimposed on a preexisting degenerative cervical spine disease, and which caused the preexisting condition to become symptomatic and require surgery. The employer contended that the claimant's surgery was not compensable because it was intended to ameliorate the claimant's degenerative disc disease and not the cervical strain. The court agreed with the Board's reasoning that, under ORS 656.005(7)(a)(B), the test did not turn upon whether the treatment was separately directed to either the compensable injury or the preexisting condition. Instead, the court affirmed the Board's decision that the resultant condition is compensable where the medical evidence establishes that the claimant's accepted injury is the major contributing cause of the claimant's disability and need for treatment. Noting that the medical evidence established that the claimant's cervical strain made his degenerative disc disease symptomatic, resulting in the need for the surgery, the court concluded there was substantial evidence to support the Board's finding that the injury was the major contributing cause of disability and the need for treatment.

We do not believe that Burtis set forth a rule of law that, in all cases where a work incident causes a previously asymptomatic condition to become symptomatic, the work incident shall be deemed the major contributing cause of the resultant condition. Indeed, the Court of Appeals has subsequently explained, in Dietz v. Ramuda, 130 Or App 397 (1994) (A decision issued subsequent to the Referee's order), that an event which precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms. There, a claimant experienced a heart attack after an extended period of smoke inhalation. The claimant had been diagnosed with preexisting, although nonsymptomatic, coronary artery disease. The court agreed with our application of ORS 656.005(7)(a)(B) in determining whether the work incident was the major contributing cause of the claimant's resultant condition. The court rejected the claimant's argument that a work event that is the precipitating cause of a disease or injury was necessarily the major cause, explaining that, although a work event that is the precipitating cause of a disease or injury may be the major contributing cause, the proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause. Id. at 401.

In both Burtis and Dietz, the court held that the proper analysis under ORS 656.005(7)(a)(B) turns on whether the medical evidence establishes that the injury is the major contributing cause of a claimant's resultant disability and need for treatment. Hence, the application of ORS 656.005(7)(a)(B) is largely dependent on an evaluation of the medical evidence in each case. See Lance A. Banaszek, 47 Van Natta 361 (1995).

Here, after evaluating the opposing medical opinions, we are most persuaded by that of Dr. McGirr. He persuasively explained that claimant's previous injury, surgeries and resulting degeneration predisposed him to the lumbar strain he suffered as a result of the August 1993 incident. While acknowledging the contributory role of the August 1993 incident itself, Dr. McGirr opined that the preexisting condition had a more significant contribution. Dr. McGirr's evaluation of the relative contribution of the preexisting condition and the August 1993 incident is precisely the analysis required under ORS 656.005(7)(a)(B). See Dietz v. Ramuda, *supra*.

Dr. Kuller, on the other hand, relied entirely on the facts that claimant was asymptomatic for about a year before the August 1993 incident,¹ and that he would not have needed treatment in the absence of the August 1993 incident. Dr. Kuller thus employed a "but for" analysis; that is, but for the August 1993 incident, claimant would not have required treatment. However, that analysis is essentially the same "precipitating cause" analysis that was rejected by the Dietz court. The mere fact that the August 1993 incident precipitated symptoms does not mean that the incident was the major cause of those symptoms. Because Dr. Kuller employed a "but for" analysis, rather than weighing the relative contribution of different causes, we conclude that her opinion is not well reasoned.

In addition, Dr. Kuller appeared to believe that claimant sustained a "fall" in the August 1993 incident. (See ex. 46-1). That is incorrect. Claimant only stepped in a six-inch-deep hole at work. (Tr. 17). Insofar as Dr. Kuller may have believed that the August 1993 incident was more traumatic to claimant's back, we discount her opinion.

¹ Actually, the record shows that claimant was asymptomatic for about two years prior to the August 1993 incident.

Therefore, based on Dr. McGirr's better-reasoned opinion, we conclude that claimant's preexisting lumbar spine condition was the major contributing cause of his disability and need for treatment following the August 1993 incident. Accordingly, we reverse the Referee's order.

ORDER

The Referee's order dated July 8, 1994 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that Dr. McGirr's opinion is most persuasive. He ignored two pivotal (and undisputed) facts which I believe support the compensability of claimant's back injury claim. He ignored the fact that, notwithstanding claimant's preexisting arthritic changes, claimant had no back symptoms for two years prior to the August 1993 work incident. He also ignored the fact that, whereas claimant was capable of performing heavy manual work for about one year prior to the work incident, after the August 1993 incident, he was unable to continue performing his work.

Dr. Kuller considered these two facts in reaching her opinion that the work incident was the primary cause of claimant's disability and need for treatment. In my view, Dr. Kuller's analysis is better reasoned and, contrary to the majority's assertion, it is entirely consistent with the analysis set forth in Dietz v. Ramuda, supra. That is, the absence of back symptoms and disability prior to the August 1993 incident certainly indicates that, as between the preexisting condition and the work incident, the work incident had a greater contribution to claimant's subsequent disability and need for treatment. Because I would affirm the Referee's conclusion that claimant's back injury claim is compensable, I respectfully dissent.

May 3, 1995

Cite as 47 Van Natta 840 (1995)

In the Matter of the Compensation of
TAMMY M. TALLMON, Claimant
 WCB Case No. 94-08793
 ORDER ON REVIEW
 Neil Jackson & Associates, Claimant Attorneys
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Myzak's order that increased claimant's unscheduled permanent disability award for an inner ear injury from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to 27 percent (86.4 degrees). On review, the issue is extent of unscheduled permanent disability.

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

There is no dispute that, due to the compensable injury, claimant has objective findings of a permanent disturbance of the vestibular mechanism that results in vestibular disequilibrium which limits her activities. (Exs. 88, 100A). Furthermore, there is no dispute that claimant's impairment is governed by former OAR 436-35-390(7)(a). (WCD Admin. Order 6-1992). The dispute solely involves the impairment rating to be awarded for claimant's limitation under that rule.

We agree with the Referee's reasoning and conclusion that claimant's impairment spans three of the four impairment value categories contained within former OAR 436-35-390(7)(a) but that it does not fit precisely within any one category. We also agree that the middle category most accurately corresponds to claimant's actual impairment, resulting in an impairment value of 23 percent. Former OAR 436-35-390(7)(a)(B). We write to respond to the employer's arguments on review.

The employer urges us to reinstate the rationale and award contained in the July 18, 1994 Order on Reconsideration. (Ex. 107). However, in concluding that claimant's impairment was 8 percent, the evaluator made several medical determinations that have no support in the record. Specifically, the

evaluator judged that many of the permanent restrictions provided by Dr. Epley, claimant's attending physician, "appear to be prophylactic in nature (in order to prevent disruption of the delicate structures and grafts within claimant's inner ear) rather than due to disequilibrium per se." (Ex. 107-4). In addition, the evaluator stated that Dr. Epley's physical capacities evaluation "appears to restrict many activities which could not possibly be related to disequilibrium; such limitations as standing/walking, lifting/carrying, reaching, crawling, exposure to extreme temperatures, and exposure to dust, fumes & gases, for example, could not possibly be due to disequilibrium." Id.

We note that Dr. Epley did not restrict claimant from exposure to dust, fumes and gases. (Ex. 100A-3). More importantly, nothing in the record supports the evaluator's conclusions that many of Dr. Epley's restrictions are not related to disequilibrium.

We rely on Dr. Epley's opinion. In addition to providing a physical capacities evaluation, Dr. Epley opined that

"although the signs of vestibular dysequilibrium [sic] are present with supportive objective findings, most of the [sic] usual activities of daily living can be performed without assistance, with the exception of thee [sic] following activities: climbing, extensive carrying, or other activities where imbalance or visual dependence may present a danger to herself or others; extensive lifting and other forms of strain. [Claimant] is able to operate a motor vehicle under limited conditions, but would be limited in conditions where visual contact with her surroundings is limited or disturbed." (Ex. 100A-1).

Former OAR 436-35-390(7)(a) evaluates impairment due to vestibular disequilibrium in terms of the injured worker's limitations in performing the "usual activities of daily living" and inability to operate a motor vehicle. Former OAR 436-35-390(7)(a)(A)-(D). Former OAR 436-35-005(1) defines activities of daily living and includes "mobility" within that definition.

Here, Dr. Epley's un rebutted opinion establishes that, due to compensable vestibular dysequilibrium, claimant has restrictions on her mobility and is unable to perform all of the usual activities of daily living without assistance, although she is able to perform most of those activities. Therefore, contrary to the employer's argument, former OAR 436-35-390(7)(a)(A) does not apply because, under that provision, the injured worker is able to perform the usual activities of daily living without assistance. Likewise, former OAR 436-35-390(7)(a)(C) does not strictly apply because that provision provides that the injured worker is not able to perform the usual activities of daily living without assistance. Here, claimant can perform most, but not all, of those activities without assistance.

Under these circumstances, we agree with the Referee that former OAR 436-35-390(7)(a)(B) most accurately evaluates claimant's impairment. In reaching this conclusion, we realize that claimant is not totally unable to drive a motor vehicle. However, her ability to drive is restricted due to her injury. That, in combination with her inability to perform all the usual activities of daily living without assistance, makes former OAR 436-35-390(7)(a)(B) the most appropriate provision to evaluate claimant's impairment.

Finally, we note that the employer argues that the Referee disregarded Dr. Epley's statement that, under former OAR 436-35-390(7)(a), "[i]f the wordage is taken absolutely laterally [sic], 8 percent [the impairment value under subsection (A)] would have to be selected." (Ex. 100A-1). We disagree. Instead, the Referee found that this statement was not entitled to deference because it constituted a legal opinion and not expert medical evidence. We agree with the Referee's evaluation.

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

ORDER

The Referee's order dated November 17, 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
ROBERT C. TOTH, Claimant
WCB Case No. 94-01227
ORDER ON RECONSIDERATION
Charles L. Lisle, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Claimant requests reconsideration of our April 18, 1995 order that upheld the insurer's denial of claimant's injury claim for a poisonous insect bite. Challenging our analysis of the medical opinions, claimant seeks reinstatement of the Referee's compensability finding.

To begin, claimant objects to our rejection of the opinion authored by Dr. Winkler. Among other reasons, we found that Dr. Winkler had attributed claimant's alleged spider bite to a type of spider that has never been found in Oregon. Asserting that the pivotal inquiry is whether the spider bite is venomous (regardless of whether the bite came from one type of spider or another similar variety), claimant contends that the specific type of spider is irrelevant.

Following our reconsideration, we continue to believe that Dr. Winkler's identification of a variety of spider which is not indigenous to Oregon is relevant to our determination regarding the degree of persuasive weight to accord his opinion. In any event, even if we discarded this basis for discounting Dr. Winkler's opinion, we would still not consider it persuasive due to its unexplained and conclusory nature. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429 (1980).

Claimant also challenges our reliance on Dr. Akre. Noting that Dr. Akre is an entomologist, claimant argues that we erred in specifically deferring to his "medical opinion." Furthermore, contending that Dr. Akre's testimony is inconsistent with research gleaned from his own treatise, claimant asserts that we should rely on Dr. Akre's treatise.

For the reasons discussed in our prior order, we continue to find the opinion expressed by Dr. Akre to be the most persuasive. We would reach this conclusion regardless of whether the opinion is characterized as either "medical," "specialist," or "entomologist."

In addition to the reasoning contained in our previous decision, we offer the following responses to several of claimant's specific objections. First, our decision to uphold the insurer's denial was not primarily premised on the fact that no spider was located at claimant's work premises. We recognize that Dr. Akre's research reveals many instances where spiders were never found. Nevertheless, when considered in conjunction with the other factors surrounding the claim (particularly when compared with evidence that spiders were present at claimant's home), the lack of evidence regarding the existence of a spider at work (either before or after the alleged incident) does not lend support to claimant's contention that he was bitten by a spider on his employer's premises.

Secondly, asserting that Dr. Akre's testimony that claimant would not have felt a spider bite is contrary to the research from his treatise, claimant disagrees with our previous reasoning that a dispute as to whether claimant felt a bite would not be relevant. As mentioned in our previous decision, the research indicates that a spider bite has been described as "not painful" and "either goes unnoticed or is felt as a mild prick." (Ex. 12-6; 13-18). Considering such research findings, we do not necessarily agree with claimant's contention that Dr. Akre's testimony is entirely at odds with the treatises. In any event, even if this portion of his testimony was viewed in the manner claimant espouses, it would not cause us to reject the remainder of Dr. Akre's opinion.

Finally, we offer similar reasoning in rejecting claimant's argument that Dr. Akre's testimony that claimant would not experience a fever from a spider bite is inconsistent with the findings contained in the treatises. The entomological society treatise does indicate that a spider bite victim experienced a fever and, subsequently, an infection. (Ex. 13-20). Nevertheless, the case study does not specifically explain whether such symptoms were attributable to the spider bite or the "localized itchiness." Such a distinction is important in that Dr. Akre's testimony related fever and secondary infections to scratching. (Tr. 106). Under such circumstances, we do not consider Dr. Akre's testimony to be inconsistent with the treatise findings.

In conclusion, based on the findings and reasoning contained in our prior order, as supplemented herein, we continue to conclude that the record does not support claimant's contention that his claim is compensable. Consequently, we adhere to our decision which upheld the employer's denial.

Accordingly, we withdraw our April 18, 1995 order. On reconsideration, as supplemented herein, we republish our April 18, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 3, 1995

Cite as 47 Van Natta 843 (1995)

In the Matter of the Compensation of
HOANG N. TRAN, Claimant
WCB Case Nos. 93-05319 & 93-03398
ORDER ON REVIEW
Schneider & Hooten, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Holtan's order that: (1) set aside the SAIF Corporation's denial, on behalf of Adult and Family Services (SAIF/AFS), of claimant's current low back condition and need for treatment; (2) upheld the SAIF Corporation's aggravation and current condition denials, on behalf of Private Industry Council (SAIF/Council), of the same condition; (3) declined to direct SAIF/Council to pay interim compensation; and (4) declined to assess penalties or attorney fees against SAIF/Council for its failure to pay interim compensation. On review, the issues are compensability, aggravation, interim compensation and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured September 1985 while working for AFS, which was insured by SAIF. SAIF/AFS accepted the claim for "strain back." (Ex. 2). Claimant's claim with SAIF/AFS was reopened in April 1987 for an aggravation. SAIF/AFS paid for a June 1987 surgery for a disc herniation at L2-3. SAIF/AFS also paid a Determination Order award which included an impairment award for the L2-3 surgery. (Ex. 24). By Determination Order and stipulation, claimant was awarded a total of 32 percent unscheduled permanent disability for the SAIF/AFS low back injury.

In July 1989, claimant suffered a second compensable low back injury while employed by SAIF/Council. SAIF/Council accepted the claim for "lumbar strain." By stipulation, claimant received 5 percent unscheduled permanent disability for her July 1989 injury claim. (Ex. 49). This award was made in contemplation of future waxing and waning of claimant's condition.

On February 26, 1993, SAIF/AFS denied that claimant's current treatment was compensably related to her September 1985 injury. On May 26, 1993, SAIF/Council issued an aggravation denial and on June 7, 1993, SAIF/Council denied claimant's current condition.

Current Condition Denials

The Referee concluded that claimant's need for medical treatment for her low back condition remained materially related to her 1985 SAIF/AFS injury. The Referee found that SAIF/AFS remained responsible for claimant's need for treatment of her low back condition because claimant's accepted 1989 lumbar strain injury with SAIF/Council had resolved by August 1991.

On review, claimant contends that SAIF/Council, as the carrier with the last accepted claim for a lumbar strain is responsible for claimant's current low back condition. We agree.

The medical evidence from Dr. Truong and Drs. Bald and Snodgrass indicates that claimant's current condition is a lumbar strain. (Exs. 51; 52; 57; 63; 71). Although claimant has some left leg symptoms, according to Dr. Flemming, claimant's current condition does not involve a recurrent disc herniation at L2-3. (Ex. 42). Accordingly, based on the medical evidence, we are persuaded that claimant's current condition for which she seeks treatment is a chronic lumbar strain, rather than an L2-3 disc condition.¹ SAIF/Council is the carrier with the latest accepted claim for lumbar strain. Thus, SAIF/ Council remains responsible for claimant's current treatment unless claimant sustains a new compensable injury involving the same condition. ORS 656.308(1).

Although there is medical evidence to the effect that the 1989 strain injury has resolved, we are not persuaded that this relieves SAIF/Council of responsibility for claimant's current condition. As previously noted, SAIF/Council is the last carrier with an accepted claim for lumbar strain. In addition, Drs. Bald and Snodgrass have indicated that claimant is experiencing waxing and waning of subjective symptomatology expected from her original strain injuries. Accordingly, in spite of evidence that the SAIF/Council injury has resolved, claimant still experiences symptoms attributable to her compensable low back strain injuries.

As the carrier with the last accepted claim for a lumbar strain, SAIF/Council remains responsible for the strain symptoms unless or until claimant establishes a new compensable injury involving the same condition. See ORS 656.308(1); Roger D. Jobe, 46 Van Natta 1812 (1994) (second order on recon); Bonni J. Mead, 46 Van Natta 1185 (1994) (on reconsideration). Inasmuch as the record does not establish that claimant has sustained a new compensable lumbar strain injury, responsibility for claimant's current low back condition remains with SAIF/Council.

Aggravation Claim Against SAIF/Council

In order to establish a compensable aggravation, claimant must prove that her compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Furthermore, because claimant has received a previous permanent disability award for her injury, she must establish that any worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8).

After our review of the record, we are not persuaded that claimant has established that her condition has worsened. Moreover, even if claimant can establish a symptomatic worsening, we conclude that such a worsening was not more than a waxing and waning contemplated by the August 15, 1990 stipulation.

Drs. Bald and Snodgrass, examining physicians, opined that claimant's symptoms were not significantly different than when she was examined by them in 1990 and when claimant was examined by Drs. Woolpert and Snodgrass in 1991. (Ex. 70-5). In addition, Dr. Bald and Dr. Snodgrass opined that claimant was experiencing the normally expected waxing and waning of subjective symptomatology that would be expected from her original injuries.

Dr. Truong was unable to state whether or not claimant's back condition had worsened beyond the last arrangement of compensation on August 15, 1990. (Ex. 71). Although Dr. Truong indicated on

¹ SAIF/AFS contends that its accepted claim was limited to "acute lumbosacral sprain and acute lumbosacral and sacral-iliac sprain" and that the September 1985 injury did not involve a herniated disc at L2-3. Because SAIF/AFS did not challenge an October 25, 1988 Determination Order which included an award for the L2-3 disc surgery (Ex. 24-2), SAIF/AFS is arguably precluded from denying an L2-3 disc herniation. See Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994). However, we need not address this issue because we are persuaded by the medical evidence that claimant's current condition for which she seeks treatment is a lumbar strain, rather than an L2-3 disc herniation.

several occasions that claimant was unable to work, those statements do not establish that claimant was suffering a worsened condition beyond that contemplated by the August 1990 stipulation. This is especially true given that, when specifically asked, Dr. Truong could not say that claimant's condition had worsened beyond the expected waxing and waning.

Based on this record, we are unable to conclude that claimant has established a compensable aggravation. Accordingly, we agree with the Referee that SAIF/Council's aggravation denial should be upheld.

Attorney Fee

Claimant argues that the Referee's \$1,500 attorney fee award for setting aside SAIF/AFS' denial is inadequate. In light of our conclusion that SAIF/Council remains responsible for claimant's current condition, we make the following attorney fee award, in lieu of the Referee's award.

Claimant is entitled to an assessed attorney fee for prevailing against SAIF/Council's current condition denial. ORS 656.386(1). Inasmuch as claimant has not finally prevailed over the aggravation portion of SAIF/Council's denial, he is not entitled to an attorney fee award for his counsel's services devoted to the aggravation issue. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on review concerning the current condition denial issue is \$3,500, to be paid by SAIF/Council. In reaching this conclusion, we have particularly considered the time devoted to the current condition denial issue (as represented by the record and claimant's counsel's statement of services on Board review), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Interim Compensation/Penalties

We adopt the Referee's reasoning and conclusion concerning the interim compensation and penalty issues as set forth in his order.

ORDER

The Referee's order dated April 21, 1994 is reversed in part and affirmed in part. That portion of the Referee's order that upheld SAIF/Council's current condition denial and set aside SAIF/AFS' denial is reversed. The Referee's award of a \$1,500 assessed attorney fee payable by SAIF/AFS is also reversed. SAIF/AFS' denial is reinstated and upheld. SAIF/Council's current condition denial is set aside and the current condition claim is remanded to SAIF/Council for processing according to law. For services at hearing and on review, claimant's attorney is awarded \$3,500, payable by SAIF/Council. The remainder of the Referee's order is affirmed.

May 4, 1995

Cite as 47 Van Natta 845 (1995)

In the Matter of the Compensation of
IVAN J. TROTTER, Claimant
WCB Case Nos. 94-05660, 93-13706, 93-12692 & 93-07917
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Marcia L. Barton (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Black's order that: (1) upheld the SAIF Corporation's denial of claimant's 1994 claim for hearing loss in 1979; (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial of claimant's 1993 claim for a worsened hearing loss condition; and (3) upheld Safeco Insurance Company's (Safeco's) denial of the same condition. On review, the issues are timeliness of claims against SAIF and Safeco, compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but not his Findings of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the facts. For the past 20 years, claimant worked for various employers as a sheet metal worker. The work was noisy, involving exposure to loud metal-on-metal contact, jackhammers and other noisy machinery. For purposes of this case, three employment periods are relevant: From 1973 to 1983, claimant worked for SAIF's insured; in 1985 and 1987, claimant worked for Liberty's insured; in 1985, 1987 and from July 1991 through November 1993, claimant worked for Safeco's insured.

Claimant initially sought treatment for hearing loss in 1979, while working for SAIF's insured. Although he was told that his hearing loss was probably work related, he did not file a claim with SAIF at the time.

Claimant continued his sheet metal work. In 1987, claimant underwent an unsolicited audiogram, which was performed by a representative of a hearing aid company.

In 1992, claimant filed a claim against Safeco's insured, his then-current employer. Thereafter, claimant filed hearing loss claims against SAIF's and Liberty's insureds. The SAIF claim referred to a 1979 injury/occupational disease date. (Ex. 18).

Timeliness of Claim Against SAIF

The Referee concluded that claimant's claim against SAIF, which was limited to claimant's hearing loss condition in 1979, was time-barred under ORS 656.807(1). Claimant asserts that his claim against SAIF was timely, because SAIF failed to show that it was prejudiced by the late filing. We need not address that argument, because there is insufficient evidence regarding the compensability of claimant's hearing loss condition in 1979. Accordingly, regardless of whether claimant's claim against SAIF was timely, we agree with the Referee's decision upholding SAIF's denial.

Timeliness of Claim Against Safeco

Claimant began working for Safeco's insured in July 1991. Claimant filed a hearing loss claim against Safeco over a year later, in November 1992. (Ex. 5). Safeco argues that it was prejudiced by claimant's failure to file a claim within a year of beginning employment with its insured and, therefore, that claimant's claim against it is time-barred under ORS 656.807(1). We disagree.

Claimant's current hearing loss claim is based on the worsening of his hearing loss that occurred after 1979 as a result of his continuing occupational noise exposure. Claimant was not told by any medical expert that his hearing loss had worsened until after he filed the claim against Safeco. Consequently, we conclude that there is no timeliness bar to the 1992 claim against Safeco.

Compensability

As we have already stated, claimant's theory of compensability is that, since 1979, he has sustained a compensable worsening of his hearing loss condition. To prevail on that theory, claimant must establish that his post-1979 work activities were the major contributing cause of a worsened hearing condition. ORS 656.802(2).

Based on our review of the evidence, we conclude that, after 1979, claimant experienced a worsening of his hearing condition. Dr. Hodgson, an otolaryngologist who examined claimant on Safeco's behalf, specifically concluded that claimant's permanent hearing loss probably had worsened since 1979. (Ex. 22-6, -25). A report of Dr. Bakos, an otolaryngologist who examined claimant on Liberty's behalf, noted a worsening in claimant's hearing loss after 1979. (See Ex. 16-2; see also Ex. 23-19). We find that evidence sufficient to establish that claimant's hearing loss condition worsened after 1979.

Moreover, we find that the preponderance of the medical evidence establishes that the major contributing cause of claimant's worsened hearing loss condition was his work exposure after 1979. The record establishes that all of claimant's sheet metal employment, both before and after 1979, involved noisy work. (See Tr. 20, 22). Based on his review of claimant's audiograms and work history, Dr. Hodgson concluded that it was more likely than not that claimant's post-1979 hearing loss worsening was caused, in major part, by his occupational noise exposure after 1979. (Ex. 22-7). On this record, we find that opinion sufficient to meet claimant's burden of proof.

We are not persuaded by the contrary causation opinions of Dr. Bakos and Dr. Springate, an otolaryngologist who examined claimant on SAIF's behalf. Dr. Bakos admitted that claimant's occupational noise exposure was the type that can cause permanent hearing loss. (Ex. 23-8). Nonetheless, he concluded, without persuasive explanation, that the cause of claimant's hearing loss was aging or presbycusis. (*Id.* at -9, -10). In reaching that conclusion, Bakos admitted that he was unable to calculate claimant's hearing loss under the applicable administrative rules. (*Id.* at 6). We find the lack of explanation and Dr. Bakos' inability to calculate claimant's hearing loss persuasive reasons to discount Bakos' opinion.

We reach a similar conclusion regarding Dr. Springate's opinion. He concluded that claimant's hearing loss pattern did not indicate that his hearing loss is noise-related; rather, he concluded that claimant's condition "could be" inherited. (Ex. 20-2). Because Springate's opinion, at best, speculates regarding the cause of claimant's hearing loss, we afford it minimal, if any, weight. See Suzeann Evans, 46 Van Natta 1863 (1994) (speculative opinion held unpersuasive).

In reaching these conclusions, we acknowledge the parties' dispute regarding the reliability and probative value of claimant's 1987 audiogram. The medical evidence is divided on the reliability issue. Because claimant's theory of compensability alleges that he experienced a hearing loss worsening after 1979, not just between 1979 and 1987, the 1987 audiogram is not imperative to our analysis of the compensability issue. Therefore, we have not resolved the dispute regarding the 1987 audiogram.

Responsibility

Next, we consider the responsibility issue. Because no carrier has accepted a hearing loss claim, we analyze this matter under the last injurious exposure rule. That rule provides that where, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Bazar, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment for 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, 401 (1993), rev den 319 Or 81 (1994).

Claimant first sought treatment for his post-1979 hearing loss condition in 1992. At the time, Safeco was on the risk. Accordingly, responsibility is initially assigned to Safeco. Safeco can shift responsibility to Liberty, the prior insurer, by showing that claimant's work exposure while Liberty was on the risk as the sole cause of claimant's worsened hearing condition, or that it was impossible for conditions while Safeco was on the risk to have caused the worsening. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

Safeco has failed to carry that burden. Dr. Hodgson's reports reveal that all of claimant's post-1979 employment, which includes that for Safeco's insured, contributed to the worsening of claimant's hearing condition. That evidence prevents Safeco from prevailing on the impossibility theory.

Safeco attempts to shift responsibility back to Liberty by relying on claimant's 1987 audiogram as proof that claimant's hearing loss did not worsen during his tenure with Safeco's insured. We reject that argument for two reasons. First, claimant worked for Liberty's insured in 1985, two years before the 1987 audiogram. Second, we find that the conflicting evidence regarding the accuracy and reliability of the 1987 audiogram is sufficient to persuade us not to rely on it in addressing the responsibility issue. Accordingly, we conclude that Safeco has not prevailed on the "sole cause" theory. Therefore, we conclude that Safeco remains responsible for claimant's worsened hearing loss condition.

Claimant is entitled to an attorney fee for prevailing over Safeco's denial. ORS 656.386(1). After considering the factors set forth in OAR 436-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on Board review is \$4,000, to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated June 28, 1994 is affirmed in part and reversed in part. That portion of the Referee's order upholding Safeco Insurance Company's denial is reversed. Safeco's denial is set aside and the claim is remanded to Safeco for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on Board review, claimant's counsel is awarded \$4,000, to be paid by Safeco.

May 4, 1995

Cite as 47 Van Natta 848 (1995)

In the Matter of the Compensation of
LADENA F. WILDMAN, Claimant
WCB Case No. AF 94020
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
James D. Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Tenenbaum's order which declined to approve claimant's counsel's request for an out-of-compensation attorney fee in connection with the SAIF Corporation's reclassification of claimant's claim from nondisabling to disabling. Claimant also moves to strike SAIF's respondent's brief as untimely. On review, the issues are motion to strike and attorney fees.

We deny the motion to strike and adopt and affirm the Referee's order with the following supplementation.

Claimant moves to strike SAIF's respondent's brief as untimely because she did not receive it until more than a month after it was mailed. Alternatively, claimant requests that we grant an extension of time in which to file her reply brief.

Inasmuch as SAIF's brief was mailed to the Board within 21 days of the date of mailing of claimant's appellant's brief, we find that it was timely. However, we have granted claimant's request for an extension of time in which to file her reply brief. Since claimant's reply brief was timely filed, as instructed, within 14 days of our letter deferring a ruling on claimant's motion to strike, we have considered it on review.

We now turn our attention to the merits of the attorney fee issue. On August 12, 1993, claimant's counsel requested that SAIF "reclassify" claimant's carpal tunnel claim from nondisabling to disabling. At the time, the claim had neither been accepted nor denied, and the 90-day period in which to accept or deny the claim had not yet expired. After SAIF refused to "reclassify," claimant's counsel requested the Director to do so on August 26, 1993. The Director declined the request on October 6, 1993 because SAIF had already denied the claim on September 9, 1993.

By stipulation dated November 29, 1993, SAIF rescinded its denial, accepted the claim and agreed to pay claimant's counsel \$1,500 for his services in overturning its denial. On March 17, 1994, after claimant's attending physician advised that claimant needed surgery, SAIF reclassified the claim to "disabling." Claimant's counsel took no action regarding reclassification between the date of claim acceptance and the date of reclassification.

Claimant's counsel requested a summary proceeding before the Hearings Division, seeking an "out-of-compensation" attorney fee for services provided in obtaining compensation without a hearing.

See ORS 656.386(2); OAR 438-15-030. The Referee found that claimant's counsel was not entitled to an out-of-compensation attorney fee. In reaching this conclusion, the Referee determined that claimant's counsel was not "instrumental" in obtaining reclassification. We agree.

Claimant's counsel asserts that, when SAIF reclassified the claim to disabling on March 17, 1994, he became entitled to an attorney fee because of his earlier request for reclassification prior to SAIF's acceptance of the claim. Although claimant's counsel contends that his request for reclassification prior to SAIF's acceptance of the claim was not premature, we disagree.

The requirement that a worker has one year from the date of his injury to submit a claim that a nondisabling injury has become disabling applies only to accepted claims. See Elsie C. Rios, 42 Van Natta 665, 667 (1990). Therefore, a request for reclassification prior to the expiration of the 90-day period in which to accept or deny a claim is "premature." Moreover, in the three and one-half months between SAIF's acceptance and its reclassification, claimant's counsel made no efforts with respect to reclassification. SAIF reclassified the claim on its own initiative after receiving notification of claimant's surgery. We, therefore, conclude that claimant's counsel was not "instrumental" in obtaining reclassification. See OAR 438-15-030.

Accordingly, we agree with the Referee that claimant's counsel is not entitled to an out-of-compensation attorney fee in connection with SAIF's reclassification of the claim. Thus, we affirm the Referee's decision.

ORDER

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

May 4, 1995

Cite as 47 Van Natta 849 (1995)

In the Matter of the Compensation of
GARY B. BOWERS, Claimant
WCB Case No. 94-04467
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes, Turner-Christian, and Gunn.

Claimant requests review of Referee Howell's order that: (1) decreased claimant's scheduled permanent disability (PPD) award for loss of use or function of the left foot from 3 percent (4.05 degrees), as awarded by an Order on Reconsideration, to zero; (2) decreased claimant's scheduled PPD award for loss of use or function of the right foot from 3 percent (4.05 degrees) to zero; (3) decreased claimant's unscheduled PPD award for a low back injury from 17 percent (54.4 degrees) to zero; and (4) declined to assess a penalty pursuant to ORS 656.268(4)(g). On review, the issues are extent of scheduled and unscheduled permanent disability and penalties.

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

The Referee found, with respect to the question of causation of claimant's permanent impairment, the opinions of examining physicians McKillop and Reimer (as initially concurred in by attending physician Newby), to be more persuasive than that of medical arbiter Smith. Therefore, relying on their opinions, the Referee concluded that claimant has no permanent impairment due to his February 1993 injury. The Referee thus reduced claimant's PPD awards to zero.

On review, claimant contends that where a medical arbiter is appointed pursuant to ORS 656.268(7), only the opinions of the attending physician and the medical arbiter may be considered in rating impairment. Because Dr. Newby never "directly" addressed the permanent disability issue, claimant argues that the findings of the medical arbiter must be used to rate impairment. We disagree.

Generally, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). However, ORS 656.268(7) provides only that where a medical arbiter or panel of medical arbiters is appointed, "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).

Impairment findings from a physician, other than the attending physician, may be used if those findings are ratified by the attending physician. OAR 436-35-007(6); Roseburg Forest Products v. Owen, 129 Or App 442, rev den 320 Or 271 (1994); Alex J. Como, 44 Van Natta 221 (1992). Drs. McKillop and Reimer's reports were submitted prior to the medical arbiter's report and concurred in by attending physician Newby. Thus, the evidentiary restrictions found in ORS 656.245(3)(b)(B) do not apply.

For the reasons expressed by the Referee, we too are persuaded that Drs. McKillop and Reimer's opinion (as concurred in by Dr. Newby) that claimant's permanent impairment is attributable to his noncompensable degenerative condition, rather than to the compensable injury, is the most logical and consistent with the facts. Consequently, claimant has not met his burden of proving that he has any impairment as a result of the compensable February 1993 injury. See ORS 656.214(2) and (5); 656.266. We therefore affirm the Referee's order which reduced claimant's scheduled and unscheduled PPD awards to zero.

ORDER

The Referee's order dated September 1, 1994 is affirmed.

Board Member Gunn dissenting.

As the courts and this Board have held, medical evidence concerning the extent of a worker's impairment is limited to the opinions of the medical arbiter and the attending physician at the time of claim closure (including any findings from nonattending physicians which have been ratified by the attending physician). See Roseburg Forest Products v. Owen, supra; Koitzsch v. Liberty Northwest Ins. Corp., supra; Alex J. Como, supra. In the instant case, the opinions concerning claimant's impairment come from attending physician Newby, examining physicians McKillop and Reimer (to the extent Dr. Newby concurred in their findings), and medical arbiter Smith.

Dr. Newby never "rated" claimant's impairment. While Drs. McKillop and Reimer discussed the causation of claimant's impairment, they likewise never made findings related to claimant's impairment. Moreover, I cannot conclude that Dr. Newby truly endorsed their findings, as evidenced by his gradual backtracking from his initial concurrence. Therefore, without clear acknowledgment and acceptance of those findings by Dr. Newby, the findings of Drs. McKillop and Reimer cannot be used.¹ See ORS 656.245(3)(b)(B).

That leaves the opinion of medical arbiter Smith. I am persuaded by the thoughtful opinion of Dr. Smith who, after carefully distinguishing between claimant's permanent impairment which resulted from the compensable injury and that attributable to noncompensable degenerative disease, opined that 50 percent of claimant's measurable impairment is "due to" the compensable injury. Therefore, the preponderance of the valid evidence establishes that claimant has permanent impairment as a result of the February 1993 injury.

On this record, then, I would reverse the Referee and reinstate the Order on Reconsideration awards of scheduled and unscheduled permanent disability. For these reasons, I respectfully dissent.

¹ Which findings are questionable at best, because Drs. McKillop and Reimer neither discussed nor purported to rate claimant's impairment.

In the Matter of the Compensation
MARIA S. CHAVEZ, Claimant
WCB Case No. 94-03718
ORDER OF ABATEMENT
Craine & Love, Claimant Attorneys
Roberts, et al., Defense Attorneys

The insurer requests abatement and reconsideration of our April 19, 1995 Order on Review, in which we affirmed the Referee's order which declined to authorize an offset of scheduled permanent disability against a subsequent award of unscheduled permanent disability. The insurer requests that we reconsider our decision.

In order to further consider the insurer's motion, we withdraw our April 19, 1995 order. In addition, we implement the following supplemental briefing schedule. Claimant's supplemental response must be filed within 14 days from the date of this order. The insurer's supplemental reply shall be due 14 days from the date of mailing of claimant's response. Thereafter, this matter shall be taken under advisement.

In submitting their respective arguments, the parties are requested to address the effect, if any, of *SAIF v. Sweeney*, 115 Or App 506 (1992), *on recon* 121 Or App 142 (1993); *Leedy v. Knox*, 34 Or app 911 (1978); and *Phillip A. Sterle, Jr.*, 46 Van Natta 506 (1994).

IT IS SO ORDERED.

May 5, 1995

Cite as 47 Van Natta 851 (1995)

In the Matter of the Compensation of
JAMES D. LOLLAR, Claimant
WCB Case Nos. 94-03241 & 94-00738
ORDER OF ABATEMENT
Gatti, Gatti, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
John B. Motley (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our April 20, 1995 Order on Review which awarded a \$600 attorney fee under ORS 656.386(1) to claimant's attorney for his pre-hearing services in obtaining rescission of SAIF's denial. In seeking reconsideration, SAIF contends that its denial was limited to responsibility.

In order to allow sufficient time to consider SAIF's motion, we withdraw our April 20, 1995 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD A. KRASNESKI, Claimant
WCB Case Nos. 94-00974, 93-12157, 93-13460 & 93-15225
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
William J. Blitz, Defense Attorney
Marcia L. Barton (Saif), Defense Attorney
Bottini, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Ramsey Waite, a self-insured employer, requests review of those portions of Referee Spangler's order that: (1) set aside its denial of responsibility for claimant's bilateral upper extremity condition; and (2) upheld the denials of responsibility of the SAIF Corporation, on behalf of Haines Masonry and Carter's Drilling, for the same condition. In its brief, SAIF, on behalf of Carter's Drilling, objects to that portion of the order finding that it waived its right to assert that claimant was precluded by a stipulation from asserting compensability. On review, the issues are whether SAIF waived the "stipulation" defense, if not, whether the stipulation precludes claimant from litigating compensability, and responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In 1978, claimant worked for Haines Masonry as a hod carrier. Claimant has a compensable February 1978 right hand injury claim with that employer; this claim included amputation of two fingers. Later in 1978 through December 1989, claimant worked for Carter's Drilling. In April 1993, claimant entered into a stipulation with SAIF, the insurer for Carter's Drilling, whereby SAIF accepted a claim for left carpal tunnel syndrome. Beginning in 1990, claimant worked for Ramsey Waite as a salesman.

Beginning in January 1992, claimant sought treatment for left upper extremity pain. Eventually, claimant was diagnosed with bilateral carpal tunnel syndrome, bilateral epicondylitis, impingement syndrome of the shoulders and bilateral pronator's syndrome.

April 1993 Stipulation

Before reaching the merits, the Referee addressed the insurers' argument that claimant was precluded by the April 1993 stipulation from litigating the compensability of his bilateral upper extremity condition. The Referee characterized the insurers' preclusion argument as constituting the "affirmative defenses" of res judicata and claim preclusion and agreed with claimant that the insurers "waived" such defenses by failing to assert them in the pleadings. The Referee also stated that "[i]t is axiomatic that issues cannot be raised for the first time during closing arguments."

On review, SAIF contends that it raised the issue at the beginning of hearing. SAIF further argues that its action was sufficient to properly raise the issue and that it was not necessary for it to allege the theory in the pleadings. Finally, SAIF alleges that, because claimant sought treatment for his bilateral upper extremity condition before the stipulation, his claim is barred.

When parties litigate an issue by implicit agreement, that issue properly is considered by the Referee even though it was not a ground relied upon by the insurer in its denial. Judith M. Morley, 46 Van Natta 882 (1994). See also Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the Referee and Board not to decide that issue). Conversely, when the claimant objects to the insurer's oral amendment to its denial, we consider it error for the Referee to consider the amended denial. Dolph M. Wiedenmann, 46 Van Natta 1584 (1994).

Here, during its opening statement, SAIF stated that its "first line of defense" was based on recent court cases and Board orders holding that, "if you have a stipulation where the words raised or raisable is included in it and the conditions you're dealing with subsequent to that stipulation were present before the stipulation was entered into * * *, then those words in effect do have meaning and those conditions should have been raised at the time that stipulation was entered into." (Tr. 8-9). There was no objection or response from claimant's attorney regarding SAIF's opening statement.

Although SAIF did not explicitly refer to the April 1993 stipulation in its opening statement, we find that it sufficiently raised the defense that the stipulation precluded claimant from litigating the compensability of any conditions which were in existence before entering into the stipulation. Thus, we conclude that SAIF orally amended its denial to include such a defense. This conclusion is further supported by SAIF's submission of the stipulation into evidence. Because claimant did not object either when SAIF raised the defense during its opening statement or when it sought admission of the stipulation into evidence, we conclude that the denial properly was amended to include this basis. Judith M. Morley, supra; Weyerhaeuser Co. v. Bryant, supra.

Our conclusion is not changed by claimant's subsequent objection to the amendment during closing arguments. Inasmuch as claimant did not object when SAIF amended its denial at the outset of the hearing, we conclude that his objection at the end of the hearing was not timely and, was therefore, without effect.¹ Thus, we proceed to the merits.

A party may not relitigate any issue resolved by a stipulation, since a party is bound to the terms of the agreement. E.g., Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993). Furthermore, when the agreement purports to resolve all issues which were raised or could have been raised, the settlement bars a subsequent claim for a condition that could have been raised before the date of the agreement. Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73 (1994). In Stoddard, the court relied on the Board's findings that the disputed condition was related to the work injury and had been diagnosed, and medical treatment had been requested, prior to the settlement to conclude that the condition was an issue that could have been raised before the date of the agreement.

Here, the April 1993 stipulation provided that the "parties agree to settle all issues raised or raisable at this time as follows: SAIF Corporation rescinds its denial and agrees to accept * * * left carpal tunnel syndrome." (Ex. 38-1). This proceeding concerns claimant's bilateral upper extremity condition, which has been diagnosed as including bilateral carpal tunnel syndrome, bilateral epicondylitis, impingement syndrome of the shoulders and bilateral pronator's syndrome. (Ex. 40). We first note that, inasmuch as SAIF accepted the claim for left CTS, the issue we now consider is whether any of the remaining conditions making up claimant's bilateral upper extremity condition claim are barred because they could have been raised before the date of the stipulation.

There is evidence that, before entering into the stipulation, claimant sought treatment for pain in the left shoulder, forearm and upper arm, the right shoulder and right elbow, as well as the left hand. (Exs. 21, 25, 31, 33, 36). Claimant was diagnosed with left shoulder impingement syndrome, left CTS, right lateral epicondylitis, possible right shoulder impingement or myofascial syndrome, left AC arthritis, and left epicondylitis. (Id.) At that time, however, except for left CTS, only the diagnoses of left AC arthritis and left epicondylitis were related to claimant's work. (Ex. 36). Therefore, we conclude that the diagnoses of left AC arthritis and left epicondylitis "could have been raised" before the settlement and, thus, are now barred against SAIF/Carter's Drilling. See Good Samaritan Hospital v. Stoddard, supra. However, in the absence of any evidence regarding causation of the remaining diagnoses, we conclude that such claims are not barred against any of the carriers. Id.

Responsibility

Applying the last injurious exposure rule (LIER), the Referee found claimant's entire bilateral upper extremity condition compensable and placed responsibility on Ramsey Waite on the basis that

¹ Neither Ramsey Waite nor SAIF/Haines Masonry argue on review that the claim is barred by the April 1993 stipulation. We note that, because these parties did not attempt to amend their denials to include this defense until closing arguments and claimant's attorney objected to such attempts, we do not consider their denials to be amended. See Dolph M. Wiedenmann, supra.

claimant first sought treatment for his condition while working for that employer. Ramsey Waite objects to this conclusion, asserting that there is no evidence that its employment could have or did contribute to claimant's condition.

We disagree with the Referee's application of the last injurious exposure rule. First, because SAIF previously accepted left CTS pursuant to the April 1993 stipulation and since that condition is part of claimant's bilateral upper extremity condition, we conclude that ORS 656.308(1) is applicable for determining responsibility for left CTS. Therefore, in order to shift responsibility, SAIF/Carter's Drilling must show that claimant sustained a new compensable occupational disease during the employment with Ramsey Waite. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993). In particular, SAIF must prove that employment conditions at Ramsey Waite were the major contributing cause of claimant's disease or its worsening. Id.

The record shows that claimant's work at SAIF/Carter's Drilling was the major contributing cause of his left CTS. (Exs. 32-6, 33-6, 34, 63-7). At most, any contribution from the work at Ramsey Waite was minor. (Ex. 27). Thus, we conclude that responsibility for claimant's left CTS remains with SAIF/Carter's Drilling.

With regard to the appropriate analysis for determining responsibility of the remaining conditions, we note that where actual causation with respect to a specific identifiable employer is proven, it is not necessary to rely on the judicially created rule of LIER in determining responsibility. See, e.g., Runft v. SAIF, 303 Or 493 (1987); Eva R. Billings, 45 Van Natta 2142, 2143 (1993). Furthermore, at hearing, claimant asserted that SAIF/Carter's Drilling was responsible for his bilateral upper extremity condition. (Tr. 6-7). None of the carriers referred to, or relied upon, LIER as a defense. Under such circumstances, and because our review of the medical evidence proves the actual cause of his bilateral upper extremity condition, we find the application of LIER to be inappropriate.

Turning to the medical evidence concerning causation, Dr. Teal, claimant's treating surgeon, first concurred with a letter drafted by SAIF's claims adjuster that work activity within the previous one to two years was the major contributing cause of claimant's bilateral epicondylitis, bilateral shoulder impingement syndrome and bilateral pronator syndrome. (Ex. 45).

Dr. Teal subsequently reported to the claims adjuster that claimant's pronator syndrome was "work related and should be considered part of his left carpal tunnel claim." (Ex. 57). Dr. Teal further stated that claimant "has had a well documented overuse problem from his previous employer and I feel this is the major contributing cause of his ongoing symptoms and present condition." (Id.). In response to the claims adjuster's letter stating that Dr. Teal's opinions regarding the pronator syndrome appeared to be inconsistent and asking for clarification, Dr. Teal reported that "it is more a legal than a medical question as to whether this should be part of his left carpal tunnel claim of [sic] whether there should be separate claims for lateral epicondylitis, pronator's syndrome, carpal tunnel syndrome, shoulder pain, etc." (Exs. 60, 61). Dr. Teal further indicated, however, that he had intended in his report to refer to "previous employment" rather than "previous employer." (Ex. 61).

Dr. Teal also responded to a "check-the-box" report drafted by claimant's attorney. In that report, Dr. Teal indicated "yes" to whether claimant's "chronic overuse syndrome," consisting of bilateral epicondylitis, bilateral shoulder impingement syndrome, and bilateral pronator's syndrome, was the result of "years of intense use of his hands including the heavy use of vibrating tools, air compressors and jumping jack." (Ex. 62-2). Dr. Teal further indicated that claimant's work at Carter's Drilling was the major contributing cause of his need for treatment and disability and that his work exposure at Ramsey Waite was not the major contributing cause of the need for treatment and disability. (Id. at 3).

Dr. McKillop, M.D., after reviewing the records, indicated that "most of the conditions under evaluation and treatment now are conditions that do not relate to [claimant's] employment with Carter's Drilling and Pump Service back in 1989." (Ex. 55-2).

Finally, Dr. Brooks, neurologist, and Dr. Coletti, orthopedist, evaluated claimant at SAIF's request. The panel found that the "etiology of the left pronator syndrome and the left ulnar neuropathy at the elbow are unknown but could be activity related" and that the "tendinitis in the left shoulder is likely activity related." (Ex. 63-6, 63-7). The panel found it unlikely, however, that work at Carter's Drilling caused such conditions because such symptoms "came on years after he stopped working for Carter's Drilling." (Id. at 7).

Based on Dr. Teal's opinion, we are persuaded that the major contributing cause of claimant's bilateral epicondylitis, bilateral shoulder impingement syndrome, and bilateral pronator's syndrome was his employment at Carter's Drilling. Although Dr. Teal at one point concurred with SAIF's "check-the-box" report stating that work activity within the previous two years (which would relate to employment with Ramsey Waite) was the major contributing cause of such conditions, Dr. Teal later explained that, with regard to pronator's syndrome, etiology was difficult to determine and that such diagnosis was the result of diagnostic studies and treatment over a period of time, (Ex. 61). We find such evidence sufficiently explains the difference between his concurrence with SAIF's report and the remaining reports, which consistently indicate that work at Carter's Drilling was the major contributing cause of claimant's conditions.

Furthermore, because we find no persuasive reasons for discounting Dr. Teal's opinion, we find he is entitled to deference as the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). Thus, we conclude that his opinion is more persuasive than that of Dr. McKillop, who did not examine claimant, and the panel of Drs. Brooks and Coletti, which examined claimant on one occasion.

Hence, we conclude that SAIF/Carter's Drilling is responsible for claimant's bilateral upper extremity condition. However, this conclusion does not include the left epicondylitis condition in light of our previous determination that such claim is barred by the April 1993 stipulation.

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 \$2,000, payable by SAIF/Carter's Drilling. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney'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 June 24, 1994 is reversed in part and affirmed in part. That portion of the order finding that SAIF/Carter's Drilling did not properly orally amend its denial is set aside. Those portions of the order setting aside Ramsey Waite's denial of responsibility and upholding SAIF/Carter's Drilling's denial of responsibility are reversed. Ramsey Waite's denial of responsibility is reinstated and upheld. SAIF/Carter's Drilling's denial of responsibility is reversed and the claim for bilateral upper extremity condition (excluding left epicondylitis) is remanded to SAIF/Carter's Drilling for processing according to law. For services on review, claimant's attorney is awarded an assessed fee of \$2,000, to be paid by SAIF/Carter's Drilling. SAIF/Carter's Drilling also is responsible for the Referee's assessed attorney fee for services at hearing. The remainder of the order is affirmed.

May 5, 1995

Cite as 47 Van Natta 855 (1995)

In the Matter of the Compensation of
SHAWN C. MANN, Claimant
WCB Case No. 93-15238
ORDER OF DISMISSAL
Galton, Scott & Colett, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

On February 10, 1995, we acknowledged a request for Board review of Referee Poland's January 25, 1995 order which had been filed by the SAIF Corporation. Contending that SAIF requested review of Referee Poland's January 25, 1995 Opinion and Order in WCB Case No. 93-15239 (rather than Referee Poland's January 25, 1995 Order of Dismissal in WCB Case No. 93-15238), Barrett Business Service/Sedgwick James & Company (Sedgwick) moves for dismissal of SAIF's request insofar as it pertains to Referee Poland's Order of Dismissal. We grant the motion.

FINDINGS OF FACT

Claimant filed hearing requests against SAIF and Sedgwick. The hearing requests were consolidated. At hearing, Sedgwick moved for dismissal of claimant's request for hearing insofar as it pertained to Sedgwick. Neither claimant nor SAIF objected to Sedgwick's motion. The Referee granted

Sedgwick's motion. The hearing proceeded regarding claimant's request for a penalty assessment against SAIF.

On January 25, 1995, the Referee issued two orders. An Order of Dismissal, dismissing claimant's hearing request regarding his claim with Sedgwick. The Referee also issued an Opinion and Order assessing SAIF a penalty for allegedly unreasonable claim processing. The caption of each order contained two WCB case numbers (93-15238, claimant's "Sedgwick" hearing request, and 93-15239, claimant's "SAIF" hearing request).

On February 8, 1995, SAIF timely requested Board review of the Referee's "order dated January 25, 1995." On February 10, 1995, the Board mailed computer-generated letters to all parties acknowledging SAIF's request for Board review of both of the Referee's orders.

CONCLUSIONS OF LAW

Although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. Riley E. Lott, Jr., 42 Van Natta 239 (1990); William E. Wood, 40 Van Natta 999 (1988).¹ On the other hand, if a party has been dismissed from a proceeding and its dismissal as a party is not contained in the appealed referee's order, it is not considered a party for purposes of Board review. Jerry R. Miller, 44 Van Natta 1444 (1992).

Here, Sedgwick was initially a party to the consolidated hearing. However, claimant's hearing request concerning Sedgwick was dismissed pursuant to a dismissal order which was separate from the Referee's Opinion and Order which addressed claimant's hearing request regarding his claim with SAIF. Thus, when SAIF requested Board review of the Referee's January 25, 1995 order, it was appealing the Referee's Opinion and Order regarding claimant's "SAIF" hearing request (WCB Case No. 93-15239); it was not requesting review of the Referee's Order of Dismissal concerning claimant's "Sedgwick" hearing request (WCB Case No. 93-15238).

Under such circumstances, SAIF's request for Board review should not have been acknowledged as an appeal of the Referee's January 25, 1995 Order of Dismissal (WCB Case No. 93-15238). Accordingly, to the extent that SAIF's request for Board review could be interpreted as such an appeal, the request is dismissed.²

IT IS SO ORDERED.

¹ In Wood, we noted that the applicable statutes and administrative rules address referee orders, as opposed to WCB case numbers. In other words, the assignment of case numbers are made purely for the administrative efficiency of the forum.

Here, to avoid the continuing consolidation of claimant's "Sedgwick" hearing request with the "SAIF" hearing request, the Referee dismissed the "Sedgwick" request by means of a separate dismissal order. Such an action is entirely appropriate and, consistent with the Miller rationale, achieves administrative efficiency. However, rather than merely reciting the WCB case number corresponding with the "Sedgwick" hearing request, the Referee's dismissal order inaccurately carried both WCB Case Numbers. Notwithstanding this oversight, as previously explained, our appellate authority is based on appealed referee orders, not WCB case numbers. Consequently, since the Referee issued two separate appealable orders, it is appropriate for us to determine to which (if any or both) referee's order SAIF's appeal was directed (irrespective of whether the WCB Case Number noted in SAIF's request pertains to one or more of the case numbers also listed in one or both referee orders).

² SAIF's request for Board review of the Referee's January 25, 1995 Opinion and Order in WCB Case No. 93-15239 is unaffected by this decision. We retain jurisdiction to consider the issues raised by SAIF's appeal from the Referee's decision. Following completion of the briefing schedule, that case will be docketed for review.

In the Matter of the Compensation of
JOHN P. PLUMMER III, Claimant
WCB Case No. 93-14478
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Hall, Turner-Christian and Haynes.

The self-insured employer requests review of Referee Michael Johnson's order which: (1) increased claimant's scheduled permanent disability award for loss of use or function of the right knee from 15 percent (22.5 degrees), as awarded by an Order on Reconsideration, to 19 percent (28.5 degrees); and (2) awarded an assessed attorney fee pursuant to ORS 656.382(2). On review, the issues are extent of scheduled permanent disability and attorney fees.

We adopt and affirm the Referee's order.

Inasmuch as claimant did not timely submit his 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).

ORDER

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

Board Member Haynes dissenting:

In this case, the majority affirmed the Referee's order which increased claimant's scheduled permanent disability award for loss of use or function of the right knee from 15 percent, as awarded by an Order on Reconsideration, to 19 percent. In doing so, the majority, as well as the Director, relied on the one-time examination of the medical arbiter, abandoning the well-established postulate that we tend to give greater weight to the claimants' treating physicians, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

Furthermore, OAR 436-35-007(9) provides that impairment is determined by the attending physician, or by the medical arbiter when one is used, "except where a preponderance of medical opinion establishes a different level of impairment." We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

Here, Dr. Kaesche has been claimant's treating physician and surgeon since claimant's first compensable knee injury in 1985. Dr. Kaesche performed both of claimant's knee surgeries, and he examined claimant's right knee approximately two times a month after the November 1992 injury, until he issued his closing report in June 1993. Therefore, I would rely on his closing report as being the most complete and well-reasoned evaluation of claimant's injury-related impairment. See Argonaut Ins. Co. v. Mageske, 93 Or App 698 (1988); Weiland, *supra*; Matlack, *supra*.

In his closing report, Dr. Kaesche reported that strength in claimant's lower extremities is 5/5 in all muscle groups. (Ex. 29-1). Further, there is no evidence in the record that there is peripheral nerve injury to cause loss of strength. See OAR 436-35-230(9). Nevertheless, the majority has awarded 6 percent permanent disability for loss of muscle strength in claimant's right leg.

Dr. Kaesche further reported full extension in the right knee, and flexion to 80 degrees, limited by claimant's obesity, not by his injury. (Ex. 29-2). Dr. Kaesche concluded that claimant has no evidence of permanent impairment related to his November 1992 knee injury. Id. Notwithstanding the treating surgeon's opinion, the majority has awarded 5 percent permanent disability for loss of range of motion in the knee, and 5 percent permanent disability for an alleged chronic inability to repetitively use the right knee.

Finally, contrary to the "standards" by which we are directed to determine the extent of permanent disability, the majority has declined to apply an offset for claimant's previous right knee meniscectomy. See OAR 436-35-007(3); 436-35-230(5). Accordingly, because I find that the preponderance of the evidence shows that claimant has no impairment to his right knee or leg that is related to his 1992 injury, I respectfully dissent.

May 5, 1995

Cite as 47 Van Natta 858 (1995)

In the Matter of the Compensation of
JAMES P. SPICER, Claimant
WCB Case No. C5-00770
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Breathouwer, et al., Claimant Attorneys
Industrial Indemnity, Insurance Carrier

Reviewed by Board Members Neidig and Hall.

On March 27, 1995, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to the agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed CDA provides that, in exchange for claimant's release of certain rights, the insurer will pay claimant \$7,500 and claimant's attorney \$2,500. The agreement further states that "\$2,000 of the amount made payable by this Claim Disposition Agreement shall become part of the carrier's lien with regard to ORS 656.576 to 656.596." By letter dated April 7, 1995, the Board requested an addendum from the parties seeking further information concerning the third party action.

In response, the parties submitted the following addendum:

"Claimant has secured a third-party recovery substantially in excess of the carrier's present lien for monies previously expended and the present value of reasonably anticipated future medical expenses. Pursuant to recent appellate decisions, the agreement of the parties to stipulate that \$2,000 of the CDA proceeds shall become part of the carrier's lien represents the parties [sic] stated intent to clarify and resolve without question what portion of the Claim Disposition Agreement proceeds shall become part of the carrier's lien on the third-party recovery."

When a carrier agrees to partially or totally reduce a lien in a CDA, the Board does not approve the agreement unless there is a provision indicating that a third party settlement or judgment has been achieved. E.g., Kenneth Hoag, 43 Van Natta 991 (1991). In particular, when no third party settlement has been reached, it is not possible to know whether any portion of the carrier's lien will be satisfied. Thus, in the absence of such information, we cannot determine the "amount to be paid the claimant," as required by OAR 436-60-145(3)(j), when part of the CDA's consideration is a partial or total reduction of a lien. Id.

Here, however, we understand the proposed CDA as not providing any reduction of the insurer's lien. Rather, the "amount to be paid the claimant" is \$7,500 and the amount to be paid claimant's attorney is \$2,500; out of that total, \$2,000 will be considered as included in the insurer's third party lien." Under such circumstances, we find this CDA distinguishable from the one disapproved in Hoag in that it provides the amount to be paid claimant. Furthermore, we find that such a provision is not unreasonable as a matter of law. See Turo v. SAIF, 131 Or App 572, 575-76 (1994) (holding that CDA payment is "compensation" reimbursable from third-party settlement proceeds to the extent that the payment is not for future compensation payable under ORS 656.273 and 656.278).

In conclusion, we hold that the CDA in this case is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Therefore, the parties' CDA is approved. Claimant's attorney fee of \$2,500 is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELAINE A. THORNLIMB, Claimant
WCB Case No. 93-00784
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

The self-insured employer requests review of Referee Mills' order that set aside its denial of claimant's stress claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issue presented by this case is whether or not the departure of a physician with whom claimant, a medical assistant (MA), worked exclusively is a condition generally inherent in every working situation under ORS 656.802(3)(b). The Referee concluded that the physician's departure was not a condition generally inherent in every working situation. We disagree.

We briefly recount the relevant facts. Claimant has a complex history of abuse and other stressors dating from childhood. In 1985, claimant became an MA in one of the employer's outpatient internal medicine clinics. Initially, claimant assisted a variety of physicians, which was stressful, because claimant never knew with whom she would be teamed. To reduce the stress occasioned by this "teaming" process, the employer began to "pair" MAs with care providers. As a result of this policy change, in 1990, claimant was "paired" with Dr. Wheeling.

Claimant became very attached to Dr. Wheeling; their personalities and work-styles were well-matched. Claimant recalls that work was much less stressful when she was working only with Dr. Wheeling and her patients.

In January 1992, Dr. Wheeling advised claimant that she was thinking of leaving the employer to practice elsewhere. As Wheeling's negotiations crystallized, she advised claimant of the increased likelihood of her departure. Finally, on May 31, 1992, Dr. Wheeling officially announced her resignation, effective two months hence. Dr. Wheeling left the employer on July 31, 1992.

The anticipated and actual effect of Dr. Wheeling's departure was devastating to claimant. She became very sad, then depressed, then suicidal, as a result of the changes wrought by Wheeling's departure, as well as other work and non-work stressors. Claimant left her employment in August 1992, because she felt she could no longer tolerate the stress associated with the "teaming" approach to caregiving that she would have to endure until she could be "paired" with another provider.

To establish the compensability of a mental disorder under ORS 656.802(1)(b), claimant must prove, *inter alia*, that the employment conditions that allegedly caused her condition, or its worsening, were not "generally inherent in every working situation." ORS 656.802(3)(b). Conditions "generally inherent in every working situation" are those common to all employments, not merely the specific occupation involved. Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). We are authorized to determine what conditions are common to all employments on a case-by-case basis. SAIF v. Campbell, 113 Or App 93, 96 (1992).

We have held that, in the context of a new administration in a nursing home, "changes in procedures, turnover in personnel, understaffing, altered job descriptions and decreased patient care" constituted conditions generally inherent in every working situation. Karen M. Colerick, 46 Van Natta 930 (1994). On this record, we conclude that Dr. Wheeling's departure is a change in personnel common to all employments.

Claimant asserts that, because of the "unusual interdependence" between claimant and Dr. Wheeling, the latter's departure was not of the type of personnel changes generally inherent in every working situation. We disagree.

The medical evidence establishes that most of the closeness claimant felt toward Dr. Wheeling was the result of claimant's borderline features, which led claimant to base an inordinate amount of her self-esteem on her contact with Dr. Wheeling, (Exs. 304-84, 305a-29), and to over-idealize Dr. Wheeling as an individual. (Ex. 306-20). Drs. Telvin, treating psychologist, Turco, claimant's examining psychiatrist, and Parvaresh, the employer's examining psychiatrist, all concluded that claimant's perceptions regarding Wheeling had significant pathological or dysfunctional components. (See Exs. 305a-29; 306-20, -51-52; 307-16 to 21).

This evidence persuades us that Dr. Wheeling's departure was especially traumatic to claimant because of her abnormal attachment to Wheeling. That is, we find that claimant's stressful reaction to Wheeling's departure was primarily the product of claimant's preexisting dysfunction, not the allegedly unique nature of her relationship with Wheeling.¹ Accordingly, we need not address claimant's "unusual interdependence" argument.

Claimant asserts that this case is analogous to Donna L. Armstrong, 45 Van Natta 1786 (1993). There, the employer implemented an operational reorganization which resulted in different lines of authority and the creation of new positions. It was unclear to many people who had authority for what and what their responsibilities were. The claimant was unsure who she was to supervise, who her supervisor was, and who had responsibility to make certain decisions. We held that the circumstances of the employer's reorganization were not common to all employments. In particular, we focused on the facts that the claimant had no defined job description, no clear supervision and an indefinite scope of responsibility, and that the employer had done nothing to assist the claimant in dealing with those issues. Id. at 1789.

This case is distinguishable from Armstrong. Here, Dr. Wheeling's departure meant that claimant had to revert, at least temporarily, to the "teaming" process she had worked under before Wheeling's arrival. Although that procedure was unsatisfactory to claimant (because of the lack of consistency of the providers with whom she would be teamed), claimant had a clear job description and supervision and a definite scope of responsibility. Furthermore, the record reveals that the employer was attempting to find a replacement physician with whom claimant could be permanently paired. For these reasons, we reject claimant's attempt to analogize this case to Armstrong.

In sum, we conclude that claimant has failed to establish that Dr. Wheeling's departure was not a condition generally inherent in every working situation. Consequently, we reverse the Referee's decision setting aside the employer's denial of claimant's stress claim.

ORDER

The Referee's order dated February 18, 1994 is reversed. The Referee's attorney fee award is also reversed. The self-insured employer's denial is reinstated and upheld.

¹ Dr. Parvaresh diagnosed a chronic dysthymic disorder. (Ex. 286-5). The Referee concluded that Dr. Parvaresh's opinion was not persuasive, because the preponderance of the evidence established that claimant experienced a major depression following Dr. Wheeling's departure. We agree.

In the Matter of the Compensation of
MAUREEN E. JOHNSON, Claimant
WCB Case No. 94-02613
ORDER ON RECONSIDERATION
James L. Edmunson, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our March 9, 1995 order which affirmed the Referee's order that: (1) denied SAIF's motion to dismiss claimant's request for hearing concerning a proposed surgery dispute involving a managed care organization (MCO); and (2) set aside its denial of claimant's low back surgery claim.

SAIF argues that claimant's proposed surgery is not appropriate. In support of its contention, SAIF has included a Medical Services Order of Dismissal issued by the Director subsequent to the date of hearing. On March 22, 1995, in order to further consider SAIF's motion, we withdrew our March 9, 1995 order and requested supplemental briefs from the parties.

Having received the parties' supplemental briefs, we proceed with our reconsideration. Based on the following reasoning, we adhere to our conclusion that the proposed surgery is appropriate.

SAIF requests that we take administrative notice of a Director's order. Specifically, that order indicates that claimant's surgeon, Dr. Franks, had withdrawn his request for Director's review of the appropriateness of claimant's medical treatment under ORS 656.260(6) "due to other medical problems affecting claimant." The Director's order contains no other details concerning why Dr. Franks withdrew his request.

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders. See Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Accordingly, inasmuch as the Director's order is an agency order, we take administrative notice of the September 20, 1994 Medical Services Order of Dismissal.

Claimant argues that SAIF raised only the jurisdictional issue on Board review and should not be allowed to raise the reasonableness and necessity issue for the first time on reconsideration. We need not address claimant's contention because, for the following reasons, we conclude that the proposed surgery is reasonable and necessary, even after consideration of the Director's order.

Four physicians give opinions concerning the reasonableness and necessity of the proposed decompression and fusion surgery. Dr. Treible, claimant's attending physician, opined that claimant's L4-5 level was functionally unstable and was producing intolerable pain. Dr. Treible believed that claimant's pain would be substantially improved by further decompression and fusing this unstable level. (Ex. 69). Dr. Treible relied, primarily, on the findings of Dr. Warnock in a November 30, 1993, CT scan. There, Dr. Warnock reported that there was a major anterolisthesis of L4 on L5. (Ex. 65). Dr. Warnock further noted that there seemed to be a fair amount of motion available at the L4-5 level.

Dr. Franks, claimant's surgeon, has indicated that claimant has genuine pain, is on chronic medications and has a treatable problem. (Ex. 74). Dr. Franks also relied on Dr. Warnock's CT scan findings of motion at L4-5. Dr. Franks expressed concern that claimant was taking too much pain medication as a result of what he believed was "genuine organic pain." Dr. Franks believed that claimant's problem was amenable to surgery.

Dr. Smith examined claimant on behalf of SAIF. He opined that claimant had "failed back syndrome" and that spinal fusion would not be helpful because she had no demonstrable instability at L4-5 with flexion and extension. (Ex. 67).

Dr. Goldmann, psychologist, believed that there were psychological issues which might impact upon claimant's ability to benefit from further surgery. He recommended that, if surgery was considered, it should be performed on medical grounds alone and based upon objective medical findings. (Ex. 68-3).

Dr. White, a physician employed by SAIF, opined that the need for lumbar fusion was a direct result of claimant's compensable injury. (Ex. 71). However, Dr. White later agreed with Dr. Smith that claimant had a "failed back syndrome" and that in such cases, repeat operations are virtually certain to fail. Dr. White also mistakenly stated that Dr. Warnock had found no movement at L4-5 when he tried flexion and extension. (Dr. White was apparently referring to an October 5, 1993 lumbar myelogram by Dr. Harris where no significant motion at L4-5 was found with flexion and extension). Dr. White also agreed with Dr. Goldmann's opinion.

Finally, Dr. Parsons agreed in a "check-the-box" opinion with Dr. Smith's conclusion that surgery would not be helpful. (Ex. 79). Dr. Parsons also wrote that claimant has never had objective findings which surgery would be likely to benefit. However, as noted by the Referee, Dr. Parsons had not seen claimant since 1992. Because of his lack of a recent opportunity to examine claimant, we agree with the Referee that Dr. Parsons' opinion is unpersuasive.

We normally defer to the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to defer to the well reasoned opinions of Drs. Treible and Franks. Their opinions are based on Dr. Warnock's CT findings of "a fair amount" of motion at L4-5.

Based on the Director's dismissal order, Dr. Franks withdrew his request for Director review of the MCO's decision not to authorize surgery. Nevertheless, we are not persuaded that this fact renders Dr. Franks' opinion unpersuasive. First, the Director's dismissal order gives very few details concerning why Dr. Franks withdrew his request. Second, and more importantly, we have previously held that, because the Director is without jurisdiction to address the issue of the appropriateness of proposed surgery, a Director's order addressing that issue is null and void. Dewey W. Kennedy, 47 Van Natta 399 (1995). Accordingly, we conclude that the Director's dismissal order does not detract from the persuasiveness of Dr. Franks' opinion. Finally, we note that even if we did not consider Dr. Franks' opinion, the opinion of Dr. Treible and the findings of Dr. Warnock support a conclusion that the proposed surgery is reasonable and necessary.

In our March 22, 1995 order of abatement, we requested that the parties discuss the effect, if any, of our recent holding in Barry W. Alertas, 47 Van Natta 324 (1995). Alertas, like the present case, involved an MCO medical services dispute. There, in a "post-hearing" chart note, the claimant's physician indicated that he was no longer recommending surgery. Finding that the chart note was not obtainable at the time of the hearing and that it was reasonably likely to affect the outcome of the case, we granted the insurer's motion for remand for admission of the chart note and for additional evidence concerning the note.

We find the present case distinguishable from Alertas. Here, as SAIF points out, it is unnecessary for us to remand to the Referee since the Director's order is a document of which we may take administrative notice. In any case, we conclude, based on the foregoing reasoning, that the Director's dismissal order is not reasonably likely to affect the outcome of this case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (a compelling basis for remand 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). Accordingly, we decline to remand.

Claimant's counsel is entitled to an assessed attorney fee, in addition to the attorney fee awarded by our March 9, 1995 order, for services expended in response to SAIF's request for reconsideration. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services on reconsideration is \$1,200. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented herein, we republish our March 9, 1995 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
JACK R. COOPER, Claimant
WCB Case No. 94-01253
ORDER DENYING RECONSIDERATION
Pozzi, Wilson, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

The insurer requests reconsideration of our April 11, 1995 order which: (1) vacated Referee Hoquet's order upholding the insurer's denial of claimant's occupational disease claim for a bilateral carpal tunnel condition; and (2) remanded for reconsideration of claimant's motion for continuance of the hearing. Contending that our decision was based on "an erroneous understanding of the actual facts of the case," the insurer seeks abatement of our decision and affirmance of the Referee's order.

In support of its motion, the insurer has submitted its counsel's affidavit which contains counsel's recollections of several "pre-hearing" conference calls between the parties and Assistant Presiding Referee Schultz. Based on these recollections, the insurer asserts that, contrary to findings contained in our recent order, the insurer had discussed the possible withdrawal of its sponsorship for the medical opinions authored by Drs. Kappes and Grewe. In light of such information, the insurer claims that we erroneously found that, during the "pre-hearing" proceedings with Referee Schultz, it neglected to preserve its option to withdraw sponsorship of the aforementioned medical reports at the upcoming hearing before Referee Hoquet.

Inasmuch as our review is confined to the record developed before the Referee, the insurer's submission is, in effect, a motion for remand for the taking of additional evidence. ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). We may remand if we determine 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. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

In submitting this new information on reconsideration, the insurer provides no explanation for its failure to contest the findings contained in Referee Schultz' interim order which: (1) documented the insurer's acknowledgment of claimant's right to cross-examination of Drs. Kappes and Grewe; and (2) gave no indication that the insurer intended to preserve its option of withdrawing sponsorship of those physicians' reports at the forthcoming hearing. Under such circumstances, we do not find a compelling reason to remand this case for the introduction of this "evidence" which the insurer has presented at this late date.

Accordingly, the insurer's motion for remand and reconsideration is denied. The parties and the Referee shall continue to proceed in accordance with the instructions contained in our April 11, 1995 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ED F. KRUPKA, Claimant
WCB Case No. 94-06791
ORDER OF DISMISSAL
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

The insurer requested review of those portions of Referee McWilliams' order that: (1) set aside its denial of claimant's occupational disease claim for a left hip condition; and (2) declined to consider the compensability of claimant's left hip condition as related to his accepted right hip condition. The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable, in lieu of the Referee's order.

Pursuant to the settlement, claimant agrees that the insurer's denial "shall forever remain in full force and effect." The agreement further provides that the parties' respective requests for hearing and review "shall be dismissed with prejudice as to all issues raised or raisable."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of the Referee's order.¹ Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

¹ We note that the settlement also contains a provision stating that the insurer will pay the remaining portions of a permanent disability award granted by a January 5, 1995 Notice of Closure in a "lump sum" within 30 days of our approval of the parties' agreement. Inasmuch as the acceleration of payments for permanent disability awards rests with the Director, we are without authority to order such a lump sum payment. See ORS 656.230; Erven Simril, 43 Van Natta 629 (1991). Thus, in granting our approval of the parties' agreement, we interpret the provision as the insurer's acknowledgment that it will voluntarily pay the remainder of claimant's permanent disability award in a lump sum.

In the Matter of the Compensation of
GRANT HELZER, Claimant
WCB Case Nos. C5-00504 & C5-00505
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Swanson, Thomas & Coon, Claimant Attorney
Beers, Zimmerman, et al., Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On March 1, 1995, the Board received the parties' claim disposition agreements (CDA) in the above-captioned matter. Pursuant to the 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.

By letter dated March 13, 1995, the Board requested an addendum from the parties to supplement the following language in the proposed agreement:

"The worker has been trained to perform the following vocations: Grocery store courtesy clerk, bottle boy, security guard, refuse removal, truck driver, garbage hauler, recycling truck route driver."

OAR 436-60-145(4)(e), as revised effective August 28, 1994 (WCD Admin. Order 94-055), provides:

"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 Department rule requires information regarding both the extent of a claimant's vocational training and the occupations which a claimant has worked.

On May 2, 1995, the Board received the parties' response to our request to supplement the above-stated CDA language. The parties have agreed that the following language should be substituted for the above-stated language:

"The worker has been trained to perform the following vocations/employments: Grocery store courtesy clerk, bottle boy, security guards, refuse removal, truck driver, garbage hauler, recycling truck route driver."

After reviewing the parties' addendum, we conclude that the proposed addendum does not correct the problem identified by our addendum letter. The substitute language continues to state that claimant has received training in the listed vocations. However, the substitute language does not provide information regarding the occupations which claimant has worked. Thus, the substitute language does not provide the information required by the above-cited Department rule.

Consequently, because the addendum does not correct the deficiency in information regarding the occupations which claimant has worked, we conclude that the proposed CDA is not a proper matter for disposition under ORS 656.236 and the administrative rules. Therefore, the CDA is disapproved on the ground that it is unreasonable as a matter of law. ORS 656.236.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RAY L. BENNETT, Claimant
WCB Case Nos. 94-08810, 94-11316, 94-11315 & 94-07834
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Roberts, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Arbitrator Neal's decision that: (1) found that neither Liberty Northwest Insurance Corporation (Liberty) nor American International Adjustment Company, Inc. (AIAC) had denied compensability of claimant's claim; (2) declined to award an attorney fee pursuant to ORS 656.386(1) for Liberty's and AIAC's alleged "pre-hearing" rescissions of their alleged compensability denials; and (3) declined to assess penalties or attorney fees payable by Liberty and AIAC for allegedly unreasonable compensability denials. On review, the issues are penalties and attorney fees.

We adopt and affirm the Arbitrator's decision with the following supplementation.

On review, claimant argues that the Arbitrator erred in declining to award attorney fees pursuant to ORS 656.386(1). We disagree.

Claimant's attorney would be entitled to an attorney fee under ORS 656.386(1) if the denials of Liberty or AIAC raised compensability issues and if claimant's attorney was instrumental in obtaining rescission of the compensability portions of the carriers' denials. See, e.g., Bonnie A. Stafford, 46 Van Natta 1539 (1994); Johnny M. Davis, 45 Van Natta 2282 (1993).

Liberty's Denial

Liberty issued a denial on June 20, 1994. (Ex. 37). That document states, in part: "After review of the investigation material available, it appears that your condition is compensable; however, responsibility may rest with one of the employers identified above. Therefore, this letter represents a denial of responsibility for your current condition." In addition, Liberty's denial indicated that a paying agent, pursuant to ORS 656.307, had been requested. The record contains a request from Liberty to the Department for issuance of a "307" order and a "307" order was issued on August 24, 1994. (Exs. 37C; 42A).

We recently addressed a similar issue in James D. Lollar, 47 Van Natta 740 (1995). That case involved a carrier's denial which also stated: "After review of the investigation material available, it appears that your condition is compensable; however, responsibility may rest with one of the employers identified above." Like the denial in this case, the denial in Lollar denied responsibility only and indicated that the carrier had requested a "307" order. The document also contained "notice of hearing" provisions and stated that it was a denial of the claim for benefits. Relying on James McGougan, 46 Van Natta 1639 (1994), we concluded that the carrier's denial in Lollar did not raise a compensability issue.

In McGougan, we held that, while the carrier's denial did contain notice of hearing provisions and stated that it was a denial of benefits, it also contained express language conceding compensability and specifically denying responsibility only. Under such circumstances, we found that the carrier's denial did not raise an issue of compensability.

Here, the pertinent language in Liberty's denial is identical to that contained in the denial discussed in Lollar. Using the same language, the responsibility denials issued in this case and in Lollar concede that claimant's condition is compensable and deny only responsibility. In addition, both in the present case and in Lollar, the carrier agreed to the issuance of a "307" order.

Like the denials in McGougan and Lollar, Liberty's denial in this case contains "notice of hearing" provisions and states that it is a denial of the claim for benefits. Notwithstanding the inclusion

of "notice of hearing" provisions and the "claim denial" language, we do not construe the denial to extend to compensability, particularly given the express language conceding compensability and denying only responsibility. See James D. Lollar, supra.

Based on our holdings in McGougan and Lollar, we conclude that the responsibility denial issued by Liberty did not raise an issue of compensability.¹ Liberty's responsibility denial clearly and unambiguously conceded that the claim was compensable and indicated that responsibility was the only issue. Under the circumstances, we agree with the Arbitrator that no ORS 656.386(1) attorney fee payable by Liberty is warranted.

AIAC's Denial

On July 11, 1994, AIAC issued a "Notice of Disclaimer and Denial of Responsibility." This document stated, in part: "It is our position that it appears as though another employer/insurer is responsible for your condition * * * We continue to investigate matters regarding compensability. Therefore, this letter represents a denial of responsibility for your current condition." (Ex. 38). On August 12, 1994, AIAC issued an amended denial letter which provided: "We have concluded our investigation into the compensability of your claim and find that your condition is compensable and related to your employment in general. It is our position that Liberty Northwest Insurance Company and their insured * * * is the responsible employer." (Ex. 41).

In its July 11, 1994 letter, AIAC did not initially concede compensability. However, AIAC's July 11, 1994 letter also did not deny compensability. Rather, AIAC's July 11, 1994 letter indicated that AIAC was continuing to investigate the compensability of the claim and that it was denying only responsibility. In its August 12, 1994 amended denial, issued within 90 days of the claim, AIAC specifically and unambiguously conceded that claimant's condition was compensable. Accordingly, inasmuch as AIAC never contested compensability, no attorney fee pursuant to ORS 656.386(1) is warranted.

In light of our conclusion that neither Liberty nor AIAC denied compensability, we reject claimant's contentions that the denials are unreasonable. We likewise reject claimant's argument that the carriers' denials did not follow the notice requirements contained in OAR 438-05-053. Under the administrative rule, a claim denial, whether based on compensability grounds or on responsibility grounds only, must contain "notice of hearing" provisions and a statement that it is a denial of the claim. Accordingly, the Arbitrator's decision is affirmed.

ORDER

The Arbitrator's order dated October 5, 1994 is affirmed.

¹ Member Gunn is bound by the principles of stare decisis to apply the holding of James D. Lollar, supra, but directs the parties to his dissenting opinion in that case.

In the Matter of the Compensation of
BARBARA J. GREEN, Claimant
WCB Case No. 94-08244
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Spangler's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for a right thumb condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant used a keyboard at home two hours per week. (Tr. 15).

CONCLUSIONS OF LAW AND OPINION

Claimant began working as a hospital transcriptionist in August 1993. She transcribes at the rate of 92 words per minute, during 90 percent of her working day. The keyboard that claimant began using when she went to work for the employer is in a different position, and the space bar harder to depress, than those she had previously used. From the time she began working for the employer, claimant used only her right thumb for spacing. (Tr. 16). Claimant also works as a transcriptionist at home two hours per week, using a keyboard that is easier to depress.

After working for the employer for approximately seven months, claimant began to notice tingling of her wrist and base of the thumb, which increased to aching in the right wrist and thumb. On March 18, 1994, claimant sought treatment for her right thumb from Dr. Dodds. He obtained a history of tingling and numbness of the wrist and thumb that had begun approximately three to six weeks before, in conjunction with claimant's work activities. (Ex. 4B-2). Dr. Dodds diagnosed right deQuervain's tendinitis, consistent with claimant's work activities. He also noted radial nerve involvement, suggestive of entrapment in the distal forearm. (Ex. 5).

The Referee concluded that claimant's work activities were not the major contributing cause of her right thumb condition. The Referee apparently reasoned that claimant worked at home two hours per day, rather than the actual two hours per week (See Tr. 15), and that Dr. Dodds, treating physician, had not considered claimant's off-work typing activities when addressing causation of claimant's thumb condition. We disagree.

Claimant was placed on modified work, and treated conservatively with a splint and physical therapy. Nevertheless, in July 1994, when claimant attempted to return to work, the symptoms returned to a significant level. (Ex. 8A). On August 3, 1994, Dr. Dodds performed surgery for the right deQuervain's tenosynovitis and radial nerve neuropathy.

In September 1994, Dr. Dodds stated that he originally felt that claimant's wrist symptoms were produced by her work activities, and that the work relationship was confirmed by claimant's repeated exacerbations when attempting to return to regular work activities. (Ex. 10). In reaching this conclusion, Dr. Dodds was aware of the extent of claimant's off-work activities. (See Ex. 9-1). Subsequently, Dr. Dodds agreed with a statement from claimant's attorney stating that claimant's work activities at the employer were the major contributing cause of her right deQuervain's tendinitis and radial nerve irritation. (Ex. 11).

On September 26, 1994, nearly two months post-surgery, Dr. Button examined claimant for SAIF. (Ex. 12). He found no indication of deQuervain's tendinitis or compression neuropathy. Dr. Button stated that the mechanics of operating the thumb for the space bar did not involve the specific tendons that were the focus of the surgery, thus work activities could not have caused the deQuervain's

tendinitis. Dr. Button also stated that he had not encountered deQuervain's tendinitis related to typing. Further, he did not believe that work activities caused the radial nerve condition because it was anatomically far removed from the point of compression as described in the surgical report. (Ex. 12-4). Dr. Dodds specifically disagreed with Dr. Button concerning the operation of the tendons that move the thumb for operation of a space bar. (Ex. 13).

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

Dr. Dodds has related claimant's right thumb condition to her work-related typing activities from the outset, and has noted the relationship of increased symptoms to attempts by claimant to return to her regular work duties. (Exs. 10, 13). Furthermore, Dr. Dodds was aware that claimant only typed two hours per week away from work. (Ex. 9).

On the other hand, we find Dr. Button's opinion less persuasive for the following reasons. To begin, he was under the mistaken impression that claimant varied between her left and right hand in using the space bar, yet the dominant left hand showed no symptoms. (Ex. 12-4). Claimant, however, testified that she had only used her right thumb for several months prior to the onset of the symptoms. Additionally, because Dr. Button had never heard of a deQuervain's tendinitis caused by typing, he did not believe typing could be a causative factor. Id. Opinions such as this that are general (rather than specific as to claimant) or merely speculative, are not particularly persuasive. See Sherman v. Western Employers Insurance, 87 Or App 602, 605 (1987); Rita Shambow, 46 Van Natta 1174 (1994).

Here, the parties do not specifically litigate the deQuervain's tendinitis and right radial nerve entrapment as separate conditions. (Tr. 3-7). Relying on the opinion of Dr. Dodds, we conclude that the deQuervain's tendinitis is compensable. Further, in view of Dr. Dodds' statement that the radial nerve neurolysis procedure was merely performed as an adjunctive step during the surgical procedure for the deQuervain's tendinitis we conclude, that claimant has met her burden of proving that her work activities were the major contributing cause of her right thumb condition. Accordingly, we reverse the Referee's order.

Claimant's attorney is entitled to an assessed 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 fee for claimant's attorney's services at hearing and on review is \$3,700, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs and counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The Referee's order dated October 27, 1994 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on Board review, claimant's counsel is awarded an assessed attorney fee of \$3,700, payable by the SAIF Corporation.

In the Matter of the Compensation of
ALLEN EHR, Claimant
WCB Case No. C5-00964
ORDER APPROVING CLAIM DISPOSITION AGREEMENT

Reviewed by the Board en banc.

On April 12, 1995, 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.

ORS 656.236 provides that the "parties" to a claim, by agreement, may make such disposition of any or all matters regarding a claim***. Additionally, a CDA must contain signature lines for all the "parties" to the agreement. DCBS Bulletin No. 217 (May 16, 1991). Here, the CDA contains signature lines for claimant and the insurer's claims examiner. There is no signature line for counsel for the insurer and no attorney has signed the CDA on the insurer's behalf. Inasmuch as the insurer is a corporation, we address the issue of whether the CDA must also be signed by an attorney on the corporate insurer's behalf.

In resolving this question, we turn to ORS 9.230. That statute provides, in part, that:

"Any action, suit or proceeding may be prosecuted or defended by a party in person, or by attorney, except that the state or a corporation appears by attorney in all cases, unless otherwise specifically provided by law."

ORS 656.236, the statute pertaining to CDA's, provides no exception to ORS 9.230. Therefore, the pivotal inquiry is whether the submission of a CDA constitutes an "action, suit or proceeding."

In determining whether a CDA is a "proceeding," we find guidance from several Oregon Attorney General opinions. Although we realize that such opinions are not binding, we nevertheless find the discussions helpful in reaching our conclusion.

In 44 Op Atty Gen 1 (1983), the Attorney General recommended that an agency not use lay hearings advocates in its contested case hearings. The attorney general noted that there had been no legislative exception to ORS 9.230 and other statutes which required that the state agency be represented by an attorney. In concluding that the lay hearings advocate was engaged in the unlawful and unauthorized practice of law, the attorney general pointed out that the lay staff member was making opening statements, closing arguments, procedural motions and evidentiary objections, in addition to examining and cross-examining witnesses at the agency's contested case hearings. Examining the "character of the acts" being performed, the Attorney General found that the hearings advocate was providing legal services which may require legal skill and knowledge. 44 Op Atty Gen 1, 8, 14 (1983).

Similarly, other Attorney General opinions refer to hearings as "proceedings." See e.g. 35 Op Atty Gen 1088 (1972) (representation of an employee at a Public Employee Relations Board disciplinary hearing constitutes practice of law; nonlawyer union business agent, therefore, may not represent employee at the hearing); 33 Op Atty Gen 384 (1967) (public employees who do not represent themselves at Civil Service Commission hearings must be represented by an attorney); 31 Op Atty Gen 52 (1962) (persons not licensed to practice law in Oregon may not appear in a representative capacity for other persons or entities before state agencies); OP-6045 (1987) (public hearing was not required to be conducted as a contested case hearing, and therefore, corporations were not required to appear through counsel. However, once the contested case portion of the hearing began, involving sworn testimony and witnesses who were subject to cross-examination, corporations must appear through counsel).

We conclude that the aforementioned opinions suggest that a contested case "hearing" is a proceeding, and the concern over representation arises where the layperson is participating in activities such as cross-examining witnesses and making evidentiary objections. Therefore, we find that a CDA, which has been submitted to the Board for approval, does not involve a contested case hearing and is not a "proceeding" requiring attorney representation.

We find further support for this conclusion by considering the common legal definition of "proceeding," as found in Black's Law Dictionary. Black's provides that a "proceeding" is the "form and manner of conducting juridical business before a court or judicial officer; regular and orderly progress in form of law; including all possible steps in an action from its commencement to the execution of judgment."

Parenthetically, we note that such reasoning is likewise applicable to Disputed Claim Settlements (DCS) and stipulations submitted prior to the filing of a hearing request or request for Board review. These requests are comparable to the "commencement" of an action, which is the beginning of a "proceeding." Because those cases do not involve a filed request for hearing or review, an action has not been commenced and, therefore, a "proceeding" has not been initiated. Consequently, a corporate insurer's claims examiner's signature unaccompanied by an attorney's signature on such an agreement would not be in violation of ORS 9.230. Conversely, consistent with ORS 9.230 and the Attorney General opinions, once a request for hearing or Board review has been filed, a corporate carrier would be required to "appear" by means of an attorney in an agreement designed to resolve the issues raised in those requests.

In conclusion, because this CDA does not involve a "proceeding" as contemplated by ORS 9.230, we hold that an attorney for the corporate insurer is not required to sign the proposed agreement. Thus, we do not consider the CDA to be unreasonable as a matter of law.

Accordingly, we conclude that the CDA in this case is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Therefore, the parties' CDA is approved.

IT IS SO ORDERED.

May 16, 1995

Cite as 47 Van Natta 871 (1995)

In the Matter of the Compensation of
PEDRO C. RODRIGUEZ, Claimant
WCB Case No. 94-05855
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorneys
John M. Pitcher, Defense Attorney

Claimant requests reconsideration of our April 18, 1995 Order on Review that adopted and affirmed those portions of a Referee's order that: (1) partially upheld the insurer's denial of claimant's back injury claim; and (2) declined to assess a penalty for an allegedly unreasonable denial. Specifically, claimant argues that the Referee exceeded the scope of her authority by partially upholding the insurer's denial of compensability. In addition, claimant renews his request for an increased attorney fee for services at the hearings level. The insurer has responded, contending that claimant's motion should be denied.

The Referee set aside the insurer's denial of claimant's "original" claim for an October 28, 1993 back/neck injury, but partially upheld the denial insofar as it pertained to claimant's "current back/neck" condition after November 3, 1993. Claimant challenges the Referee's ruling, arguing he was deprived of due process because he lacked notice that anything beyond the compensability of his original injury was at issue. Thus, he contends that the Referee should have decided only whether the initial injury occurred, not whether claimant's current condition is compensable. We disagree.

Our "first task is to determine which provisions of the Workers' Compensation Law are applicable." Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)). In this case, the denial asserts that claimant's back/neck condition is not "related to [his] work activity with [the employer] on or about 10/28/93." (Ex. 18-1, emphasis added). At the outset of the hearing, claimant agreed with the Referee's statement that the basis of the insurer's denial "is that the employer does not believe an injury occurred on [October 28, 1993] or if it did it was not compensable." (Tr. 1, emphasis added). In our view, this statement of issues encompasses the compensability of claimant's back/neck condition, as well as the question of whether an injury occurred as claimant says it did. Compare Laverne J. Butler, 43 Van Natta 2454 (1991) (Where the denial and the issue presented at hearing were limited to whether the initial injury was compensable, the referee did not err in deciding only that issue); Vickie J. Hemmer, 43 Van Natta 2719 (1991).

Based on the denial, the presentation of issues at hearing, and the medical evidence, we agree with the Referee that ORS 656.005(7)(a)(B) is applicable. As we stated in our Order on Review, we further agree with the Referee that the medical evidence establishes that claimant did suffer an October 28, 1993 work injury. However, the medical evidence also established that claimant had a preexisting spinal disease which combined with his compensable injury to prolong his disability or need for treatment and that the compensable injury was not the major contributing cause of his need for treatment after November 3, 1993. Under these circumstances, claimant's back/neck condition was not compensable after November 3, 1993. See ORS 656.005(7)(a)(B).

In addition, we agree with the Referee that claimant has not established that the insurer's denial was unreasonable, because the insurer had a legitimate doubt regarding its liability for claimant's back/neck condition, based on medical evidence in its possession at the time of the denial. Finally, we conclude that the Referee's attorney fee award was reasonable under the circumstances of this case, for the reasons stated in our Order on Review. See OAR 438-15-010(4).

Accordingly, we withdraw our April 18, 1995 order. On reconsideration, we adhere to our April 18, 1995 order, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 17, 1995

Cite as 47 Van Natta 872 (1995)

In the Matter of the Compensation of
JOSEPH R. KLINSKY, Claimant
WCB Case No. 93-11480
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

The insurer requests review of that portion of Referee Livesley's order that set aside its partial denial of claimant's medical services claim for low back surgery. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back strain at work in September 1976. He filed a claim for a back strain which the insurer accepted as a disabling injury. Preexisting degenerative arthritis and spinal stenosis were also diagnosed, though not accepted as part of the 1976 injury claim. The claim was closed with an award of 50 percent unscheduled permanent disability, which did not include an award for preexisting degenerative changes.

On September 20, 1993, the insurer issued a partial denial which provided, in relevant part:

"We have recently received information that you are seeking treatment for a condition diagnosed as spinal stenosis and requesting authorization for a decompressive laminectomy which you allege to be related to your injury of September 16, 1976.

"Medical information in your file indicates that your current condition diagnosed as spinal stenosis is unrelated to your industrial injury of September 16, 1976 and, therefore, we deny your rights for medical benefits."

At hearing, claimant framed the issue as the insurer's ".245 denial." (Tr. 1). The insurer interpreted its partial denial to deny that claimant's spinal stenosis was "an accepted component of the [claim]." (*Id.*). The Referee identified the issue for resolution as the "partial denial of .245 benefits[,] decompressive laminectomy, as unrelated to the accepted" injury. (Opinion and Order at 1). Applying Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994), the Referee concluded that the 1993 surgery bears a material relationship to the compensable condition. Accordingly, the Referee set aside the insurer's partial denial.

On review, the dispositive issue is what standard applies to determine the compensability of the disputed medical treatment claim. Claimant argues that his claim is for continued medical treatment for the compensable back injury under ORS 656.245(1), and that the treatment is compensable because it was caused in material part by the compensable injury. The insurer argues that the medical treatment claim is for noncompensable spinal stenosis and that the claim is therefore subject to ORS 656.005(7)(a). We agree with the insurer.

In Beck v. James River Corp., *supra*, the Court of Appeals held 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, rather than to claims for continued medical treatment of a compensable condition under ORS 656.245(1). In Beck, the claimant suffered a compensable left shoulder injury. The claimant subsequently received a diagnostic EMG for a noncompensable neck condition, which caused violent muscle contractions in the left shoulder, resulting in the need for treatment of the shoulder. The court found that the EMG, though unrelated to the compensable injury, was an intervening event which caused the need for further treatment of the compensable shoulder condition. The court concluded, therefore, that the applicable statute was ORS 656.245(1), rather than ORS 656.005(7)(a).

Here, we find that the condition requiring treatment has not been accepted. Claimant's original claim was accepted for a back strain only. (Ex. 3). The disputed medical treatment consists of medical services claimant sought in 1993 for low back and leg pain, which culminated in a decompressive laminectomy at L3 through S1 in October 1993. The principal diagnosis for surgery, according to treating orthopedic surgeon Dr. Schroeder, was spinal stenosis at L3-4 and L4-5. (Ex. 35). That diagnosis is uncontroverted. Dr. Schroeder explained that spinal stenosis is a narrowing of the spinal canal related primarily to degenerative changes. (Ex. 37-27). While the medical evidence shows that the accepted back strain aggravated the preexisting degenerative condition, (*see* exs. 9-1, 37-17, 38-12), we find that the surgery and related treatment were directed to the spinal stenosis itself.

There is no evidence that the insurer accepted the spinal stenosis condition. Contrary to claimant's contention, the insurer's mere payment of medical bills, even for treatment relating to the spinal stenosis, does not constitute an acceptance of the spinal stenosis.¹ *See* ORS 656.262(9); Olson v. Safeway Stores, Inc., 132 Or App 424, 427 (1995). Furthermore, although claimant was previously awarded 50 percent unscheduled permanent disability, the award was limited to disability resulting from the accepted back strain, and did not include consideration of the degenerative back condition. (*See* exs. 19, 20). Therefore, the insurer was not precluded from denying the degenerative back condition.²

Because claimant sought treatment for a condition which was not previously accepted, he must establish the compensability of that condition under ORS 656.005(7)(a). *See Beck v. James River Corp.*, *supra*. His treating physicians, Drs. Filarski and Schroeder, opined that the accepted back strain in 1976 aggravated the preexisting degenerative back condition, causing and/or prolonging claimant's disability and need for treatment. (*See* exs. 9, 37-17, 37-22). Their opinions are uncontroverted. Therefore, we conclude that claimant must establish the compensability of the spinal stenosis under the "major contributing cause" standard applicable to "resultant conditions" under ORS 656.005(7)(a)(B).

¹ Because we reject claimant's contention that the insurer's payment of medical bills constituted an acceptance, we need not address the insurer's argument that claimant did not raise this contention at hearing and is therefore precluded from raising it for the first time on review.

² Unlike in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), there was no finding that claimant had been awarded permanent disability compensation for his degenerative back condition. *See Olson v. Safeway Stores, Inc.*, *supra*, 132 Or App at 428 n 1. In fact, the prior referee who increased claimant's unscheduled permanent disability award to 50 percent expressly refused to consider the degenerative condition in rating claimant's permanent disability. (Ex. 19-4). Therefore, Messmer is not applicable to this case.

Given the multiple potential causes of claimant's back condition, we find that the causation issue is a medically complex question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993). There is no medical opinion to support a finding that the accepted back strain in 1976 was the major contributing cause of claimant's need for surgery and related treatment. On the contrary, Drs. Schroeder, Malkin and Brooks opined that the major cause of claimant's back symptoms and need for treatment was the degenerative condition. (Exs. 31-4, 32, 36, 37-27, 38-33). Therefore, we conclude that claimant's spinal stenosis and resultant need for treatment were not compensable. Accordingly, we reinstate and uphold the insurer's partial denial.

Given our conclusion that claimant did not establish the compensability of the spinal stenosis and resultant surgery on the merits, we need not address the insurer's argument that claimant was barred by issue preclusion from asserting the spinal stenosis claim.

Finally, claimant asserted, as an alternative theory of recovery, that the spinal stenosis was compensable as an occupational disease. However, we find no medical evidence to support a finding that employment conditions alone were the major contributing cause of the spinal stenosis or its worsening. At most, the medical evidence shows that repetitive "insults" (*i.e.*, microtraumas) from claimant's employments and lifestyle resulted in the progressive degeneration of his back. (Ex. 37-29). In any event, there is no indication that the physicians had sufficient information about claimant's lifestyle (*i.e.*, off-work) activities to render an informed opinion on this issue. This record is not sufficient to carry claimant's burden of proof. See ORS 656.266. Accordingly, claimant's occupational disease claim must fail. See ORS 656.802(1)(b), (2).

ORDER

The Referee's order dated September 14, 1994 is reversed in part and affirmed in part. The insurer's September 20, 1993 partial denial is reinstated and upheld in its entirety. The Referee's attorney fee award is also reversed. The remainder of the order is affirmed.

May 18, 1995

Cite as 47 Van Natta 874 (1995)

In the Matter of the Compensation of
DALE B. FARRAR, Claimant
 WCB Case No. 94-08645
 ORDER ON REVIEW
 Coons, et al., Claimant Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Baker's order that set aside its denial of claimant's C5-6 disc herniation injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a remodeling construction worker, has had a history of headaches for many years. (Exs. 1, 1a). In March 1993, he underwent an MRI, which revealed a small C5-6 left/central disc herniation. (Ex. 1a-2; 2).

In April 1993, claimant was examined by Dr. Serbu, consulting neurosurgeon. Serbu recorded that claimant had mild neck aching, and a very slightly diminished left biceps jerk. (Ex. 2A-1, -2). In May 1993, Dr. Serbu planned to perform surgery to repair the disc herniation; however, the surgery was canceled. (Ex. 2B-1; see Exs. 2C-2, -3; 13-2; Tr. 27).

Claimant consulted Dr. Hacker, neurosurgeon, in June 1993. Hacker reported that claimant had had an onset of neck pain six months earlier and that he currently was complaining of pain radiating into his skull, bilaterally to the scapula and down the back of both arms. (Ex. 3-2). Hacker's differential diagnosis included unusual symptomatic presentation for small cervical disc hernia. (*Id.*) Hacker recommended surgery only as a last resort. (*Id.* at 1, -3).

On April 11, 1994, while he was working under a house, claimant raised up and struck the back of his neck on a floor joist. (Exs. 4, 5; Tr. 20). After the incident, claimant experienced severe neck pain and was unable to work. (Exs. 4, 5; Tr. 26). Claimant initially treated with Dr. Serbu and then Dr. Floyd, who referred claimant to Dr. Hacker. (Ex. 2C-3). Claimant filed an injury claim for the April 11 incident on April 13, 1994. (Ex. 4).

In May 1994, Dr. Hacker reported that claimant had described an increase in neck and headache pain, and pains radiating throughout his arms, following the April 11 injury. (Ex. 7). Hacker also noted a diminished left biceps reflex. (Ex. 8). Claimant underwent a discogram, which revealed a severe subjective pain response at C4-5 and C5-6. (Ex. 9). Thereafter, Dr. Hacker diagnosed C4-5 and C5-6 symptomatic discogenic pain syndrome and recommended surgery. (Ex. 11).

In June 1994, Drs. Barth, neurologist, and Arbeene, orthopedic surgeon, examined claimant on the insurer's behalf. They reported that claimant's neck pain had begun about six years earlier without specific injury and that claimant's current neck pain was in the same location and of the same type, but had become more severe since the April 11 injury. (Ex. 13-2, -3). They found an absent left biceps deep tendon reflex. (*Id.* at 4). Drs. Barth and Arbeene concluded that claimant's symptomology had increased in severity and frequency following the April 11 injury. (*Id.* at 5). They also concluded that the condition had objectively worsened, as manifested by the absent left biceps deep tendon reflex. (*Id.*) They attributed these changes, in major part, to the natural worsening of claimant's preexisting disc degeneration and herniation, not to the blow to the back of claimant's neck on April 11. (*Id.*) Dr. Barth subsequently issued a report, stating that, after reviewing claimant's radiological studies, he continued to adhere to his conclusion that the major cause of claimant's disability and need for treatment was the preexisting condition. (Ex. 21).

The insurer denied claimant's C5-6 disc herniation injury claim in July 1994. (Ex. 14). Subsequently, after reviewing Drs. Barth's and Arbeene's report, Dr. Hacker issued a report, stating that, because claimant did not develop cervical radiculopathy until after the April 11 incident, and because his overall pain syndrome had changed, Hacker "would expect that this incident did contribute significantly to his need for [surgery]." (Ex. 14A).

On July 29, 1994, Dr. Hacker examined claimant, noting claimant's complaints of increasing arm pain and weakness, and finding an absent left biceps reflex. (Ex. 17). Hacker recommended surgery in the very near future. (*Id.*)

Thereafter, in a letter to the insurer, Dr. Hacker stated that claimant had a preexisting cervical condition that combined with his April 11 injury to result in his present disability and need for surgical treatment. (Ex. 18-1). Hacker concluded that, in view of claimant's post-injury neurological deficit -- weakness and absent biceps reflex -- the injury significantly worsened his clinical picture, necessitating treatment. (*Id.* at 2).

Finally, Dr. Serbu issued a report, stating that he had seen claimant on April 15, 1994, and that his symptoms were much the same as those in 1993. (Ex. 22). Serbu also stated that claimant had not mentioned the April 11 injury. (*Id.*)

Based on the record, claimant is a credible witness.

CONCLUSIONS OF LAW AND OPINION

The insurer first argues that claimant has failed to prove that he suffered an injury at work on April 11, 1994. We reject that argument outright. There is sufficient evidence, in the form of credible witness testimony and the medical records, to establish that claimant sustained a work-related injury on April 11, 1994. That claimant failed to report the injury immediately, may have complained of neck pain to a co-worker before the injury, and told the co-worker that he had re-injured a previous injury, does not undercut this conclusion.

Turning to the merits of this case, we conclude that claimant has proven the compensability of his current neck condition. The parties do not dispute that claimant suffered from a preexisting C5-6 cervical condition, which combined with his injury to produce his current disability and need for

treatment. Accordingly, he must satisfy the major contributing cause standard of ORS 656.005(7)(a)(B). Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, 594, rev den 318 Or 27 (1993). The relative contribution of each cause of the resultant condition, including the precipitating cause, must be evaluated. Dietz v. Ramuda, 130 Or App 397, 401-02 (1994).

When, as here, the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We find no persuasive reasons not to rely on the reports of Dr. Hacker, treating neurosurgeon.

Dr. Hacker concluded that claimant's April 11 injury contributed "significantly" to claimant's current need for treatment. While Dr. Hacker did not use the magic words "major contributing cause," we nevertheless conclude that his reports are sufficient to meet claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986) (magic words unnecessary); Richard B. Caulkins, 46 Van Natta 1178 (1994) (physician's report that claimant's trauma was a "significant" factor in claimant's need for medical treatment held to satisfy major contributing cause standard). We are particularly persuaded by Dr. Hacker's analysis concerning the post-injury changes in claimant's neurological and symptomatic status, viz., the absence of a left biceps reflex, and increasing arm pain and weakness.

Conversely, we are not persuaded by Drs. Barth's and Arbeene's conclusion that, notwithstanding claimant's increased symptoms and objective worsening following the April 1994 injury, his current need for treatment was the product of the natural worsening of his preexisting cervical disc condition. We discount that analysis, because it is based on a one-time examination of claimant and because it does not, in view of Dr. Hacker's compelling reasoning, adequately explain claimant's marked post-injury neurological and symptomatic changes. Further, because Dr. Serbu's final report does not address causation, we have disregarded that document.¹

The insurer argues that, because Dr. Hacker erroneously stated that claimant had no neurological deficit before the April 1994 injury, we should discount Hacker's reports. The insurer's argument appears to be that, because claimant displayed radiating pain in his neck and arms in 1993, claimant necessarily had a pre-injury neurological deficit. We disagree. Dr. Hacker's final report convinces us that the neurological deficit to which he referred was claimant's post-injury weakness and absent left biceps tendon reflex. Consequently, we find no error in Dr. Hacker's statement that claimant did not develop a neurological deficit until after the April 1994 injury.

Next, the insurer asserts that, under Edwin I. Spurgeon, 46 Van Natta 1824 (1994), claimant's claim fails. We disagree. In that case, we concluded that the claimant had failed to establish the compensability of an injury involving a preexisting symptomatic condition. In reaching that conclusion, we distinguished Spurgeon from U-Haul of Oregon v. Burtis, 120 Or App 353, rev den 318 Or 26 (1993), which holds that an asymptomatic preexisting condition that is rendered symptomatic by a work injury is compensable under ORS 656.005(7)(a)(B), if the injury is the major contributing cause of the resulting disability or need for treatment.

In Spurgeon, we noted that, unlike Burtis, the claimant's preexisting condition had been symptomatic before the injury, and surgery had been recommended for that condition before the injury occurred. 46 Van Natta at 1825. Last, and most important, we found that the medical evidence failed to establish that the claimant's work injury was the major contributing cause of his current need for medical treatment. Id.

Here, the insurer asserts, in effect, that Spurgeon stands for the proposition that, where a worker sustains an injury that renders a symptomatic preexisting condition more symptomatic, the increased symptoms are per se not compensable. (See Insurer's Appellant's Brief at 4). We disagree. Spurgeon establishes only that, when a worker seeks compensation for increased symptoms of a

¹ We note that Dr. Serbu's final report states that claimant did not mention the April 11 injury during their April 15 office visit. (Ex. 22). Arguably, the report undercuts claimant's credibility. We conclude otherwise, because there is no detailed report of the April 15 office visit; further, claimant testified that it was a five minute interaction, suggesting that very little was discussed. (Tr. 32).

preexisting condition which has combined with a compensable injury to form a "resultant condition," compensability is not established when medical evidence fails to satisfy the major contributing cause standard of ORS 656.005(7)(a)(B). Here, unlike Spurgeon, the medical evidence satisfies that standard. Accordingly, we reject the insurer's argument under Spurgeon.²

In sum, we find that the preponderance of the medical evidence establishes the compensability of claimant's current cervical condition under ORS 656.005(7)(a)(B). Accordingly, we affirm the Referee's decision setting aside the insurer's denial.

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

ORDER

The Referee's order dated November 17, 1994 is affirmed. For services on review, claimant's attorney is awarded \$1,000, payable by the insurer.

² We recognize that, here, as in Spurgeon, surgery had been recommended for claimant's preexisting C5-6 disc herniation before the April 11 accident occurred. Given that the medical evidence establishes major causation, we find that similarity insufficient to warrant the application of Spurgeon to this case.

May 18, 1995

Cite as 47 Van Natta 877 (1995)

In the Matter of the Compensation of
CARAN KRUGER, Claimant
WCB Case No. CV-95001
ORDER ON RECONSIDERATION (CRIME VICTIM COMPENSATION)
Mary Williams, Assistant Attorney General

On April 20, 1995, Special Hearings Officer Celia M. Fitzwater issued Findings of Fact, Conclusions and Proposed Order reversing the Department of Justice's December 22, 1994 Order on Reconsideration which had denied applicant's claim for benefits under the Crime Victim's Compensation Act. Specifically, Hearings Officer Fitzwater found that: (1) applicant was the victim of a compensable crime; (2) applicant fully cooperated with law enforcement; (3) there was no substantial provocation by applicant and her injuries were not substantially attributable to a wrongful act; and (4) applicant's award should be reduced by 50 percent.

The Department has objected to the order, asserting that the proposed order "includes factual findings which would require the Department to reject the application for failure to meet the statutory eligibility requirements as defined by administrative rule." In particular, as it did at hearing, the Department asserts that applicant did not fully cooperate with law enforcement. We further understand the Department as contending that the Hearing Officer did not apply such requirement in finding applicant eligible for benefits.

We conclude that we need not address the issue of whether applicant fully cooperated with law enforcement inasmuch as we find that applicant is not eligible for benefits because her injuries were substantially attributable to her own wrongful act. See ORS 147.015(5). Based on the Hearing Officer's findings of fact, with which we agree, applicant was not the initial aggressor. However, there is substantial evidence that applicant, at minimum, was a mutual combatant in the altercation. For example, applicant used some wood to hit Ms. Mischuk, pulled Ms. Mischuk's hair, and, most notably, followed Ms. Mischuk to her truck and pounded on the window after Ms. Mischuk had left applicant's house. While at the truck, applicant again pulled Ms. Mischuk's hair, causing her head to hit the truck.

Therefore, we conclude that applicant's injuries are substantially attributable to her own wrongful act and she is not eligible for crime victims' compensation benefits. See ORS 147.015(5). Hence, we affirm the Department's order denying benefits.

IT IS SO ORDERED.

May 18, 1995

Cite as 47 Van Natta 878 (1995)

In the Matter of the Compensation of
JAMES D. LOLLAR, Claimant
 WCB Case Nos. 94-03241 & 94-00738
 ORDER ON RECONSIDERATION
 Gatti, Gatti, et al., Claimant Attorneys
 Lundeen, et al., Defense Attorneys
 John B. Motley (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our April 20, 1995 Order on Review which awarded a \$600 attorney fee under ORS 656.386(1) to claimant's attorney for services in obtaining rescission of the compensability portion of SAIF's denial prior to hearing. On May 5, 1995, we withdrew our order to allow claimant to respond to SAIF's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

SAIF contends, based on the language of its denial, that the denial raised no compensability issues. For the reasons expressed in our original order, we continue to believe that the wording of SAIF's denial raised issues of compensability.

However, SAIF also asserts that claimant's attorney agreed at hearing that its denial was a responsibility denial. SAIF further argues that claimant's counsel did not argue that he was entitled to an attorney fee under ORS 656.386(1) for services in obtaining a pre-hearing rescission of the compensability portion of SAIF's denial. Claimant does not contest these assertions. Instead, he responds that SAIF's denial was not limited to responsibility. As previously discussed, we concur with claimant's characterization of SAIF's denial. Nevertheless, for the following reasons, we agree with SAIF's contention that claimant neglected to raise the "compensability rescission" issue at hearing.

Here, claimant's attorney agreed without objection that the only issue at hearing was responsibility. (Tr. 1). There is no indication in the record that claimant's attorney contended that SAIF's denial raised compensability issues or that he sought an attorney fee for obtaining rescission of a compensability denial prior to hearing.¹ The record reveals that claimant did not seek attorney fees until after the hearing on reconsideration before the Referee. We have previously declined to address issues not raised at hearing. See, e.g., Larry L. Schutte, 45 Van Natta 2085 (1993) (Board declined to address issue raised for the first time in closing argument).

In reaching this decision, we draw on the reasoning expressed in Angela M. Stratis, 46 Van Natta 816 (1994). In Stratis, the claimant's attorney indicated that she was appealing a carrier's "responsibility denials." No objection was made to this statement of the issues. Given the parties' characterization of the denial as one of responsibility, we concluded that the denial was limited to responsibility. Consequently, we declined to award the claimant an attorney fee under ORS 656.386(1).

¹ Relying on Wright Schuchart Harbor v. Johnson, 133 Or App 680 (1995), claimant argues that, when "the totality of circumstances are taken into consideration," the compensability issue and its related issues remained viable. Insofar as claimant asserts that it was unnecessary to raise the compensability issue because the carriers were only contesting responsibility for the claim, we agree with claimant's assertion. However, we disagree with claimant's reasoning concerning his entitlement to an attorney fee for the rescission of the compensability portion of SAIF's denial. Inasmuch as that issue was viable at the commencement of the hearing, we conclude that, based on the totality of the circumstances, claimant's failure to raise the issue during the hearing precludes him from obtaining such an award.

Here, given the parties' characterization of the denial as a responsibility denial, and the lack of a contention at hearing that the denial either raised compensability issues or that claimant was entitled to a "386(1)" attorney fee, we conclude, as we did in Stratis, that claimant is not entitled to an attorney fee award. Therefore, on reconsideration, we withdraw that portion of our prior order which awarded a \$600 attorney fee pursuant to ORS 656.386(1).

Finally, in his response to SAIF's motion for reconsideration, claimant seeks an attorney fee for his active and meaningful participation at hearing regarding the responsibility issue. In support of this request, claimant cites Darrell W. Vinson, 47 Van Natta 356 (1995). However, as we stated in our prior order, since no "307" order issued, an attorney fee under ORS 656.307(5) is not appropriate. Because Vinson pertained to a claimant's entitlement to an attorney fee award under ORS 656.307(5), that holding has no application to this case.

Accordingly, on reconsideration, as modified herein, we republish the Board's April 20, 1995 order.² The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

² In republishing the Board's initial order, Member Hall recognizes that the majority has disagreed with his dissenting position that claimant was entitled to an attorney fee award under ORS 656.386(1) because Liberty's denial did not expressly concede compensability. This action should not be interpreted as an indication that he does not continue to hold the views expressed in his dissenting opinion. Rather, by signing this order, Member Hall is merely acknowledging that, as modified by this order, the majority decision in the Board's initial order remains.

May 18, 1995

Cite as 47 Van Natta 879 (1995)

In the Matter of the Compensation of
EVELENA M. MacFARLANE, Claimant
 WCB Case Nos. 93-09634 & 92-11556
 ORDER ON REVIEW
 Foss, Whitty, et al., Claimant Attorneys
 Cowling, Heysell, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee Black's order which: (1) set aside its "de facto" denial of claimant's cervical degenerative disk disease; (2) set aside its "de facto" denial of claimant's low back degenerative disk disease; and (3) set aside its "de facto" denial of claimant's L2-3 disk condition and proposed surgery. Claimant cross-requests review of that portion of the Referee's order which found claimant's degenerative neck condition compensable only until November 14, 1991. On review, the issues are compensability and medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's preexisting lumbar and cervical degenerative disk disease combined with a February 1991 work injury, and that the resultant cervical and lumbar conditions are compensable under ORS 656.005(7)(a)(B). The Referee also concluded that claimant's degenerative cervical and lumbar conditions had compensably worsened, but that the cervical condition was compensable only until November 14, 1991. We agree with each of these conclusions, based on the following reasoning.

First, we briefly summarize the relevant facts. Claimant, an intensive care unit nurse, sustained a lifting injury on February 3, 1991. This injury was accepted as a cervical and lumbar muscle strain

with related radicular symptoms. (See Ex. 56). Claimant asserts that her preexisting degenerative lumbar and cervical disk disease was compensably worsened by the February 1991 work injury. (See Exs. 65, 66A). Claimant was also diagnosed with an L2-3 disk rupture or fragment, allegedly resulting from the 1991 injury. The employer denied authorization for surgery at the L2-3 level, on the ground that the proposed surgery is not compensably related to the accepted condition. (Ex. 72).

Cervical Condition

The Referee found that claimant's preexisting degenerative cervical condition combined with the February 1991 work injury, and that the work injury was the major contributing cause of her resultant condition. After our review of the record, we agree with the Referee's analysis and evaluation of medical evidence on this issue.

The Referee also found that the cervical condition was compensable only until November 1991. Claimant cross-appealed on this issue, contending that the Referee erred in so limiting the compensability of her cervical condition. We agree with the Referee.

Dr. Holmes, who followed claimant at a pain center from June until November 1991, opined that by November 1991 claimant's neck was nearly symptom-free. (Ex. 67-7). He noted that claimant's primary neck problem was a soft tissue injury which resolved with treatment, leaving the preexisting cervical problems. (Ex. 67-11, -22). Dr. Kendrick, claimant's treating neurosurgeon, disagreed with Dr. Holmes, but conceded that a reasonable case could be made for his (Dr. Holmes') opinion. (Ex. 66-36 to -37). On this issue, we consider Dr. Holmes' opinion to be more fully developed and, therefore, more persuasive. Accordingly, we affirm that portion of the Referee's order which found claimant's resultant cervical condition compensable only until November 1991.

Lumbar Condition

The Referee found that claimant's preexisting lumbar degenerative disease had compensably worsened. Therefore, the Referee concluded that claimant's lumbar condition was compensable. In addition, the Referee found that the preexisting lumbar condition had combined with the February 1991 work injury to cause an L2-3 disk herniation/fragment, the major contributing cause of which was the 1991 work injury. Therefore, the Referee found the L2-3 disk condition to be compensable under ORS 656.005(7)(a)(B). Finally, the Referee found the proposed L2-3 surgery compensable. We agree and add the following supplementation.

Dr. Kendrick, claimant's long-time treating neurosurgeon, opined that the February 1991 lifting incident was the major contributing cause of the worsening of claimant's preexisting lumbar degenerative disease. (Ex. 65). He explained the likely mechanism whereby an industrial injury adversely affects degenerative disease, and opined that this mechanism is a reasonable explanation for the L2-3 disk rupture. (Ex. 66 at 21-22). Dr. Kendrick also opined that the February 1991 work injury was the major contributing cause of the L2-3 disk herniation or fragment. (Exs. 62A, 66-18). He explained that the L2-3 disk rupture seen on a February 19, 1991 MRI was probably recent because the rupture was very focal and because claimant had not had prior back or leg pain. (Ex. 66 at 24, 44).

Dr. Holmes held a contrary opinion. He opined that the major contributing cause of claimant's current impairment is her preexisting lumbar degenerative disease, and that claimant's degenerative condition would have probably progressed to the same point regardless of any injury. (Ex. 59A). However, he was unable to give an opinion as to when that progression would have occurred naturally. (Ex. 67-23). Dr. Holmes explained that the primary area of degenerative disk disease was at L2-3, caused in major part by the aging process and the "degenerative cascade" unrelated to the February 1991 injury. (Ex. 67 at 12-13, 17). However, he was unable to give an opinion, within reasonable medical probability, regarding the major contributing cause of the L2-3 disk rupture or fragment. (Ex. 67 at 17-18).

When medical opinions differ, we ordinarily give greater weight to those opinions which are well-reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). We also generally give greater weight to the treating doctor's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

We find no persuasive reason not to defer to Dr. Kendrick's opinion on this issue. He is claimant's long-time treating neurosurgeon who previously performed surgery on her cervical spine. His opinions are based on complete information, are well-reasoned, and are based on his expertise as a neurosurgeon. In addition, we find Dr. Holmes' opinions less persuasive because he was unable to render an opinion, within reasonable medical probability, on certain key questions. Therefore, we defer to Dr. Kendrick's opinion. Accordingly, we conclude, based on Dr. Kendrick's opinion, that the February 1991 work injury was the major contributing cause of a worsening of claimant's preexisting lumbar degenerative disease.

We turn now to the compensability of claimant's L2-3 disk rupture or fragment and the proposed L2-3 surgery. Based on the medical evidence in the record, we find that claimant's L2-3 disk condition and proposed surgery are compensable because the February 1991 injury was the major contributing cause of the disk condition.

In doing so, we again rely on Dr. Kendrick's opinion. He opined that the February 1991 work injury was the major contributing cause of the L2-3 disk herniation or fragment, explaining the basis for his opinion with reference to the appearance of the rupture, as well as the absence of back or leg pain prior to the February 1991 incident. By contrast, Dr. Holmes was unable to give an opinion, within reasonable medical probability, regarding the cause of the disk herniation or fragment. Accordingly, we conclude that claimant's L2-3 disk condition is compensable.

Since we have found both the L2-3 disk condition and claimant's lumbar degenerative disk disease compensable, the surgery recommended by Dr. Kitchel is also compensable. (See Ex. 80 at 8, 12-14, 19, 25). The employer does not contest the reasonableness or necessity of the surgery. (Ex. 72). Accordingly, we affirm that portion of the Referee's order which set aside the employer's purported denial of March 10, 1993. (*Id.*)

Attorney Fees

Inasmuch as we have not disallowed or reduced the compensation awarded by the Referee, claimant is entitled to an assessed attorney fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services concerning the issues raised by the employer's request for review is \$1,100, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and her attorney's statement of services), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee award for services devoted to her unsuccessful cross-request for review.

ORDER

The Referee's order dated May 9, 1994 is affirmed. Claimant's attorney is awarded \$1,100 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
MONA R. SKELTON, Claimant
WCB Case No. TP-95002
THIRD PARTY DISTRIBUTION ORDER
Rasmussen & Henry, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Claimant has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute concerns the paying agency's entitlement to a lien for anticipated future medical expenditures.¹ ORS 656.593(1)(c). We conclude that the paying agency has not established that it is reasonably certain that it will incur such expenditures.

FINDINGS OF FACT

In June 1992, claimant was compensably injured when she went to a grocery store, at her employer's request. While in the store, claimant slipped and fell, injuring her right elbow. Claimant received emergency room treatment. X-rays showed a minimally displaced radial head fracture. Claimant was treated with a removable splint, and she missed approximately five days of work.

The paying agency accepted the claim and has provided compensation. Claimant's claim was closed by a November 9, 1993 Notice of Closure. Finding claimant medically stationary as of September 17, 1992, the closure notice did not award permanent disability. The Notice of Closure was subsequently affirmed. Although claimant requested a hearing, it was subsequently dismissed at her request.

Claimant has minimal complaints or functional problems with her right elbow. Although there are no current surgery recommendations, the possibility of future elbow surgery has been discussed by claimant's examining physicians. These physicians do not indicate that either future surgery or further medical treatment is reasonably anticipated.

Claimant retained legal counsel to explore the possibility of bringing suit against the third party. The cause of action was settled for \$15,000. Following distribution of litigation costs, attorney fees, and claimant's statutory one-third share, a dispute remains concerning the disbursement of the remaining balance of settlement proceeds.

The paying agency has expended \$1,998.15 in time loss and medical expenses. It predicts that it will incur approximately \$1,200 in future claim expenditures, such as surgery and medical treatment. Claimant does not challenge the paying agency's entitlement to receive reimbursement for its actual claim costs. However, it contests the agency's claim for future claim costs.

It is not reasonably certain that the paying agency will incur future claim expenditures.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The paying agency has a lien against the worker's cause of action, which lien shall be preferred to all claims except the cost of recovering such damages. ORS 656.580(2). The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

¹ Claimant also petitioned the Board for approval of the third party settlement for the amount of \$15,000. However, the paying agency has raised no objection to the appropriateness of the settlement amount. Under such circumstances, we find that there is no dispute concerning the propriety of the \$15,000 compromise. See ORS 656.587.

Since claimant settled her third party claim and the paying agency has approved that settlement, the paying agency is authorized to accept as its share of the proceeds "an amount which is just and proper;" provided that claimant receives at least the amount to which she is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). The amounts referred to in ORS 656.593(1) and (2) pertain to attorney fees, litigation expenses, and claimant's statutory 1/3 share of the settlement. Thereafter, any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

After the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, the paying agency shall be paid and retain the balance of the third party recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Such other costs do not include any compensation which may become payable under ORS 656.273 or 656.278. Id. The balance of the recovery shall be paid to the worker or beneficiaries. ORS 656.593(1)(d).

In determining a "just and proper" distribution, we judge each case based on its own merits. Urness v. Liberty Northwest, 130 Or App 454 (1994). Since "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes regarding third party settlements. Id. Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination was based on the merits of the case. Id.

Thus, in reaching our determination regarding a "just and proper" distribution, we judge this case based on its own merits and not on an inapplicable statutory distribution scheme. See Urness v. Liberty Northwest, supra. However, to assist us in conducting our deliberations, we have examined the components of compensation which are subject to reimbursement from a third party judgment under Section (1)(c).

Such an examination provides some general guidance to us in determining what portion of the remaining balance of claimant's third party settlement would be "just and proper" for the paying agency to receive in satisfaction of its lien for future claim costs. To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Donald P. Bond, 40 Van Natta 361, on recon 40 Van Natta 480 (1988); Leonard Henderson, 40 Van Natta 31 (1988).

Here, the paying agency contends that it has established that future expenditures for claimant's medical services are "reasonably to be expected." See ORS 656.593(1)(c). We disagree.

In Cynthia G. Lavelle, 41 Van Natta 1399 (1989), the claimant's treating doctor found that there was no way to predict whether the claimant would experience future problems that would result in back surgery. The doctor who examined the claimant on behalf of the insurer reported that the claimant's sacroiliac joint might become more symptomatic, and if so, could be fused at some time in the future. However, he further stated that additional treatment would not likely be beneficial and, therefore, he did not recommend such procedures.

In Lavelle, we concluded that surgery for the claimant was only speculative, and future problems were neither expected nor necessary. Consequently, we concluded that it was not reasonably certain that the paying agency would incur future expenditure concerning the claimant's back condition. As a result, we found that the paying agency was not entitled to a lien for anticipated future expenditures. Cynthia G. Lavelle, supra.

Similarly, in the present case, we do not find that it is reasonably certain that the paying agency will incur future expenditures concerning claimant's right elbow condition. Claimant was last examined by her treating doctor, Dr. Benz, on June 3, 1993. At that time, Dr. Benz noted that claimant was only having a couple of small complaints with regard to her arm function. Dr. Benz reported that claimant was medically stationary as of September 17, 1992, with very minimal impairment based on functional complaints and objective x-ray findings. Dr. Benz concluded that no further treatment was necessary.

Dr. Nash, who evaluated claimant in June 1994, diagnosed "history of fracture of the right radial head, with ongoing minimal displacement," "ulnar nerve compression at the elbow, symptomatic on the right, myofascial trigger point changes, right supinator muscle." Reporting that claimant's "problems are...now considered to be permanent," Dr. Nash determined that claimant had "no current surgical option." Although noting that there was a "possibility" that surgery might be indicated in the future for release of the peripheral nerve entrapment in the right upper extremity, Dr. Nash repeated that "no surgery is indicated as of this date."

Dr. Gambee, orthopedist, examined claimant at the paying agency's request. Characterizing claimant's prognosis as excellent, Dr. Gambee foresaw that claimant "could conceivably require head resection in the future that would be necessitated by the described [elbow] fracture." Nevertheless, Dr. Gambee concluded that claimant "certainly does not need [surgery] now, and it is the considered opinion of this examiner, on a more probable than not basis, she will not need surgery."

After considering the aforementioned medical opinions, we find that, at most, they support a conclusion that future surgery is only a "possibility." Such a finding is insufficient to satisfy the "reasonably certain" standard set forth in Lavelle. Moreover, since claimant's attending physician has reported that no further treatment was necessary, we are not persuaded that it is reasonably certain that the paying agency will incur any future medical expenses concerning claimant's right elbow condition. Consequently, we conclude that the paying agency is not entitled to a lien for future anticipated claim expenditures.

Accordingly, we hold that the paying agency is not entitled to recover its projected \$1,200 lien for anticipated future expenditures. Following distribution of \$1,998.15 to the paying agency (as reimbursement for its undisputed actual claim costs), claimant's counsel is directed to forward the remaining balance of the third party recovery to claimant.

IT IS SO ORDERED.

May 18, 1995

Cite as 47 Van Natta 884 (1995)

In the Matter of the Compensation of
JOYCE A. SMITH, Claimant
 WCB Case No. 94-02738
 ORDER ON REVIEW
 Malagon, Moore, et al., Claimant Attorneys
 Brian L. Pocock, Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Black's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

To establish the compensability of her occupational disease claim, claimant must prove that her work activities were the major contributing cause of her bilateral shoulder condition, or its worsening. See ORS 656.802(2). Claimant argues that we should give deference to the opinion of her treating physician, Dr. Nagel, orthopedic surgeon. When the medical evidence is divided, we tend to give greater weight to claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to defer to the opinion of Dr. Nagel.

Dr. Nagel reported that an MRI of the left shoulder confirmed the diagnosis of calcific tendinitis with no evidence of rotator cuff tear, although there was some mild impingement of the rotator cuff.¹ (Ex. 4A). Dr. Nagel recommended a course of physical therapy and swimming. Dr. Nagel also diagnosed right shoulder calcific tendinitis with impingement on the acromioclavicular joint. (Ex. 4B). After claimant's right shoulder did not respond to conservative treatment, Dr. Nagel performed a surgical decompression and excision of the calcific deposit. (Ex. 8). Dr. Nagel reported that claimant's work activities were the major contributing cause of claimant's shoulder pain, namely the improper set-up of her work station for 8 years. (Exs. 4A, 5B, 8, 10).

Dr. Nagel's opinion is supported by the opinions of Dr. Smith, orthopedic surgeon, and Dr. Watson, neurologist, who examined claimant on behalf of the employer. They diagnosed calcific tendinitis, supraspinatus tendon, right shoulder and possible mild impingement syndrome, left shoulder. (Ex. 4C). They explained that calcific tendinitis is the deposition of calcium salts into a degenerated area of a tendon, the precise cause of which is unknown. The calcium deposit can be present for years without any symptoms.

Drs. Smith and Watson reported that claimant's calcific tendinitis in her right shoulder was preexisting but was asymptomatic until aggravated by her work. They opined that it was probable that claimant's work, particularly the use of her arms overhead, caused the preexisting calcium deposit in the right supraspinatus tendon to become symptomatic. They explained:

"In the shoulder, a calcium deposit usually sits quietly within the supraspinatus tendon, and is asymptomatic until activity of the shoulder causes extravasation of some of the calcium into the adjacent bursa. This will then cause a calcific bursitis, which can be very painful. She has an element of this in her shoulder." (Ex. 4C).

In a subsequent report, Dr. Smith said that he had not been aware that claimant had "scraped the paint off her house with a hand scraper" and he now believed that the paint scraping was a more likely cause for her acute shoulder symptoms than her work activities. (Ex. 5).

Dr. Smith's impression of claimant's paint scraping activities was not accurate. The Referee concluded that the issue of paint scraping was a "red herring." Based on claimant's credible testimony, the Referee found no substantial shoulder exposure from claimant doing some detail work around vents and hatches on the trailer home that her husband had resurfaced. We agree with the Referee's conclusion concerning the paint scraping. Therefore, Dr. Smith's subsequent opinion that paint scraping caused claimant's symptoms is not persuasive.

The employer relies on the opinion of Dr. Woolpert, orthopedic surgeon. Dr. Woolpert reported that claimant's shoulder problem was related to preexisting calcification, degenerative change and impingement type of phenomena. (Ex. 6). In light of those problems, Dr. Woolpert anticipated that claimant would have increased symptoms with usage of the arm. He concluded that the calcification was a symptomatic exacerbation of a preexisting condition.

In a later report, Dr. Woolpert reported that the changes noted in claimant's shoulder were quite common in shoulders of most individuals over 50 years of age regardless of the level or type of activity. (Ex. 9). He said that the pathological changes in the rotator cuff were "idiopathic in causation with an age relationship." Dr. Woolpert concluded that the changes in claimant's shoulder and her need for treatment would have occurred regardless of her work activity.

In light of Dr. Woolpert's first report that claimant's symptoms would increase with usage of the arm, we do not find his later conclusion that the changes in claimant's shoulder would have occurred regardless of her work activity to be persuasive. Since Dr. Woolpert did not explain this inconsistency, we attach little probative value to it. See Kelso v. City of Salem, 87 Or App 630 (1987).

¹ We note that the Referee found that claimant's left shoulder did not require treatment beyond evaluation and did not show the calcific process that was seen in the right shoulder. In light of Dr. Nagel's report, we disagree with the Referee's findings.

We find that the medical evidence establishes that claimant had preexisting calcium deposits in her shoulders. Based on the reports from Drs. Nagel, Smith and Watson, we find that claimant's work activities were the major contributing cause of a change in the calcium deposits which resulted in a pathological worsening of her shoulder condition. In reaching this conclusion, we acknowledge that none of these physicians expressly stated that claimant's calcification condition was pathologically worsened by her work activities. Nevertheless, it is well-settled that medical opinions need not mimic statutory language or use "magic words." See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Based on the physicians' collective opinions, we find that the medical evidence satisfies claimant's burden of proof. We further conclude that claimant's condition was unrelated to non-work activities. Consequently, we set aside the employer's denial of claimant's bilateral shoulder condition.

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 is \$4,250, payable by the employer. 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, and the hearing record), the complexity of the issues, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 23, 1994 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$4,250, to be paid by the employer.

May 18, 1995

Cite as 47 Van Natta 886 (1995)

In the Matter of the Compensation of
ROBIN L. SMITH, Claimant
 WCB Case No. 93-07304
 ORDER ON RECONSIDERATION
 Philip H. Garrow, Claimant Attorney
 Beers, Zimmerman, et al., Defense Attorneys

On April 12, 1995, we abated our March 14, 1995 order that: (1) set aside the insurer's "de facto" denial of claimant's medical services claim for medical bills and travel/prescription reimbursement; (2) awarded an insurer-paid attorney fee under ORS 656.386(1); and (3) assessed a penalty under ORS 656.262(10) for unreasonable claim processing. We took this action in order to consider the insurer's motion for reconsideration. Having received claimant's response and the insurer's reply, we proceed with our reconsideration.

In our original order, we found that the insurer had failed to comply with the administrative rules governing the proper notice of the eligible medical providers and the manner in which a claimant is to be provided compensable medical services under a Managed Care Organization (MCO). We further concluded that the insurer improperly refused to reimburse claimant for medical and related expenses and that such conduct was unreasonable given the express requirements of the applicable administrative rules.

The insurer urges us to reconsider our finding that it did not comply with OAR 436-10-100(22)&(23), arguing that it gave claimant and Dr. Belza appropriate notice under those rules and, nevertheless, that it complied with their "intent."¹ For the reasons cited in our original order, we adhere to our conclusion that the insurer's March 22, 1993 letter did not clearly reject Dr. Belza as claimant's attending physician or expressly provide that any further bills would not be reimbursed.

¹ The insurer correctly notes the typographical error in our original order when we mistakenly referred to OAR 436-10-060(22)&(23) instead of OAR 436-10-100(22)&(23).

Thus, we still conclude that the insurer did not comply with the requirements of OAR 436-10-100(22). Cf. Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986) (strict compliance required with administrative rule setting forth procedural requirements for terminating temporary disability). Moreover, we continue to find that the insurer did not clearly inform claimant of the manner in which she could receive medical services as required by OAR 436-10-100(23).

The insurer also contends that its claims processing was not unreasonable and that there is no evidence of unpaid bills for treatment or related services. The insurer's contentions notwithstanding, it did not expressly inform claimant (as required by OAR 436-10-100 (22)) that Dr. Belza's medical treatment would not be paid until it sent her its November 24, 1993 letter. The insurer's conduct was therefore unreasonable in light of the clear requirements of the aforementioned rule. Thus, claimant is entitled to a 25 percent penalty pursuant to ORS 656.262(10) on "amounts then due" at the time of the insurer's November 24, 1993 letter. The amount of the penalty, if any, is a claim processing matter that is not before the Board. However, we note that there is likely an amount "then due" on which to base the penalty. (Ex. 64).²

Claimant's counsel is entitled to an additional assessed attorney fee for time spent responding to the insurer's reconsideration request. See ORS 656.386(1); Susan A. Michl, 47 Van Natta 162 (1995). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that an additional reasonable fee for claimant's counsel's services regarding the insurer's request for reconsideration regarding the "de facto" denial issue is \$500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the claimant's response to the reconsideration request), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our March 14, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our March 14, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

² The insurer argues that claimant sought treatment from two physicians, Dr. Becker and Dr. Belza, at the same time. The insurer asserts that claimant is entitled to only one attending physician, Dr. Becker, who was approved to be her treating physician. As explained in our original order, we construed claimant's request to treat with Dr. Belza as a request for change of attending physician. Inasmuch as we have no jurisdiction over such requests, see Tracy Johnson, 43 Van Natta 2546 (1991), the attending physician issue is for the Director to resolve. In any event, given its failure to comply with OAR 436-10-100(22), the insurer's refusal to pay for Dr. Belza's treatment was unreasonable.

May 18, 1995

Cite as 47 Van Natta 887 (1995)

In the Matter of the Compensation of
JOHNNY C. TINKER, Claimant
WCB Case Nos. 92-10036 & 92-03014
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Podnar's order that: (1) upheld Giesy, Greer & Gunn's denial of claimant's medical services claim for his current low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition. In its brief, Giesy contends that the Referee abused his discretion by admitting Exhibits 45, 46 and 47 (a three-part report from Dr. Gritzka, an examining physician) into evidence without permitting Giesy an opportunity for cross-examination. On review, the issues are evidence, compensability, and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, Giesy contends that the Referee abused his discretion by admitting Exhibits 45, 46, and 47 into evidence. Specifically, Giesy argues that the record was left open for claimant to either depose his former treating doctor, or to obtain a rebuttal report from doctors previously involved in claimant's care. Giesy contends that, because Exhibits 45, 46, and 47 were authored by Dr. Gritzka, who did not examine claimant until after the hearing, the Referee's admission of those exhibits exceeded the scope of rebuttal evidence.

We do not reach the evidentiary issue in this case, as we find that the reports from Dr. Gritzka are not persuasive. As noted by the Referee, Dr. Gritzka's final report on the issue is conclusory and does not provide any analysis to support his conclusion that the 1982 injury and resulting surgery are the major cause of claimant's current condition. Additionally, Dr. Gritzka did not consider or discuss the other factors that the remaining medical experts (including claimant's prior treating physician) found to have contributed to claimant's current condition. Finally, claimant first saw Dr. Gritzka in March 1994, which was nearly three years since the last time he had sought treatment for his condition. Additionally, claimant had been in five motor vehicle accidents within a six-month period of time, yet Dr. Gritzka did not discuss any contributions the accidents may have had on claimant's current back condition.

For the aforementioned reasons, we do not find Dr. Gritzka's opinion to be persuasive. Accordingly, because we do not rely on his opinion in reaching our conclusion, Giesy's evidentiary issue is moot.

Compensability

The Referee held that ORS 656.005(7)(a)(B) applied to claimant's claim. Furthermore, the Referee concluded that, because claimant's noncompensable 1978 injury, his industrial injuries and surgeries, and his obesity and deconditioning all contributed to his condition, no single industrial injury was the major cause of claimant's condition. Therefore, the Referee upheld both denials of compensability.

On review, claimant argues that ORS 656.005(7)(a)(B) does not apply because his 1978 preexisting degenerative disc condition was accepted in 1982 when Giesy accepted his low back injury at L4-5. Specifically, claimant contends that the injury with Giesy's insured in 1982 worsened the 1978 noncompensable injury and related surgeries. Consequently, claimant argues that, when Giesy accepted the 1982 injury, it also accepted claimant's preexisting 1978 back condition. We agree.

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). Claimant's 1978 injury consisted of herniated discs at L4-5, L3-4, and L5-S1. His surgery involved laminectomies at all three levels. Claimant was asymptomatic until his work injury with Giesy's insured in 1982.

A Form 801 describes claimant's August 18, 1982 injury as a "back injury." The affected part of the body was listed as "back (lower)." The Form 801 further provided that the claim was deferred.

Claimant's 1982 injury was diagnosed as: herniated nucleus pulposus at L4-5, right sided L-5 nerve root impingement. On October 14, 1982, Dr. Kaesche, claimant's treating doctor, stated that a myelogram showed a substantial defect at L4-5. Dr. Kaesche recommended a laminectomy and discectomy. In late October 1982, claimant underwent a laminectomy and discectomy at the L4-L5 level. In November 1982, Giesy accepted claimant's claim as disabling.

We agree with claimant that, by accepting his L4-5 and L5 condition, Giesy also accepted claimant's prior condition at the same level. Specifically, claimant's 1982 injury and his preexisting condition arising from the 1978 injury and subsequent surgeries occurred at the same level and there is no evidence that the diagnosis and surgeries performed were different in 1982 than in 1978. Accordingly, we conclude that Giesy accepted claimant's 1978 condition. SAIF v. Tull, *supra*.

Under the circumstances, we find that, because claimant's condition was accepted, there was no "preexisting disease." Rather, there is only a compensable condition which Giesy has accepted. See Joyce E. Soper, 46 Van Natta 740 (1994). Additionally, there is no evidence that the compensable low back condition combined with any other preexisting disease. Therefore, with respect to the Giesy claim, we do not decide this case based on ORS 656.005(7)(a)(B). See Lizbeth Meeker, 44 Van Natta 2069, 2071 (1992).

Responsibility

ORS 656.308(1) provides, in part: "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."

Here, the persuasive medical evidence establishes that claimant's current disability is related to his condition accepted in 1982 by Giesy. Specifically, in June 1992, the Medical Consultants diagnosed: (1) status postoperative three-level lumbar laminectomy and discectomy, L3 to S1, due to previous injury in 1975, and the laminectomy done in 1978; (2) status postoperative laminectomy and discectomy L4-5, related to on-the-job injury on August 18, 1982; and (3) chronic recurrent episodes of lower back pain with leg symptoms. (Ex. 36-5).

On September 24, 1992, Dr. Kaesche, the physician who treated claimant beginning in 1982, reported that claimant's condition was a combination of two failed surgeries (i.e., his surgeries in 1978 and 1982) and his current activity level. Additionally, in November 1992, Dr. Kaesche reported that claimant's basic "underlying problem of a multiple level laminectomy is the major cause of his back pain and of his objective abnormalities."

We conclude that the persuasive medical evidence establishes that claimant's current condition is the same as his prior condition, which included an L4-5 condition and surgeries. Therefore, Giesy is responsible for claimant's current condition unless it can show that claimant sustained a new compensable injury at Liberty's insured that involved the "same condition."

Claimant's prior accepted condition involved disc herniations and the resulting surgeries. However, claimant's 1990 injury with Liberty's insured was diagnosed as a back "strain." The 1990 strain at Liberty's insured did not result in time lost from work, and the claim was closed in February 1990. Furthermore, none of the doctors who have examined or treated claimant have opined that the 1990 strain is the same as the prior herniations/post-laminectomy condition accepted by Giesy. Consequently, we find that, because the 1982 and 1990 claims do not involve the "same condition," ORS 656.308(1) does not apply. Smurfit Newsprint v. DeRosset, 118 Or App 368, 371 (1993). Finally, there is no evidence that claimant's work with Liberty's insured worsened his underlying condition, as opposed to his symptoms. Bracke v. Baza'r, 293 Or 239 (1982). Inasmuch as Giesy has failed to establish that claimant suffered a new compensable injury/disease, Giesy remains responsible for claimant's condition, including his current low back condition.

Claimant is entitled to an assessed attorney fee for prevailing over Giesy's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is \$3,000, to be paid by Giesy. 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 August 25, 1994 is reversed in part and affirmed in part. Giesy's denial is set aside and the claim is remanded to Giesy for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$3,000, to be paid by Giesy. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JERRY CARROLL, Claimant
WCB Case No. 94-00301
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn, Turner-Christian, and Haynes.

The self-insured employer requests review of that portion of Referee Hoguet'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.

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

ORDER

The Referee's order dated August 4, 1994 is affirmed. For services on Board review, claimant's attorney is awarded \$1,000, payable by the self-insured employer.

Board Member Haynes dissenting.

The employer asserts that the Referee erred in concluding that claimant has established a compensable aggravation. Particularly, the employer asserts that the Referee erroneously found that claimant has proved a compensable worsening of his accepted low back condition and that the alleged worsening was more than a waxing and waning of symptoms of the accepted condition as contemplated by the Order on Reconsideration. I agree.

First, I note that the Referee found that, based on claimant's attitude, appearance, and demeanor, claimant was an unreliable witness. That finding undermines the reliability of the evidence that is based on claimant's statements. Because the evidence on which claimant relies is based on his statements, I am not inclined to afford it persuasive force. See Somers v. SAIF, 77 Or App 259, 263 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Second, the record is not at all clear regarding the worsening issue. Dr. Hoppert, treating physician, stated, in a conclusory concurrence letter drafted by claimant's counsel, that claimant had experienced a symptomatic worsening of his low back condition. (Ex. 38-2). Hoppert also stated, in an equally conclusory letter drafted by the employer's counsel, that claimant had suffered an exacerbation of his low back condition. (Ex. 39-1). However, throughout the record, Dr. Hoppert has maintained that claimant's low back condition remained medically stationary. (Exs. 27-3, -4, -5, 39, 43-6, -7).

On this record, I find that Dr. Hoppert's apparently conflicting statements -- on the one hand, that claimant's low back condition has worsened, and, on the other, that claimant remains medically stationary -- create significant doubt about whether claimant's condition has worsened. See Diana Traver, 47 Van Natta 8, 9 (1995) (physician's continued assertion that the claimant was medically stationary supported conclusion that the claimant's condition had not worsened).

Finally, assuming that claimant has established a compensable worsening, I nevertheless agree with the employer that claimant has failed to overcome the "waxing and waning" hurdle. The parties do not dispute that the Order on Reconsideration pertaining to claimant's accepted low back claim contemplated future waxing and waning of low back symptoms. Therefore, claimant must prove that his allegedly worsened condition is more than the waxing and waning of symptoms of the accepted condition, as contemplated by the Order on Reconsideration. ORS 656.273(8).

After reviewing the evidence, I conclude that claimant has failed to meet that burden. In reaching this conclusion, I rely on the uncontroverted reports of Dr. Hoppert, who had the opportunity to observe claimant both before and after closure of his accepted low back claim. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986) (more weight given to report of physician who had opportunity to observe claimant before onset of symptoms). Dr. Hoppert opined several times that claimant's current symptoms were no more than a waxing and waning of symptoms of his accepted low back condition. (Exs. 27-3, 39, 43-7). I find those opinions persuasive evidence that claimant's current low back symptoms are not more than a waxing and waning of symptoms of his accepted low back condition.¹

In reaching this conclusion, I acknowledge that, when claimant sought further medical treatment for his low back in 1993, his physicians intermittently restricted him from full time, full duty work, and declined to recertify his Department of Transportation card, which would have authorized him to return to his work without restrictions. (See Ex. 35(c)). In my view, the restrictions were an attempt to control claimant's ongoing low back symptoms, not a determination that his symptoms had exceeded the waxing and waning of symptoms contemplated by the Order on Reconsideration. Therefore, notwithstanding the restrictions, I conclude that claimant has failed to prove that his current low back symptoms are more than a contemplated waxing and waning of symptoms of his accepted low back condition.

For these reasons, I conclude that claimant has failed to establish a compensable aggravation claim. Accordingly, I would reverse the Referee's decision setting aside the employer's denial of that claim. Because the majority has concluded otherwise, I dissent.

¹ Claimant argues that Michael C. Dewbre, 45 Van Natta 1097 (1993) supports his position. I disagree. There, the treating physician had opined that the claimant's condition represented a waxing and waning of symptoms contemplated with a chronic shoulder condition. We were not persuaded by that opinion, because it did not address the question of whether the waxing and waning of the claimant's symptoms was contemplated by the previous award. We found no evidence that such a waxing and waning was contemplated by the previous award. Therefore, notwithstanding the treating physician's "waxing and waning" opinion, we concluded that the claimant had established a compensable aggravation.

Dewbre is distinguishable because, here, there is evidence that the previous award contemplated waxing and waning of claimant's low back symptoms. Consequently, I reject claimant's argument.

May 19, 1995

Cite as 47 Van Natta 891 (1995)

In the Matter of the Compensation of
THURMAN M. MITCHELL, Claimant
WCB Case No. 91-14771
ORDER ON REMAND
Malagon, Moore, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Mitchell v. Burnt Mountain Logging, 125 Or App 278 (1993). The court has reversed our prior order which adopted and affirmed a Referee's order that held that the Hearings Division lacked jurisdiction to consider a claim for reimbursement of travel expenses incurred in the course of medical treatment. Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), rev den 320 Or 453 (1994), the court has reversed and remanded for further proceedings.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his left knee in 1989. At the time, claimant lived on the coast and received treatment from Dr. Jones. When Dr. Jones moved out of the area, he referred claimant to Dr. Whitney in Coos Bay. In 1991, after claimant moved to Eastern Oregon, he sought treatment from local physician Dr. Bird. Claimant did not wish to continue treatment with Dr. Bird. Based on Dr. Jones' prior referral, claimant began to travel to Coos Bay to treat with Dr. Whitney.

On August 6, 1991, the SAIF Corporation approved Dr. Whitney as claimant's treating physician. On that same date, SAIF issued a partial denial of reimbursement for travel expenses from claimant's home in Bend to Dr. Whitney's office in Coos Bay. Citing former OAR 436-10-100(5) (WCD Admin. Order 32-1990),¹ SAIF advised claimant that it was "only obligated to reimburse [him] for reasonable expenses to the nearest metropolitan area where like medical services are available." Thereafter, claimant timely requested a hearing, challenging SAIF's denial and requesting a penalty for SAIF's allegedly unreasonable conduct. No party sought Director review.

Finding that reimbursement of an injured worker's "medical mileage" constitutes medical services, the Referee concluded that this dispute was not a matter concerning a claim over which the Hearings Division had jurisdiction. In so holding, the Referee relied on our decision in Stanley Meyers, 43 Van Natta 2643 (1991). We adopted and affirmed the Referee's order. Claimant appealed.

In light of its decision in Meyers v. Darigold, Inc., supra, the court reversed and remanded for reconsideration. Mitchell v. Burnt Mountain Logging, supra. In Meyers, the court held that the Board has jurisdiction to consider medical treatment disputes if no party has requested that the Director resolve the dispute. Therefore, concluding that SAIF did not give the notice required by ORS 656.327(1)(a) to invoke Director review, the court here has remanded for us to consider the merits of claimant's travel reimbursement claim. In accordance with the court's mandate, we proceed with our review.

The question presented on review is whether SAIF must reimburse claimant for travel expenses associated with reasonable and necessary medical services received from an approved Coos Bay attending physician, although SAIF notified claimant, in accordance with former OAR 436-10-100(5), that travel expenses would be limited to the Bend area and provided claimant with a list of physicians who practice in the local area. For the following reasons, we answer in the affirmative.

In Charles M. Andersen, 43 Van Natta 463 (1991), we were called upon to construe former OAR 436-60-050(4) (WCD Admin. Order 4-1987)² and to apply the rule to similar facts. Relying on Smith v. Chase Bag Company, 54 Or App 261 (1981), we reasoned that to deny reimbursement for a relocated worker's travel expenses associated with reasonable and necessary services with an approved physician selected in accordance with ORS 656.245(3) was inconsistent with the statute which permits a worker to choose an attending physician within the State of Oregon. Consequently, we gave the former rule no effect. We held, therefore, that the claimant was entitled to reimbursement of reasonable travel expenses, the rule notwithstanding. 43 Van Natta at 466.

Here, as in Andersen, claimant lives in one part of the state and travels to another part of the state to treat with an approved attending physician. Although former OAR 436-10-100(5) purports to allow an insurer to limit reimbursement to a specified geographical area, we find that the rule suffers from the same infirmity as its predecessor. As with former OAR 436-60-050(4), former OAR 436-10-100(5) also impermissibly limits travel reimbursement to relocated workers to a particular geographical area. Therefore, based upon the reasoning expressed in Andersen, we give the rule no effect.³

¹ Former OAR 436-10-100(5) (now renumbered OAR 436-10-100(12)) provided in relevant part:

"Reimbursement by the insurer to the worker for transportation costs to visit their medical service provider may be limited to . . . a reasonable distance from the nearest city or metropolitan area in which the worker resides and where a physician providing like services is available."

² Former OAR 436-60-050(4) provided in relevant part: "Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to . . . the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available."

³ Contrary to SAIF's contention on remand, we previously addressed the determinative issue presented here: whether any reasonableness limitation may be imposed on the distance a claimant may travel to receive medical services from an attending physician, and concluded that no such limitation may be imposed. As a predicate to finding that former OAR 436-60-050(4) conflicted with ORS 656.245, in Charles M. Andersen, supra, we first held that where the medical services at issue are compensable, all travel expenses associated with those medical services are compensable. See Bill J. Goodrich, 43 Van Natta 984 (1991). Here, the key inquiry is whether Dr. Whitney is claimant's attending physician. Because he is, travel costs incurred to treat with him are reasonable medical expenses. SAIF had the choice of rejecting Dr. Whitney as claimant's attending physician. It chose not to do so. By that decision, it accepts the consequences - reimbursing claimant for reasonable travel costs.

Accordingly, we conclude that SAIF must reimburse claimant for expenses incurred traveling between Bend and Coos Bay to treat with attending physician Whitney.

Claimant also seeks a penalty for SAIF's allegedly unreasonable denial. Specifically, claimant contends that the Board's decision in Charles M. Andersen, supra, removed any legitimate doubt that SAIF was not liable for claimant's travel expense claim. 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). 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 denial is not unreasonable.

Although SAIF's conduct was contrary to the Andersen holding, at the time it issued its denial, SAIF was following an amended version of the Department rule that was not addressed in the Andersen decision. Because it was a different rule, SAIF was entitled to comply with the rule. Although we have given former OAR 436-10-100(5) no effect, we still find that SAIF did not act unreasonably in relying on a validly enacted rule. See Forney v. Western States Plywood, 297 Or 628, 633 (1984) (An insurer does not act unreasonably when it relies in good faith on an administrative rule). Consequently, no penalty will be assessed. Darcine L. Fox, 44 Van Natta 1 (1992); Mary E. Weaver, 43 Van Natta 2618, 2619 (1991) ("As a general rule, we do not in such circumstances assess a penalty; for to do so would penalize the insurer for complying with a valid administrative rule.").

Claimant has finally prevailed after remand with respect to the compensability of the denied medical services claim. Under the circumstances, he is entitled to a reasonable attorney fee for services before every prior forum. See ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991). Since claimant's counsel provided services at hearing, on Board review, before the court and on remand, a reasonable fee for such efforts shall be awarded.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services is \$4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the medical services 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. We further note that claimant is not entitled to an attorney fee for his unsuccessful efforts to obtain a penalty.

Accordingly, on reconsideration, the Referee's June 8, 1992 order is reversed. Claimant's request for hearing is reinstated. The SAIF Corporation's partial denial of claimant's medical services claim for travel expenses is set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing, on Board review, before the appellate court, and on remand concerning the medical services issue, claimant's attorney is awarded a \$4,500 attorney fee, payable by SAIF.

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY G. TABOR, Claimant
WCB Case Nos. 93-09985 & 93-02614
ORDER ON RECONSIDERATION
James L. Edmunson, Claimant Attorney
Brian L. Pocock, Defense Attorney

Claimant requests reconsideration of those portions of our April 24, 1995 Order on Review which: (1) vacated that portion of the Referee's order which affirmed a Director's Proposed and Final Order Concerning A Bona Fide Medical Services Dispute; and (2) awarded an attorney fee of \$1,000 for claimant's counsel's services on review.

Claimant contends that, by vacating the portion of the Referee's order which affirmed the Director's order, we also vacated the Referee's attorney fee award of \$2,800. Claimant requests that we affirm the Referee's award as a reasonable fee for counsel's services in setting aside the employer's "de facto" denial of claimant's proposed surgery.

Our order did not vacate the Referee's attorney fee award. However, we should have clarified that the attorney fee award was proper for claimant's counsel's services in setting aside the employer's "de facto" denial of medical services.

Moreover, a claim for medical benefits is a "claim for compensation" under ORS 656.386(1), provided the denial is not confined to the issue of the amount of compensation or extent of disability. See SAIF v. Allen, 320 Or 192 (1994). Inasmuch as the employer neither accepted nor denied the request for surgery within 90 days, the denial is presumed conclusively to encompass the compensability of a claim. SAIF v. Williams, 133 Or App 766 (1995). Moreover, the record does not establish that the employer's denial was limited to the amount of compensation due claimant. Consequently, we find that claimant is entitled to an attorney fee award under ORS 656.386(1). See SAIF v. Allen, supra; SAIF v. Williams, supra; SAIF v. Atchley, 133 Or App 596 (1995). Accordingly, since claimant finally prevailed in overturning the employer's "de facto" denial of claimant's claim for medical services, we conclude that the Referee's attorney fee award was appropriate. ORS 656.386(1); SAIF v. Atchley, supra; SAIF v. Blackwell, 131 Or App 519 (1994).

Finally, claimant's counsel contends that the attorney fee we awarded for services on review was inadequate. Claimant requests that we increase our \$1,000 fee to \$1,750, as requested in counsel's statement of services. We deny counsel's request after once again considering the factors set forth in OAR 438-15-010(4). In particular, we note that a considerable portion of counsel's brief was devoted to whether the Director's order was supported by substantial evidence. However, as noted in our original order, the law was well-settled at the time of briefing that the Director did not have jurisdiction over medical services disputes concerning proposed surgery. In light of this, we decline claimant's request to increase his counsel's fee beyond the \$1,000 granted in our initial order.

Accordingly, we withdraw our April 24, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our April 24, 1995 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
CARAN KRUGER, Claimant
WCB Case No. CV-95001
FINDINGS OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIMS ACT)
Mary Williams, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Celia M. Fitzwater, special hearings officer, on April 10, 1995, in Salem, Oregon. Applicant, Caran Kruger, was present and not represented by counsel. The Department of Justice Crime Victims' Compensation Fund (Department) was represented by Mary Williams, Assistant Attorney General. The court reporter was Angela Trafton. Exhibits 1 through 30 were admitted into evidence. The record was closed April 10, 1995. Fred McGrew and Joanne McGrew were present as witnesses for applicant. Deputy Douglas Shackelford, Bill Koch, and Becky Ewing were present as witnesses for the Department.

Applicant has requested review by the Workers' Compensation Board of the Department's December 22, 1994 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on the finding that the applicant's injuries were attributable to the wrongful act of the applicant or the substantial provocation of the applicant.

FINDINGS OF FACT

On January 4, 1994, applicant was in her home when Carole Mischuk arrived. Applicant formerly had a relationship and lived with Ms. Mischuk. According to applicant's testimony and a statement she provided to the Department, after Ms. Mischuk learned that she could not get into a separate shop building because it was locked, she obtained a hammer from her vehicle and began using it to break off the lock. Ms. Mischuk then used the hammer to hit applicant. Applicant wrestled Ms. Mischuk to the ground. When Ms. Mischuk got back up, she attempted to break the shop's window with the hammer; the hammer head then flew off the handle. Ms. Mischuk broke the window with the handle.

Applicant went into her house and called 911. Ms. Mischuk entered the house and began "destroying" various items, including the answering machine, coffee maker, drinking glasses, and a louvered door. Ms. Mischuk also continued hitting applicant with the hammer handle; applicant grabbed a "piece of wood" and used it to hit Ms. Mischuk. Applicant again attempted to call 911, whereupon Ms. Mischuk began pulling applicant's hair. Applicant pulled Ms. Mischuk's hair. Ms. Mischuk punched applicant in the face.

Applicant called 911 a third time and went outside. Ms. Mischuk got into her truck. Applicant went over to the truck and pounded on the window. Ms. Mischuk tried to open the truck door but rolled down the window and again used the hammer handle to hit applicant. Applicant grabbed and pulled Ms. Mischuk's hair, causing her head to hit the truck. Ms. Mischuk then released applicant, threatened to harm her and her house, and left.

Applicant called her friend, Joann McGrew. Ms. McGrew and her husband, Fred McGrew, went to applicant's house. Both testified that applicant was injured and the house was damaged.

Douglas Shackelford, a deputy sheriff, responding to the 911 call, went to applicant's house to investigate. He also observed injuries to applicant and damage to the house, which he found showed an "obvious disturbance." Deputy Shackelford, after learning through his radio that Ms. Mischuk was in custody at the Sandy police station as a result of applicant's complaint, drove to the police station and spoke with Ms. Mischuk. Deputy Shackelford then called applicant's house and first spoke with Mr. McGrew; the deputy explained to Mr. McGrew that, after speaking with Ms. Mischuk, he thought both women were responsible for the incident and that he would not charge Ms. Mischuk unless he also charged applicant with a crime. Deputy Shackelford then spoke with applicant, relating the same information.

At hearing, applicant testified that she told Deputy Shackelford to "come and get me" and that she was willing to go to jail in order for Ms. Mischuk to be charged. Deputy Shackelford, during his testimony, did not deny that applicant had made the statement and conceded that applicant was very angry with him because she wanted to press charges against Ms. Mischuk. However, Deputy Shackelford also testified that, at the end of the conversation with applicant, he understood that applicant did not want to prosecute because she did not want to be arrested and charged with a crime.

After this conversation, Ms. Mischuk was released from custody and has never been charged with a crime relating to the incident. Because there were no charges, no arrest report was filed. On January 20, 1994, applicant applied for crime victims' compensation.

CONCLUSIONS OF LAW AND OPINION

On June 28, 1994, the Department denied the application, finding that applicant did not fully cooperate with law enforcement in the apprehension and prosecution of her assailant and that applicant provoked her assailant and contributed to her injuries by becoming involved in mutual combat. At hearing, Bill Koch, the claims examiner who drafted the denial, testified that he relied on a document completed by Deputy Shackelford stating that there was "no crime" but "mutual combat" and that "each decided not to pursue criminal charges against each other." (Ex. 12-1). The document further indicated that Deputy Shackelford found applicant to be "far less than truthful" and the "other party clearly forthright in her account." (Id.).

On reconsideration, the Department also considered testimony and written statements from Joann McGrew and Fred McGrew and testimony from Deputy Shackelford. In its order, the Department stated it would "rely on the professional judgment of Deputy Shackelford in this matter in determining the incident to be one of mutual combat, with the victim also inflicting injuries on the assailant." The order further provided that the "fact that the deputy felt that the arrest of one of these persons would result in the arrest of both of them is substantiation that the victim's injuries were attributable to the wrongful act of the victim or the substantial provocation of the victim." Therefore, on reconsideration, the Department adhered to its previous order denying compensation.

The standard for review for cases appealed to the Board under the Crime Victims' Compensation Act is de novo on the entire record. ORS 147.155(5).

A person is eligible for crime victims' compensation if a victim of a "compensable crime." ORS 147.015(1). "Compensable crime" is an "intentional, knowing or reckless act that results in serious bodily injury * * * which, if committed by a person of full legal capacity, would be punishable as a crime in this state." ORS 147.005(4).

In considering whether applicant was a victim of a compensable crime, I first address the credibility of applicant's version of the event. In denying her application, the Department has relied on Deputy Shackelford's assessment that the event was mutual combat; Deputy Shackelford in turn based his opinion on finding more reliable Ms. Mischuk's statement. Although Deputy Shackelford did not at hearing describe his interview with Ms. Mischuk, the Department's Order on Reconsideration provides such evidence, based on its telephonic interview with Deputy Shackelford. Specifically, the order states that applicant followed Ms. Mischuk to the shop and they began arguing after Ms. Mischuk found the shop to be locked. Applicant hit Ms. Mischuk with a board; applicant then went into the house and, after emerging, told Ms. Mischuk she had called the police. Ms. Mischuk went to her vehicle to leave; applicant slammed the door on Ms. Mischuk's legs, grabbed her hair and slammed her head against the window. Ms. Mischuk then hit applicant in the face and used a hammer to hit her on the wrist, arms and hands.

I am not persuaded by such evidence. Although the Department's order refers to notes that Deputy Shackelford took at the time of the incident, none are contained in the record. As stated above, no police report was filed. Thus, there is no documentary evidence supporting the deputy's recollection. Furthermore, Deputy Shackelford indicated at hearing that his memory of the event was not sharp because it had occurred over a year previous to the hearing. Other factors I have considered include the consistency between applicant's testimony at hearing and her statement to the Department. I found nothing in applicant's demeanor at hearing indicating that she was not credible. Finally, I note there is inconsistency between Ms. Mischuk's statement (as related by Deputy Shackelford) that the entire conflict was outside, and the corroborating testimony that applicant's house was damaged. In short, I simply do not find that Deputy Shackelford's recollection of Ms. Mischuk's statement outweighs applicant's testimony.

Based on applicant's testimony, I find that Ms. Mischuk's conduct in hitting applicant with the hammer while outside the shop was intentional and resulted in bodily injury. Therefore, I conclude that applicant was a victim of a compensable crime.

I next address the Department's contention that the application should be denied because applicant did not fully cooperate with law enforcement. In order to be eligible for compensation, the victim must have "cooperated fully with law enforcement officials in the apprehension and prosecution of the assailant or the department has found that the applicant's failure to cooperate was for good cause[.]" By rule, "failure to cooperate" is "any act or omission by a victim that prejudices a law enforcement agency in the timely investigation of a crime or which causes the agency to abandon its investigation, or which prejudices a prosecuting official in a timely prosecution of the crime or causes or contributes to a decision by the official to abandon prosecution." OAR 147-76-010(3). According to the Department, applicant caused Deputy Shackelford to abandon his prosecution of Ms. Mischuk because applicant told the deputy that she did not want to be charged with a crime and, therefore, not to charge Ms. Mischuk.

The record with regard to this issue is in dispute. Applicant testified that she told Deputy Shackelford to "come and get me" if it was necessary to arrest her in order to charge Ms. Mischuk. Joann and Fred McGrew corroborate claimant's testimony. Although not disputing that applicant made that particular statement, Deputy Shackelford told the Department and testified at hearing that applicant's ultimate decision was not to pursue charges against Ms. Mischuk if it meant having to be herself arrested and charged with a crime.

I do not construe a "failure to cooperate" as including a victim's decision not to be prosecuted. Although, in a strict sense, applicant did cause Deputy Shackelford to "abandon prosecution" (based on his testimony), it was only because the deputy had made any prosecution of Ms. Mischuk contingent on applicant's agreement to be herself prosecuted. Because of the coercive nature of such a choice, even assuming that applicant did agree not to pursue prosecution of Ms. Mischuk, I find no "failure to cooperate" with such action. Moreover, applicant promptly reported the crime, spoke with Deputy Shackelford about the incident, and continued to express to Deputy Shackelford her desire to prosecute Ms. Mischuk. Under such circumstances, I conclude that applicant satisfied ORS 147.015(3).

Finally, the Department contends that applicant is not eligible for compensation because her injuries were substantially attributable to her own wrongful act and she substantially provoked her assailant. Eligibility for benefits in part is based on finding that the victim's injury "was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim." ORS 147.015(5). "Substantially attributable to the victim's wrongful act" means "directly or indirectly attributable to an intentional and unlawful act from which there can be a reasonable inference that, had the act not been committed, the crime complained of likely would not have occurred." OAR 147-76-010(6). "Substantial provocation" is "a voluntary act from which there can be a reasonable inference that, had the act not occurred, the crime likely would not have occurred." OAR 147-76-010(8).

I do not find that applicant's conduct was such that, but for her actions, her injuries would not have occurred. In this regard, applicant testified that Ms. Mischuk appeared to be in an agitated state when she arrived at the house. Applicant's testimony also showed that Ms. Mischuk hit applicant with the hammer after applicant had done nothing more than attempt to calm her and followed applicant into her home, damaging items. Hence, I find that there was no substantial provocation by applicant or that her injuries were substantially attributable to a wrongful act. Thus, applicant is eligible for benefits.

However, the award of compensation is denied or reduced according to the degree or extent to which the victim's acts or conduct provoked or contributed to the injuries. ORS 147.125(1)(c). I find several instances of contribution by applicant to her injuries. Most notably, after Ms. Mischuk had left the house and gone to her vehicle, applicant followed her and pounded on the window, thereby instigating additional physical fighting which resulted in further injury. During the fight in the house, applicant used a wooden object against Ms. Mischuk and pulled her hair. I find this conduct shows that applicant intended to assault Ms. Mischuk, rather than merely defend herself, further escalating the physical nature of the battle and contributing to applicant's injuries. Specifically, I find that applicant's contribution to her injuries was 50 percent and, therefore, her benefits should be reduced by this amount.

Finally, in reviewing the medical records, I found evidence that applicant's psychological treatment was due to a variety of factors. I note that only those expenses that are materially related to the compensable crime are reimbursable and part of applicant's compensable claim. See Sue C. Chesselot, 42 Van Natta 357 (1990).

PROPOSED ORDER

I recommend that the June 28, 1994 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered December 22, 1994, be reversed. I also recommend that applicant's claim be remanded to the Department with instructions to accept and process the claim in accordance with law. However, I further recommend that applicant's benefits be limited to 50 percent of her expenses and loss of earnings, up to the statutory maximum.

 May 23, 1995

Cite as 47 Van Natta 898 (1995)

In the Matter of the Compensation of
CLARENCE W. ALLEN, Claimant
 WCB Case No. 94-05504
 ORDER ON REVIEW
 Welch, Bruun, et al., Claimant Attorneys
 Bostwick, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Portland Community College (PCC), a self-insured employer, requests review of Referee Lipton's order that set aside its denial of claimant's low back injury claim. On review, the issue is whether claimant is PCC's worker under amended ORS 656.046(1).

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

We briefly summarize the facts. In 1988, claimant sustained a compensable injury with an insured of a carrier that is not a party to these proceedings. As a result of that injury, claimant received vocational assistance, which included truck transportation broker skills training at Rapid Transfer, a transportation and storage company. (E.g., Ex. 5A-1). The training program was administered by PCC. (Tr. 6).

On November 10, 1993, while participating in the Rapid Transfer training program, claimant injured his low back. He filed a claim with PCC, who denied the claim. The Referee set aside the denial, concluding that, under ORS 656.046, claimant was PCC's worker.

Subsequent to the Referee's order, we issued our decisions in Harvey Callendar, 46 Van Natta 1832 (1994), and Michael C. Steelman, 46 Van Natta 1852 (1994). In both cases, we held that the claimant was not PCC's worker under former ORS 656.046(1), which provided, in part:

"All persons registered at a college and participating as unpaid trainees in a work experience program who are subject to the direction of noncollege-employed supervisors * * * are considered workers for the college subject to ORS 656.001 to 656.794 for purposes of this section. However, trainees who are subject to other provisions of this chapter or are covered by the Federal Employee's Compensation Act shall not be subject to the provisions of this section." (Emphasis added.)

In Steelman, the claimant was injured while in an approved training program (ATP) under the auspices of PCC, but provided on-site by another employer. We held that, because a person in an ATP was subject to other provisions of ORS chapter 656, particularly ORS 656.340, the claimant was per se excluded from former ORS 656.046(1)'s coverage, and was not PCC's worker. 46 Van Natta at 1853.

In Callendar, the claimant also was injured while working in an ATP under PCC's auspices, and while subject to the direction of noncollege-employed supervisors. For the same reasons as those stated in Steelman, we concluded that the claimant was not PCC's worker under former ORS 656.046(1).¹ 46 Van Natta at 1833.

¹ In Callendar, we also noted that, because it was arguable that the claimant's injury was a consequence of the work injury that had necessitated the ATP, ORS 656.005(7)(a)(A) would be applicable. Because that would render the claimant subject to another provision of ORS Chapter 656, for that additional reason, we concluded that the claimant was not PCC's worker under former ORS 656.046(1). Harvey Callendar, *supra*, 46 Van Natta at 1833.

Here, PCC asserts that Steelman and Callendar support its position that claimant is not its worker under ORS 656.046(1). We disagree. As claimant correctly notes, those cases concerned former ORS 656.046(1), whereas this case concerns the present version of ORS 656.046(1), which became effective on November 4, 1993, shortly before claimant's current low back injury occurred. Or Laws 1993, ch 18, § 139.

As amended, ORS 656.046(1) provides, in part:

"All persons registered at a college and participating as unpaid trainees in a work experience program who are subject to the direction of noncollege-employed supervisors * * * are considered workers for the college subject to this chapter for purposes of this section. However, trainees who are covered by the Federal Employees Compensation Act shall not be subject to the provisions of this section."

As can be seen by comparing the former and amended versions of ORS 656.046(1), the 1993 legislature deleted from that provision the language, trainees who are "subject to other provisions of this chapter." Because our holdings in Steelman and Callendar were based on the deleted language, we find them inapplicable to the present case. Therefore, we analyze this matter without considering those cases.

Under amended ORS 656.046(1), a person is considered a worker of a college if she or he is: (1) registered at the college; (2) participating as an unpaid trainee; (3) in a work experience program; and (4) subject to the direction of noncollege-employed supervisors.²

PCC asserts that claimant failed to establish that he was an unpaid trainee, because he received time loss benefits while he was participating in the ATP. We disagree.

In determining whether claimant was an "unpaid trainee" under ORS 656.046(1), we must discern the legislature's intent. ORS 174.020. We look first to the text and context of amended ORS 656.046(1). ORS 174.020; Porter v. Hill, 314 Or 86, 91 (1992). Only if those sources are unavailing do we resort to legislative history and other extrinsic aids. See PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993).

The phrase "unpaid trainee" is not defined in amended ORS 656.046, or elsewhere in the Act. However, based on the text and context of the statute, we interpret the phrase as referring to the claimant in his capacity as a "worker" for the "noncollege-employed" supervisor under the program. As such, the source of any remuneration to the "worker" (which would transform him into a "paid trainee" and, thus, not subject to the statute) would be either the college or the "noncollege employed" supervisor.

Such a construction of the phrase would be consistent with the statutory scheme. In other words, if the trainee was receiving payment from the "noncollege-employed" supervisor, that entity would be an "employer" and responsible for any claim arising from the "worker's" employment. On the other hand, if the worker was an "unpaid trainee," the college (as the entity responsible for coordinating the worker experience program) would likewise be responsible for the processing of the trainee's workers' compensation claim.

The trainee's receipt of time loss benefits under the prior workers' compensation claim would not transform him into a "paid trainee." As previously discussed, the source of such benefits would not be the "noncollege-employed" supervisor. Rather, those benefits are provided by the carrier responsible for the worker's prior injury claim as compensation for the loss of wages occasioned by the injury that led to the worker's need for further training. See Cutright v. Weyerhaeuser, 299 Or 290, 296-298, 302 (1985). As such, those benefits would not constitute payment for the training the worker receives while participating in a program under the direction and control of a "noncollege-employed" supervisor. See OAR 436-120-085(9)(c) (vocational skills training is subject to the condition that no wage is paid to the worker).

² This case does not address that portion of amended ORS 656.046(1) concerning "trainees participating in college directed vocational education projects[.]"

Moreover, were the receipt of time loss benefits considered to be sufficient to make an injured worker a "paid trainee," such a construction of the statute would essentially obviate its purpose. In other words, it is the common practice that injured workers receive time loss benefits while engaged in authorized training programs. OAR 436-120-740(2). Thus, if an injured worker was not considered as an "unpaid trainee" by receiving such benefits, few, if any, trainees would be subject to the statute. Since the statute was obviously designed to provide coverage to these "unpaid trainees" for injuries sustained during their "'noncollege-employed' supervisor" programs, such a construction of the statute would preclude most, if not all, trainees from receiving coverage.

In conclusion, we hold that, although claimant received time loss benefits while participating in a training program, he was an "unpaid trainee" for purposes of amended ORS 656.046(1), because he received no remuneration from Rapid Transfer (his "noncolleged-employed" supervisor) for the training he received. (Tr. 7).³

PCC next asserts that claimant has failed to establish that, when he injured his low back, he was in a "work experience program." We disagree.

"Work experience program" is not defined in the statute. We must, therefore, follow the usual path in ascertaining the legislature's intent. We find the phrase self-explanatory, and conclude that, for purposes of amended ORS 656.046(1), a "work experience program" is a process through which one receives at-work training in particular vocational skills.

This interpretation finds support in the context of amended ORS 656.046(1): The legislature's use of the word "trainee" in conjunction with "work experience program" reveals that the latter phrase means at-work vocational skills training programs. It also finds some support in OAR 436-120-075(3)(b), which defines "skills training" as a program that "teaches the worker job skills in a self-contained program under the auspices of a community college, but with the training site at the location of an employer, who teaches the skills on behalf of the college." (Emphasis added).

Applying our interpretation to claimant, we conclude that he was in a "work experience program" when he sustained his current low back injury. The evidence establishes that, when he sustained his current low back injury, claimant was in a "professional skills training program" at Rapid Transfer, training for the occupation of Truck Transportation Broker. (E.g., Ex. 5A-1). We conclude that that program was a "work experience program" for purposes of amended ORS 656.046(1).

Last, PCC asserts that claimant has failed to establish that he was registered at the college, and that his supervisor was not a college employee. We disagree. The "801" form regarding this claim, which a PCC representative signed, indicates that claimant was a student in a professional skills program at PCC. (Ex. 6).⁴ We find that evidence sufficient to establish that claimant was "registered" at PCC.

Further, the record establishes that claimant's training actually occurred on Rapid Transit's premises and that PCC merely administered the program. (Tr. 6). Claimant testified that his trainer had been hired to work in "the dispatch office" to do brokering. (Tr. 9). We find that evidence sufficient to establish that claimant's supervisor was an employee of Rapid Transfer, not PCC.

In sum, we agree with the Referee that, pursuant to amended ORS 656.046(1), claimant has established that he was a worker for PCC when he sustained his current low back injury. Accordingly, we affirm the Referee's decision setting aside PCC's denial of claimant's low back injury claim.

Claimant's attorney 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,

³ We note that, in claimant's "801" form, the "wage" box contains the notation, "n/a," further establishing that claimant received no wages for his work in the training program.

⁴ PCC's name was listed in the "employer name" box; Rapid Transfer's name and address was listed in the "employer address" box. (Ex. 6).

we find that a reasonable fee for claimant's attorney's services on review is \$1,500, to be paid by PCC. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 19, 1994 is affirmed. For services on review, claimant's counsel is awarded \$1,500, payable by Portland Community College.

May 23, 1995

Cite as 47 Van Natta 901 (1995)

In the Matter of the Compensation of
TERRY M. BLETH, Claimant
WCB Case No. C5-01079
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Roberts, et al., Defense Attorneys

On April 21, 1995, the Board received the parties' Claim Disposition Agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed CDA provides that the subject accepted condition is a lumbar strain and there are no other conditions that previously or presently relate to the claim. The agreement further states that "[a]ny later-diagnosed conditions claimant contends are related to this claim are also encompassed by this CDA."

Generally, we disapprove CDA's that attempt to resolve disputes that do not relate directly to the accepted claim. *E.g.*, Donald Rhuman, 45 Van Natta 1493 (1993) (CDA disapproved that resolved claims processing dispute). Similarly, we generally disapprove CDA's that attempt to resolve additional claims, as opposed to issues pertaining to the accepted claim addressed by the CDA, and those providing for the "settlement of any existing disputes regarding nonmedical benefits." *E.g.*, Barbara L. Whiting, 46 Van Natta 1684 (1994) (CDA approved after limiting agreement to resolution of all issues pertaining to the accepted claim); Harold A. Edwards, 47 Van Natta 472, on recon 47 Van Natta 691 (1995) (CDA approved after modification of provision disposing of nonmedical issues under the accepted claim).

Moreover, we have addressed whether additional benefits are available to a claimant subsequent to a CDA. In Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), the claimant entered into a CDA that listed the accepted conditions as "lumbar sprain/strain, and L4-5 disk protrusion." The CDA also provided that the claimant released all benefits except medical services. The claimant then underwent surgery at L5-S1, for which the insurer paid medical costs. The claimant sought payment of temporary total disability benefits relating to the surgery.

We addressed the claimant's contention that, because the CDA did not explicitly refer to the L5-S1 condition, the claimant did not release his right under the CDA to any benefits for that condition. We disagreed, finding that the CDA disposed of the claim, as opposed to the listed conditions. 46 Van Natta 1770-71. Specifically, we held that the claimant "is no longer entitled to receive temporary disability, permanent disability, vocational rehabilitation, or survivor benefits for that claim or for any resultant condition or component of the claim, including future, unidentified conditions which may someday arise from the claim." *Id.* at 1772. Therefore, we concluded that, because the claimant was seeking benefits for a condition which he contended was related to his industrial injury and the claimant had released his "non-medical services" benefits for the claim pursuant to the CDA, he was not entitled to further temporary disability benefits. *Id.* Accord Michael R. Heckard, 47 Van Natta 188 (1995) (CDA that provided for full release of the claimant's "non-medical services" benefits under the claim limited the claimant to entitlement to such benefits for conditions resulting directly or indirectly from the claim, whether or not listed in the CDA).

We reach a different result, however, for "new injury" claims. In Christopher J. Kaufman, 47 Van Natta 433 (1995), the claimant entered into a CDA disposing of an April 1992 injury claim. The claimant subsequently sought benefits for an injury he contended was separate and distinct from the April 1992 injury claim. In discussing whether the claim was barred by the CDA, we found that, as a "new injury," the claim could not have been subject to the CDA and, therefore, the analysis in Trevitts was not applicable. Id. at 434. We further noted that, as an aggravation claim, the claimant would continue to be entitled under the CDA for medical services. Id. Therefore, we remanded the matter for a hearing concerning the denial of the new injury claim and entitlement to medical services under the prior accepted claim.

Here, we find the proposed agreement's language that "[a]ny later-diagnosed conditions claimant contends are related to this claim are also encompassed by this CDA" is entirely consistent with Trevitts. In particular, the CDA pertains only to subsequently identified conditions rather than claims. Thus, unlike the initial CDA in Whitney, there is no attempt to resolve any claim but that addressed by the CDA. Likewise, there is no provision attempting to settle existing disputes, as was found objectionable in Edwards.

Because the agreement disposes of the claim, does not propose to resolve any existing disputes, and provides for the full release of claimant's "non-medical" services benefits, the language conforms with the holdings in Trevitts, Whitney, and Edwards. Moreover, the CDA is consistent with the Trevitts rationale that claimant would be limited to medical services for any subsequently diagnosed or consequential conditions arising from the claim. Finally, we note that the CDA would not preclude claimant from litigating a "new injury" claim or to subsequently pursue medical services benefits for a previously unaccepted condition. See Christopher J. Kaufman, supra.

Consequently, we hold that the CDA is in accordance with the terms and conditions prescribed by the Director. ORS 656.236(1). Therefore, the parties' CDA is approved.

IT IS SO ORDERED.

Board Member Hall dissenting.

Because the proposed Claim Disposition Agreement (CDA) improperly attempts to resolve future claims, I must respectfully dissent.

As I discussed in my dissenting opinion in Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), a CDA is designed to settle accepted claims. Here, the CDA purports to release not only claimant's future "non-medical service" benefits for his presently accepted conditions, but also for "[a]ny later-diagnosed conditions claimant contends are related to this claim . . ." Since the proposed CDA attempts to settle claimant's rights to benefits resulting from future unidentified and currently unaccepted conditions, the disposition exceeds the terms and conditions set forth by the Director for such an agreement. See OAR 436-60-005(9); OAR 436-60-145(4)(a); OAR 438-09-001(1); Donald Rhuman, 45 Van Natta 1493 (1993).

In essence, the proposed CDA is attempting to resolve future claims. Yet, our approval authority is confined to issues that are raised or raisable before the Board at the time the CDA is submitted for approval. See Roberta L. Bohan, 46 Van Natta 2235 (1994). Inasmuch as the future "later-diagnosed conditions" issue is not ripe for our review, it is beyond our authority to approve a provision which purports to release claimant's benefits resulting from such unidentified conditions.

In conclusion, based on the reasoning expressed above, I submit that the proposed disposition must be disapproved as unreasonable as a matter of law. Consequently, I respectfully register this dissenting opinion.

In the Matter of the Compensation of
CHARLES F. DELONGE, Claimant
WCB Case No. 93-14601
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Referee Mongrain's order which upheld the self-insured employer's denial of his occupational disease/injury claim for a cardiac condition. On review, the issue is compensability.

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

Claimant, a firefighter, filed a claim for coronary artery disease first detected after he experienced an attack of angina responding to a medical call in a smoke-filled room. The Referee held that claimant should not have the benefit of the so-called "firefighter's presumption" of ORS 656.802(4) because he never had a "competent and rigid" medical examination that would have revealed any preexisting coronary disease. See SAIF v. Bales, 107 Or App 198 (1991). Moreover, the Referee found that, even if the presumption were applicable, it was rebutted by "clear and convincing" medical evidence that claimant's condition or impairment was unrelated to his employment.

Subsequent to the Referee's order, the court held in Winston-Dillard RFPD v. Addis, 134 Or App 98 (1995), that the medical examination required by ORS 656.802(4) need not exclude any possibility of a disqualifying condition, but rather should be a customary test that the medical profession would use under the circumstances.

Here, we need not decide, however, whether the tests given to claimant in this case satisfy this criterion. Even assuming the presumption of ORS 656.802(4) applies, we still agree, for the reasons cited in the Referee's order, that "clear and convincing" evidence establishes that claimant's condition and impairment is unrelated to his employment. Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated August 29, 1994 is affirmed.

In the Matter of the Compensation of
MONIQUE E. HERLONG, Claimant

WCB Case No. 93-14905

ORDER ON REVIEW

Brad L. Larson, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Neidig, Turner-Christian, and Gunn.

Claimant requests review of Referee Herman's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for a right hand/wrist condition. On review, the issue is compensability.

We adopt and affirm the Referee's order with the following supplementation to address claimant's arguments on review.

Claimant contends that a medical opinion based on deductive reasoning should be sufficient for establishing compensability. We have already decided this question adversely to claimant. ORS 656.266, adopted in 1987, provides that the "burden of proving that an injury or occupational disease is compensable . . . is upon the worker." The statute further provides that the "worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred." In Ruben G. Rothe, 45 Van Natta 369, 371 (1993), we reviewed the legislative history related to the enactment of ORS 656.266 and noted that Representative Shiprack specifically commented that the legislation was designed to require cases to be decided on "clearly proven facts instead of deductive reasoning. . ."

Here, claimant's attending physician, Dr. Thayer, opined with respect to the cause of her upper extremity problems that because there were no "avocational or medical reasons" for claimant's problems, the major cause of her condition was her work exposure. Dr. Thayer continued by noting that he did not have a detailed knowledge of claimant's work exposure, and that she had not dramatically improved with rest and one-handed work. (Ex. 10). We find such an opinion to be no more than the "deductive reasoning" that is insufficient to prove causation under ORS 656.266. In other words, we find that Dr. Thayer's opinion failed to affirmatively establish the requisite causal connection between claimant's upper extremity condition and her work exposure.

Claimant also contends that the Referee erred in not considering the compensability of her upper extremity condition as an occupational disease. We find no error. The Referee considered both injury and occupational disease theories of compensability, and found that claimant failed to meet either standard of compensability. In other words, the Referee found that claimant failed to establish that work was either a material or the major contributing cause of her upper extremity condition. After our review of the record, we agree with the Referee's analysis and conclusions.

ORDER

The Referee's order dated June 24, 1994 is affirmed.

Board Member Gunn dissenting.

Because I believe the majority's decision expands the application of ORS 656.266 and our decision in Ruben G. Rothe, 45 Van Natta 369 (1993), I respectfully dissent.

Here, the majority rejected the opinion of claimant's treating doctor because it was based on "deductive reasoning." The very process of diagnosis is based on "deductive reasoning"; that is, the systematic elimination by a doctor of other potential causes of a condition. The elimination of potential causes is part of the diagnostic process used by all medical professionals. This elimination of causes, or "deductive reasoning," is simply a standard tool of the medical profession. Removing the accepted tool of deductive reasoning from the arsenal of medical professionals who treat injured workers unfairly handicaps those medical providers in their delivery of services to injured workers.

We rely on the treating doctor's judgment regarding a patient's subjective symptoms when we determine whether there are "objective findings" of an injury or disease. Georgia-Pacific Corporation v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Similarly, we must rely on the treating doctor's judgment in the use of appropriate methods, including "deductive reasoning," for rendering diagnoses. Accepting a physician's use of deductive reasoning in making a diagnosis is consistent with our reliance on the physician's judgment regarding a patient's subjective symptomatology. We must recognize that there is a distinction between a medical doctor using deductive reasoning to diagnose an illness and a fact-finder weighing the evidence.

Accordingly, I believe the majority's position constitutes an overly broad interpretation of ORS 656.266 and our decision in Rothe, supra. Therefore, I dissent.

May 23, 1995

Cite as 47 Van Natta 905 (1995)

In the Matter of the Compensation of
PHILLIP A. KISTER, Claimant
WCB Case No. 94-01314
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Referee McCullough's order that upheld the self-insured employer's denial of claimant's bilateral carpal tunnel syndrome (CTS) and right medial epicondylitis claim. On review, the issue is compensability.

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

Claimant has alleged that his CTS is a compensable occupational disease. To prevail on that theory, he must prove by a preponderance of the evidence that his work activities were the major contributing cause of the onset or worsening of that condition. ORS 656.802(2).

Dr. Rabie, treating physician, has rendered several opinions that state that claimant's CTS is caused, in major part, by his work activities. (Exs. 16, 18, 19-2, 20-2, 26). In his final opinion, however, Dr. Rabie concluded that, "had it not been for [claimant's] work activities as a metal fabricator, * * * he would not have developed [CTS] * * *". Therefore, I feel that his work activities are to a major contributing degree the factors responsible for his need for treatment for [CTS]." (Ex. 26). That "but for" his work exposure, claimant would not have developed CTS does not necessarily lead to the conclusion that the work exposure was the major contributing cause of the CTS. Accordingly, we find that reasoning insufficient to meet claimant's burden of proof. Further, because it is Dr. Rabie's final word in this case, we agree with the Referee that claimant has failed to establish the compensability of his CTS. Therefore, we affirm the Referee's decision upholding the employer's denial of that condition.

ORDER

The Referee's order dated November 7, 1994 is affirmed.

In the Matter of the Compensation of
KATHY R. MONFORT, Claimant
WCB Case No. 94-02165
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Referee Michael V. Johnson's order that increased claimant's unscheduled permanent disability award for a right shoulder injury from 20 percent (64 degrees), as granted by an Order on Reconsideration, to 36 percent (115.2 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant has worked for the employer since August 1983. She initially started in the labor pool which required performing different jobs daily. The jobs included palletizing, lifting, restacking, and slitter helper. (Tr. 6, 8). Sometime in either 1985 or 1986, claimant began working as a rewinder. In 1991, claimant was on a weekly rotation schedule where she worked as a rewinder, a slitter helper and a palletizer. (Tr. 12-13).

CONCLUSIONS OF LAW AND OPINION

The only dispute concerns the correct value for adaptability. The Referee found that, although claimant was injured while performing her job as a rewinder (medium work category), given her rotating job assignments, her regular work was heavy. The Referee further determined that, since claimant's prior functional capacity was heavy and that her residual functional capacity was sedentary, claimant's adaptability value was 7.

The Referee apparently applied the standards contained in WCD Admin. Order 93-052. However, those standards have expired. 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 on August 18, 1993 and a request for reconsideration has been made. Thus, the standards in effect at the time of the September 29, 1993 Determination Order (those contained in WCD Admin. Order 6-1992) apply to claimant's claim. Cornell D. Garrett, 46 Van Natta 340 (1994), aff'd mem Garrett v. Still Water Corporation, 130 Or App 679 (1994).

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 or had returned to his or her regular work. Former OAR 436-35-310(2). "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 determine whether claimant was released to, or returned to, her regular work at the time of determination.

Here, claimant worked rotating assignments between rewinder (medium work category), slitter helper (heavy category) and palletizer (heavy category). Her assignments were weekly and were dependent upon the number of job orders for the entire plant. Generally, claimant spent 50 percent of her time as a rewinder and 50 percent as a palletizer and/or slitter helper. She was injured while performing her work as a rewinder.

Although claimant has been released for and has returned to work as a rewinder, she has not been released to perform the slitter helper or palletizer jobs. Dr. Chapman, claimant's treating physician, released claimant for her regular rewinder position, but not her slitter duties. Dr. Chapman also restricted claimant from pushing or pulling over 25 pounds, repetitive lifting over 25 pounds, or 35 pounds if it was below chest level, and percussive pounding motions.

Because claimant no longer performs her full range of job duties and because claimant's attending physician only released claimant to the rewinder position with restrictions, we conclude that claimant did not return to her regular work. See Jim M. Greene, 46 Van Natta 1527 (1994) (the Board determined that the claimant was not released to, or returned to, regular work where he no longer performed heavy lifting and where attending physician released him to full duty but with limitations).

Inasmuch as we have found that claimant has not returned to her regular work, we now proceed to determine claimant's adaptability. The adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity (RFC) at the time of determination. Former OAR 436-35-310(1). Prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's job-at-injury. Former OAR 436-35-270(3)(g).

There may be more than one DOT that arguably describes a claimant's work. See, e.g., Arliss I. King, 45 Van Natta 823 (1993). In determining which DOT is most applicable, we consider the record as a whole, as it relates to the worker's job duties as well as strength demands, to find the position which most appropriately describes the worker's job at injury.¹ Nevertheless, the most applicable DOT determines the strength category. See former OAR 436-35-300(3); 436-35-270(30)(g); Cornell D. Garrett, supra; William D. Knox, 45 Van Natta 854 (1993).

We find that, although claimant was injured while performing "medium" work as a rewinder, an integral part of claimant's rotating job required heavy duties as a palletizer and slitter helper. Under such circumstances, we conclude that the most appropriate DOT code is 699.682-030 for "slitting-machine-operator helper." See Jim M. Greene, supra (the claimant's full range of job duties were considered in finding that his heavy duties were not merely incidental, but a required and integral part of his job). This job description requires "heavy" strength.

Accordingly, because claimant's job at injury was in the heavy category and because she is now limited to performing work in the light category, her adaptability value is 5. Former OAR 436-35-310(4).

When claimant's age/education value (4) is multiplied by her adaptability value (5), the product is 20. The result is added to claimant impairment value (8) for a total of 28. Former OAR 436-35-280. Therefore, claimant is entitled to 28 percent unscheduled permanent disability. Consequently, the Referee's 36 percent unscheduled permanent disability award is reduced to 28 percent.

ORDER

The Referee's order dated September 22, 1994 is modified. In lieu of the Referee's award and in addition to the Order on Reconsideration award of 20 percent (64 degrees), claimant is awarded an additional 8 percent (25.6 degrees) unscheduled permanent disability, for a total award of 28 percent (89.6 degrees) unscheduled permanent disability. Claimant's counsel's out-of-compensation attorney fee, as awarded by the Referee's order, shall be modified accordingly.

¹ The job claimant held at the time of injury was rewinder. See Douglas P. Evans, 43 Van Natta 337 (1991) (the Board applied DOT for spreader operator to a claimant who regularly worked as a sander operator (medium work), but was temporarily working as a spreader operator (heavy work) when he was injured. However, we look at more than just the job title to determine the appropriate DOT. William L. Knox, infra.

In the Matter of the Compensation of
CHARLES L. SIMONS, Claimant
WCB Case No. 94-09195
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Referee Galton's order that: (1) found that the Hearings Division had jurisdiction over claimant's request for claim reclassification; (2) reclassified claimant's compensable right foot injury claim as disabling; and (3) assessed a penalty for allegedly unreasonable claims processing. On review, the issues are jurisdiction, claim reclassification, and penalties. We reverse.

FINDINGS OF FACT

On April 13, 1993, claimant filed an 801 form for a right foot injury occurring on April 12, 1993. The 801 form indicated that the claim was accepted as a nondisabling injury. On May 12, 1993, the employer sent him a formal notice of acceptance informing claimant that it had accepted his injury as a nondisabling right foot fracture. The notice of acceptance also stated that "Additional information regarding your claim is enclosed." Part of the additional information enclosed was described as concerning a "non-disabling injury" and a "disabling injury." The bottom of the notice of acceptance also indicated that there were enclosures. Claimant received the notice of acceptance and the enclosures shortly thereafter.

By letter dated April 13, 1994, claimant's counsel requested the employer to submit claimant's claim for closure and rate his disability. The employer forwarded claimant's request to the Benefits Section of the Workers' Compensation Division. On May 18, 1994, the Benefits Section responded to claimant's counsel, stating that the Evaluation Section would take no action on claimant's request for claim closure because claimant's injury was nondisabling.

On May 26, 1994, claimant's counsel requested the employer to reopen claimant's claim on an aggravation basis. The employer issued an aggravation denial, dated August 24, 1994. Thereafter, claimant requested a hearing raising the issues of reclassification and protesting the employer's aggravation denial among other things. Prior to the hearing, claimant withdrew his request for hearing with regard to the employer's August 24, 1994 aggravation denial.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the Hearings Division had jurisdiction over claimant's request for reclassification and concluded that claimant's claim should be reclassified as disabling. We disagree.

Pursuant to ORS 656.277, a claimant has one year, from the date of injury, in which to seek reclassification of his or her claim. See Donald R. Dodgin, 45 Van Natta 1642 (1993). If a request for classification is not made within the one year time period, the claim cannot be reclassified and a claimant must make a claim for aggravation pursuant to ORS 656.273. ORS 656.277(1) and (2); Charles B. Tyler, 45 Van Natta 972 (1993). However, claimant must be notified of the classification of the claim within a sufficient time period that would allow the status of the claim to be challenged. Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993); Dennis Hutchinson, 46 Van Natta 539 (1994).

In Hutchinson, *supra*, the claimant was injured in November 1990. On August 28, 1991, the carrier accepted the claimant's claim and classified it as nondisabling on August 28, 1991. In September 1992, claimant objected to the classification of his claim. We held that the claimant's request for reclassification was untimely and noted that the claimant had sufficient time (two months) after the carrier's acceptance in which to challenge the classification of his claim.

Here, claimant was injured on April 12, 1993. He was sent a Notice of Acceptance on May 12, 1993 which informed him that his claim was classified as nondisabling. (Ex. 4). Claimant testified that he did receive the notice of acceptance, but could not recall if he had received the explanation of his rights (Exhibits 4-2 and 4-3) which were referenced by the notice of acceptance. (Tr. 12). Linda Gray, a senior claims examiner for the employer, testified that it was the employer's normal procedure to enclose the required explanation of an injured worker's rights, with the notice of acceptance. (Tr. 27)

This testimony is further supported by the notice of acceptance which refers to "enclosures" in two places. (Ex. 4-1). In light of the above, we conclude that it is more likely than not that claimant received Exhibits 4-2 and 4-3, which explained claimant's rights with regard to the nondisabling status of his claim, when he received the May 12, 1993 notice of acceptance.

As noted above, claimant was injured on April 12, 1993. He received notification that his claim was classified as nondisabling approximately one month later. Claimant had sufficient time, approximately 11 months, in which to challenge this classification. Hutchinson, supra. The first document that could be construed as a request for reclassification is the April 13, 1994 letter from claimant's counsel to the employer requesting that claimant's claim be closed and his disability be rated. This request was not within a year of claimant's date of injury and is consequently untimely. Because claimant requested reclassification of his claim more than a year after the date of injury, neither the Hearings Division nor the Board has jurisdiction over the request. Charles B. Tyler, supra at 974. Rather, claimant's request was properly processed by the employer as a claim for aggravation under ORS 656.273.

Inasmuch as we have found that the Referee lacked jurisdiction to decide the reclassification issue, and in light of the fact that claimant had previously withdrawn his appeal of the employer's denial of his aggravation claim, it follows that claimant is not entitled to the temporary disability benefits ordered by the Referee. Moreover, there are no longer any "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support 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, we reverse the Referee's award of temporary disability benefits and penalties.

ORDER

The Referee's order dated November 22, 1994 is vacated in part and reversed in part. That portion of the Referee's order which directed the self-insured employer to reclassify claimant's claim as disabling is vacated. Those portions of the Referee's order which awarded claimant temporary disability benefits and penalties are reversed.

May 23, 1995

Cite as 47 Van Natta 909 (1995)

In the Matter of the Compensation of
VERNON C. SMITH, Claimant
 WCB Case No. 94-01958
 ORDER ON REVIEW

Ransom & Gilbertson, Claimant Attorneys
 Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of that portion of Referee Podnar's order that set aside its denial of claimant's occupational disease claim for a right shoulder impingement syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a right shoulder injury at work in October 1992. The insurer denied claimant's claim for "pain in right arm and shoulder." Thereafter, claimant requested a hearing. Noting that claimant's primary treating physician had withdrawn an earlier diagnosis of subacromial impingement syndrome, on October 14, 1993, the insurer formally accepted a "right posterior interscapular muscle strain (rhomboid)." When the parties were unable to agree upon the attorney fee for claimant's counsel's services in securing the insurer's rescission of its denial, the matter was submitted to a prior referee for resolution. The insurer's denial was not litigated.

Claimant continued to have right arm and shoulder pain and, in November 1993, began treating with Dr. Hutson. Dr. Hutson diagnosed degenerative arthritis of the acromioclavicular (AC) joint with

resultant impingement syndrome causing subacromial bursitis. On January 12, 1994, Dr. Hutson requested authorization to perform an arthroscopic subacromial decompression and excision of the distal clavicle. On February 17, 1994, the insurer issued a denial of the proposed surgery on the basis that claimant's current condition was "unrelated to [his] industrial injury of October 15, 1992."

The claim was closed on March 22, 1994, without an award of permanent disability. On that same date, the insurer issued an amended denial, which provided, in relevant part:

"At this time we will be denying the surgery for arthroscopic subacromial decompression and excision of the distal clavicle and the associated time loss and disability resulting from the proposed surgery as it is not related to the accepted condition."

At hearing, the parties framed the issue as the insurer's February 17, and March 22, 1994 denials of surgery with associated time loss and disability. (Tr. 1). Finding that claimant's work activity was the major contributing cause of his need to seek treatment and disability relative to his right shoulder, the Referee concluded that the impingement syndrome was compensable as an occupational disease. The Referee therefore set aside the insurer's partial denials.

On review, the insurer contends that the Referee erred in finding that claimant established the compensability of an occupational disease claim for an impingement syndrome under ORS 656.802(1)(c), (2). Specifically, the insurer argues that because no physician has related claimant's impingement syndrome to his work activities by the requisite causal standard, claimant failed to prove the compensability of the condition for which he seeks medical services.

Claimant argues that, because the prior referee ordered the insurer to accept claimant's claim for a "right arm/shoulder" condition, the insurer could not unilaterally limit its acceptance to a rhomboid muscle strain. Claimant therefore characterizes the insurer's denials as impermissible "back-up" denials under Georgia-Pacific Corp. v. Piowar, 305 Or 494 (1988). See ORS 656.262(6). Claimant thus contends that, his right shoulder condition having been accepted, the cause of his current need for treatment is irrelevant. In the alternative, claimant seeks the adoption of the Referee's order. We agree with the insurer and reverse.

As it is potentially dispositive of this dispute, we begin with claimant's argument. Contrary to claimant's assertion, there is no prior order directing the insurer to accept claimant's degenerative right shoulder condition with impingement syndrome. Although claimant requested a hearing concerning the compensability of his right arm and shoulder condition, the insurer later withdrew its denial and formally accepted a right shoulder strain. The insurer's denial was not litigated on the merits. Rather, the only issue before the prior referee was claimant's counsel's fee for securing the insurer's rescission of the denials. The prior order merely recited, inter alia, that the insurer had agreed to rescind its denials; it did not purport to define the scope of the insurer's acceptance.

Consequently, claimant's reliance on Piowar, supra, is misplaced. In Piowar, the Supreme Court held that where an insurer accepts a symptom of a disease, it has accepted the underlying disease. 305 Or at 499. However, the Court went on to explain that where an insurer specifically accepts in writing only one of several conditions encompassed in a single claim, the insurer has not accepted the other conditions allegedly related to the accepted part of the claim. Id. at 500.

Here, we find that the condition requiring treatment (impingement syndrome) has not been accepted. Claimant's original claim was accepted for a right shoulder strain only. (Ex. 27). The disputed medical treatment consists of medical services claimant sought in 1994 for right shoulder pain, for which arthroscopic subacromial decompression and excision of the distal clavicle have been recommended. The principal diagnosis for surgery, according to treating orthopedic surgeon Dr. Hutson, was the impingement syndrome attributable to claimant's preexisting shoulder arthritis. No physician has suggested that claimant's need for surgery is related to the accepted muscle strain. While Dr. Hutson opined that claimant's work activities exacerbated the preexisting condition, we find that the surgery is proposed to treat the noncompensable impingement syndrome itself. Thus, the insurer was not precluded from denying the impingement syndrome and surgery therefor.¹ We turn to the insurer's argument.

¹ Furthermore, inasmuch as the claim was closed without an award of permanent disability, the insurer is not precluded by the closure order from denying that the preexisting condition is part of the compensable claim. See Messmer v. Deluxe Cabinet Works, 132 Or App 424 (1994), rev den 320 Or 507 (1995).

To prevail on an occupational disease claim, claimant must prove that his employment conditions were the major contributing cause of the impingement syndrome or its worsening. See ORS 656.802. "Major contributing cause" means an activity or exposure or combination of activities or exposures that contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145 (1983).

It is undisputed that claimant's impingement syndrome was preexisting. Claimant must therefore establish a pathological worsening of his right shoulder condition. Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. Weller v. Union Carbide, 288 Or 27, 35 (1979). We find no medical evidence to support a finding that employment conditions alone were the major contributing cause of the impingement syndrome or its worsening. At most, the medical evidence shows that work activities caused claimant's preexisting condition to become symptomatic.

Dr. Hutson explained that claimant's "current symptoms . . . seem to have been brought on by his work activities causing the impingement to become symptomatic. So basically we are dealing with a preexisting condition that was exacerbated by his work activities." That is not sufficient to carry claimant's burden of proof. See ORS 656.266. On this record, then, we conclude that claimant's impingement syndrome and resultant need for treatment are not compensable. Accordingly, we reinstate and uphold the insurer's denials.

ORDER

The Referee's order dated May 26, 1994 is reversed in part and affirmed in part. The insurer's February 17, 1994 and March 22, 1994 denials are reinstated and upheld in their entirety. The Referee's attorney fee award is also reversed. The remainder of the order is affirmed.

May 23, 1995

Cite as 47 Van Natta 911 (1995)

In the Matter of the Compensation of
TAMI S. THOMAS, Claimant
WCB Case No. 94-05744
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Gunn.

Claimant requests review of that portion of Referee Mills' order that upheld the self-insured employer's denial of her aggravation claim for a fibromyalgia condition. On review, the issue is the compensability of her aggravation claim.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated September 15, 1994 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's decision that claimant has not established the compensability of her fibromyalgia condition. Because I believe the majority misinterprets the medical evidence, I dissent.

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 Cheryl A. Trask, 47 Van Natta 322 (1995) (the claimant's compensable bilateral carpal tunnel syndrome and its sequelae were the major contributing cause of her consequential fibromyalgia condition); Albert H. Olson, 46 Van Natta 1848 (1994).

Here, Dr. Knopf reported that claimant had ongoing neck pain and "may be developing a fibromyalgia rheumatica syndrome which is complicating the picture. It may well be that her original injury did create a chronic myofascial syndrome which makes an objective diagnosis difficult." (Ex. 20). Dr. Knopf suspected that claimant's September 5, 1991 injury was at least partially the causative incident for the recurring symptoms.

On April 14, 1994, Dr. Knopf reported that claimant's cervical pain appeared to be secondary to the fibromyalgia rheumatica. (Ex. 20). One month later, Dr. Knopf said that claimant was medically stationary from the injuries received in the compensable injury and had made a complete recovery. (Ex. 34A). However, claimant was still having some ongoing pain, which Dr. Knopf believed was related to a fibromyalgia rheumatica "which is a secondary condition that has been exacerbated by the original injury." (*Id.*).

Dr. Knopf's opinion is supported by the opinion of Dr. Lee, who reported that claimant had demonstrated specific trigger points in areas which were "all related to her diagnosis of chronic fibromyalgia or been exacerbated by the original injury." (Ex. 36). Dr. Lee noted that the diagnosis of fibromyalgia or myofascial pain were usually made after ruling out other obvious problems. Dr. Lee concluded that claimant's compensable injury was the major contributing cause of her current disability and need for treatment. He explained that her work injury caused the development of the chronic presence of trigger points in the muscle groups.

Although Dr. Knopf did not expressly state that claimant's compensable injury was the "major contributing cause" of her fibromyalgia, "magic words" are not required to prove compensability. I would conclude that the opinions of Drs. Knopf and Lee establish that claimant's compensable injury was the major contributing cause of her consequential fibromyalgia condition.

May 24, 1995

Cite as 47 Van Natta 912 (1995)

In the Matter of the Compensation of
JAMES U. BAMIN, Claimant
 WCB Case No. 93-04019
 ORDER ON REVIEW (REMANDING)
 Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant, *pro se*, requests review of Referee Baker's order that dismissed his request for hearing on the ground that claimant had abandoned his hearing request. On review, the issue is propriety of the Referee's dismissal order. We remand.

FINDINGS OF FACT

In December 1993, claimant's former attorney resigned from further representation of claimant. The hearing set for December 15, 1993 was postponed to allow claimant to retain new counsel. On June 2, 1994, notice of the rescheduled August 2, 1994 hearing was sent to claimant at his last known address. The notice was not returned undelivered by the postal service.

Claimant failed to appear personally or by representative at a hearing convened on August 2, 1994. The Referee found that there was no justification for claimant's failure to appear at hearing. The Referee concluded that claimant had abandoned the case and he dismissed claimant's request for hearing pursuant to OAR 438-06-071.

CONCLUSIONS OF LAW AND OPINION

A Referee shall dismiss a request for hearing if claimant and his attorney fail to attend a scheduled hearing unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 438-06-071(2). We have previously held that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. *Brent D. Christensen*, 47 Van Natta 10 (1995); *Olga G. Semeniuk*, 46 Van Natta 152 (1994); *Stacy W. McMahan*, 45 Van Natta 333 (1993). In *McMahan*, we treated the claimant's request for review of the dismissal order as a motion for reconsideration of the Referee's order. See also *Isabel Mendoza-Lopez*, 43 Van Natta 2765 (1991); *Laurie Frick*, 43 Van Natta 2584 (1991).

In claimant's request for review, he stated that since English is not his first language, he has been at a disadvantage in pursuing his claim. In his brief on review, claimant refers to the merits of the case and states that he needs an interpreter because his native language is Burmese.

Considering these circumstances, we interpret claimant's submissions as a motion for reconsideration of the Referee's order. Inasmuch as the Referee did not have an opportunity to rule on the motion, this matter must be remanded to the Referee for consideration of the motion. See Olga G. Semeniuk, supra (the claimant's explanations for her failure to appear at the hearing included her inability to obtain an attorney in Oregon and an interpreter who spoke her Ukrainian language).

We emphasize that our decision should not be interpreted as a ruling that a postponement should be granted. Rather, we find that the Referee is the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. See Brent D. Christensen, supra; Olga G. Semeniuk, supra.

Accordingly, the Referee's order dated October 24, 1994 is vacated. This matter is remanded to Referee Baker to determine whether postponement of claimant's hearing request is justified. In making this determination, the Referee shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the Referee finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the Referee. If the Referee finds that a postponement is not justified, the Referee shall proceed with the issuance of a dismissal order.

ORDER

The Referee's order dated October 24, 1994 is vacated. This matter is remanded to Referee Baker for further proceedings consistent with this order.

May 24, 1995

Cite as 47 Van Natta 913 (1995)

In the Matter of the Compensation of
RAMON L. CORTEZ, Claimant
WCB Case No. 94-07974
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Hazelett's order that dismissed claimant's request for hearing on the insurer's denial of claimant's low back injury claim. On review, the issue is timeliness of claimant's hearing request, and, if claimant's request for hearing was timely, compensability.

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

Claimant contends that, although he received the denial letter, he was unable to understand the meaning of the document.

Notification occurs, and the 60-day and 180 day periods begin to run, when claimant has either actual or constructive receipt of the denial. SAIF v. Edison, 117 Or App 455 (1992). Here, claimant actually received the denial on April 20, 1994. Thus, claimant received actual notice of the denial more than 60 days before filing his July 5, 1994 request for hearing. Therefore, in order for the request for hearing to be timely, claimant must prove good cause for failing to file within 60 days of receipt of the denial letter. In proving good cause, whether or not claimant had actual knowledge of the denial, he must show reasonable diligence. See Giusti Wine Co. v. Adams, 102 Or App 329, 332 (1990); Anastacio L. Duran, Sr., 45 Van Natta 71 (1993).

Here, claimant maintains that he did not understand that the letter came from the insurer (see Tr. 15), and that, combined with his employer's alleged statements about his lack of workers' compensation insurance, were sufficient to create excusable neglect. We disagree. Claimant had consulted an attorney regarding his claim just a little more than a week prior to receipt of the document. Moreover, claimant's counsel knew the identity of the insurer prior to claimant's receipt of the denial. (Ex. 3B). However, claimant did not contact the attorney or anyone else for assistance in understanding the document. Failure to take steps necessary to understand mail is substantially the same as refusal to accept mail, and neither constitutes good cause for failing to timely file a request for hearing. Bertha Vega, 45 Van Natta 378, aff'd mem Vega v. Imperial Hotel, 125 Or App 378, rev den 319 Or 36 (1993).

Under these circumstances, we conclude that claimant failed to exercise reasonable diligence. Accordingly, we find that claimant filed his request for hearing more than 60 days after notification of the denial, and that he failed to prove good cause for his untimely filing.

ORDER

The Referee's order dated November 1, 1994 is affirmed.

May 24, 1995

Cite as 47 Van Natta 914 (1995)

In the Matter of the Compensation of
ARMANDO FLORES, Claimant
 WCB Case No. C5-01095
 ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
 Gatti, Gatti, et al., Claimant Attorney
 Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Niedig and Hall.

On April 24, 1995, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A CDA shall not be approved if, within 30 days of submitting the disposition to us, the worker requests that we disapprove the disposition. ORS 656.236(1)(c). Here, on May 8, 1995, the Board received a letter from claimant stating that he had been "denied all type of help" and that he had signed the CDA because he "had no choice but to accept nothing." The letter also asked the Board to "look into this a little further."

Although claimant does not explicitly request disapproval of the CDA, we understand him as indicating that he felt coerced into signing the agreement. In view of claimant's expressions that he did not freely enter into the CDA, we treat his letter as a request for disapproval. Because we received claimant's letter prior to the 30th day following submission of the CDA to the Board, we disapprove the disposition. ORS 656.236(1)(c).

Inasmuch as we disapprove the proposed CDA, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Finally, we note that we are not in a position to advise claimant regarding any aspect of his claim, including the proposed CDA. If claimant's intent is not to request disapproval, he may move for reconsideration of this order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

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

This matter is before the Board on remand from the Court of Appeals. Reynolds Metals v. Thrasher, 133 Or App 30 (February 15, 1995). The court reversed our prior order, Marvin Thrasher, 45 Van Natta 1495 (1993), that set aside a left knee chondromalacia condition denial. Concluding that we erroneously considered the compensability of claimant's current resulting condition, *i.e.*, the combination of claimant's knee injury and his chondromalacia condition, the court remanded for determination of the compensability of the underlying chondromalacia condition.

FINDINGS OF FACT

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

Although the insurer noted its acceptance of a disabling injury to claimant's left knee on a Form 801, it did not issue a formal acceptance of any diagnosed condition.

CONCLUSIONS OF LAW AND OPINION

We briefly recite the procedural history of the claim. Claimant sought reconsideration of a September 1991 Determination Order, requesting additional compensation for chondromalacia. An April 14, 1992 Order on Reconsideration did not grant claimant's request.

Following a hearing at which claimant unsuccessfully sought an award for chondromalacia, the insurer issued a denial of chondromalacia. Claimant requested this hearing on the denial. The Referee found that claimant's chondromalacia condition was compensable. We affirmed. Marvin Thrasher, supra.

On appeal, the court agreed with the insurer's argument that we had erroneously considered the compensability of claimant's current resulting condition rather than the issue posed by the insurer's partial denial: the compensability of the underlying chondromalacia condition. Consequently, the court reversed and remanded for us to determine whether claimant's chondromalacia condition was compensable.

We now summarize the relevant facts. Claimant was employed as a utility maintenance worker with the employer for 16 years. On September 4, 1990, claimant sustained a disabling injury to his left knee when a pile of bricks fell and struck his knee, which he twisted when he fell against a brick basket. (Ex. 1). The insurer accepted the injury claim.

Claimant sought treatment for pain in the medial joint and swelling in the knee. An arthrogram revealed a large amount of fluid in the left knee joint, but was otherwise normal. (Exs. 2 and 11). Claimant was initially diagnosed with an acute knee strain. (Ex. 1-3 and 4).

In October 1990, claimant was released to regular work. Claimant's medial joint pain and swelling persisted. In January 1991, Dr. Utterback suspected a medial meniscus tear and, in February 1991, performed an arthroscopy. When the arthroscopy revealed extensive chondromalacia, Dr. Utterback recommended that claimant discontinue weight bearing activities.

The insurer contends that chondromalacia is a coincidentally co-existing condition in claimant's knee.¹ Claimant contends that chondromalacia is an accepted part of his injury claim. (Tr. 7).

¹ Although there is no formal acceptance in the record, the carrier has conceded compensability of a resultant condition (the combination of claimant's injury and chondromalacia) and need for treatment (Employer's Reply Brief at 2 and 39), apparently assuming that claimant's chondromalacia preexisted his 1990 traumatic injury. As noted above, the record does not establish that chondromalacia was preexisting, as opposed to traumatically induced.

The record does not establish that claimant's chondromalacia preexisted his injury. (Exs. 2 and 11; see record generally). Because claimant's chondromalacia condition arose in the context of an industrial injury, we begin by examining whether the condition arose directly from the injury. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (a condition that arises directly, even if belatedly, from the original injury is subject to a material contributing cause standard, not a major contributing cause standard).

Subsequent to the injury, claimant sought treatment for symptoms of joint pain and swelling. Dr. Lockwood, who initially treated claimant, and Dr. Utterback, claimant's attending physician, each attributed claimant's condition, manifested by the joint pain and swelling, to the industrial injury. (Exs. 2 and 3-1). After diagnosing claimant's chondromalacia condition, Dr. Utterback opined that the 1990 work injury was the initiating factor, and that, therefore, the injury was the major contributing cause of claimant's current activity restrictions. (Ex. 10). Subsequently, Dr. Utterback rated claimant's impairment from chondromalacia as caused by the work injury.² (Ex. 15). In addition, Dr. Farris, who performed an examination for the insurer, also agreed that the chondromalacia findings resulted from the 1990 injury. (Ex. 11). Dr. Utterback reviewed and agreed with Dr. Farris' findings. (Ex. 12).

Based on this record, we conclude that claimant's chondromalacia condition, arose directly and materially from claimant's industrial injury.³ Consequently, we hold that claimant's chondromalacia condition is compensable. Albany General Hospital v. Gasperino, supra.

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 compensability issue. Since claimant has previously been awarded attorney fees for services at hearing and on Board review, we shall not disturb those awards. However, claimant is also entitled to a reasonable attorney fee for services concerning the compensability issue before 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 before the court 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 appellant's 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, the Referee's order dated September 4, 1992 is affirmed. We republish that portion of our prior order that awarded an insurer-paid \$1,500 attorney fee. Finally, for services before the court, claimant's attorney is awarded \$2,000, payable by the insurer.

IT IS SO ORDERED.

² The insurer contends that, because there is no evidence that Dr. Utterback read claimant's questionnaire regarding impairment in its entirety, his finding of impairment from chondromalacia does not prove that the chondromalacia resulted from the accepted injury. We are unwilling to make such an assumption. Because Dr. Utterback indicated no other potential cause of claimant's impairment due to chondromalacia, we find his response is most reasonably construed as showing that claimant's chondromalacia was due to the accepted injury. See, e.g., Edith N. Carter, 46 Van Natta 2400 (1994) and David J. Schafer, 46 Van Natta 2298 (1994) (in the absence of evidence that a medical arbiter rated impairment due to causes other than claimant's compensable injury, we have attributed an arbiter's impairment findings as due to the compensable injury).

³ Because Dr. Utterback's May 8, 1992 opinion addresses only the major cause of claimant's condition, we do not find that it serves to defeat claimant's claim. Gasperino, supra.

In the Matter of the Compensation of
DALE A. WARREN, Claimant
WCB Case No. 94-07798
ORDER ON REVIEW
Dobbins, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Referee Baker's order that declined to award temporary disability benefits. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

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

Claimant worked for the employer as a courier at the time he sustained a compensable lumbar strain in August 1993. Claimant's regular schedule as a courier was 40 hours of work per week. (Ex. 1). His rate of pay was \$6.40 per hour. Id.

On May 2, 1994, the employer reassigned claimant to a "fueler route" job, which involved fueling and cleaning the delivery vehicles. (Tr. 50). The fueler route job was a 30 hour per week job. (Tr. 31). This reassignment was made so that claimant would not have contact with customers due to some customer complaints about claimant's attitude. (Tr. 25, 49).

On April 21, 1994, Dr. Lee, M.D., became claimant's attending physician. (Ex. 11). On May 31, 1994, Dr. Lee recommended that claimant work 30 hours per week, instead of full-time. (Ex. 14). On June 7, 1994, Dr. Lee prescribed further treatment for claimant's compensable low back strain and limited claimant to 30 hours of light to medium work per week. (Ex. 16). As of June 23, 1994, Dr. Lee continued to recommend part-time work with weight limitations "as before." (Ex. 18).

On June 3, 1994, the employer laid off claimant. This lay off was part of a general reduction in force caused by a downturn in business. (Ex. 15A, Tr. 10-11, 12, 45-47). But for this downturn in business, claimant would have continued in the fueler route job. (Tr. 31). Claimant remained eligible for rehire at the time he was laid off. (Ex. 15A).

CONCLUSIONS OF LAW AND OPINION

Finding that it was as likely as not that claimant's hours were reduced and he was laid off for reasons unrelated to the work injury, the Referee concluded that claimant was not entitled to any temporary disability benefits because he had not proved that he lost any wages as a result of the compensable injury. Claimant argues that he was restricted to modified work due to the compensable lumbar strain and is entitled to temporary disability benefits on that basis. We agree with claimant.

The initial question presented is whether claimant is entitled to temporary partial disability (TPD) benefits as of May 31, 1994, the date Dr. Lee restricted claimant to 30 hours of work per week. SAIF argues that claimant's regular job at the time of this restriction was the fueler route job, which was a 30 hour per week job. Therefore, SAIF argues, Dr. Lee's restriction to 30 hours of work per week was a release to regular work and claimant is not entitled to any temporary disability. SAIF cites John McConnell, 45 Van Natta 1197 (1993), in support of its argument. We disagree with SAIF's argument and find McConnell inapposite.

In McConnell, the claimant incurred an occupational disease. Thus, ORS 656.210(2)(b)(B) applied to that claim. Under ORS 656.210(2)(b)(B), for a worker who incurs an occupational disease, temporary total disability (TTD) benefits are based on the wage of the worker "at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease." In McConnell, medical verification of the claimant's inability to work due to the occupational disease first occurred while the claimant was working for a subsequent employer at a job that was in the light category.

The dispute in McConnell was whether the claimant's return to that light duty job following a period of total disability from work constituted a return to "regular employment" within the meaning of ORS 656.268(3)(a) so as to permit the termination of TTD benefits. Applying ORS 656.210(2)(b)(B), we determined that, inasmuch as the claimant's TTD benefits for his occupational disease are based on his wage at the time there is medical verification of his inability to work, a return to the job claimant was performing at the time of his medically verified disability is a return to regular work that would permit termination of TTD benefits. See also Randel G. Jensen, 45 Van Natta 1749 (1993) (the claimant was entitled to temporary disability benefits as of the date of his doctor's post-termination restriction to modified work, which constituted medical verification of the claimant's inability to work due to his occupational disease).

Here, claimant's lumbar strain was accepted as a nondisabling injury, not an occupational disease. (Ex. 6). SAIF is bound by the express language of its acceptance. SAIF v. Mize, 129 Or App 636, 639-40 (1994). Therefore, ORS 656.210(2)(b)(B) and the reasoning in McConnell and Jensen are inapplicable to the present case. Furthermore, TTD benefits for injuries are based on the worker's at-injury wage. ORS 656.210(2)(b)(A).

In addition, in defining TPD, ORS 656.212 provides:

"When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury." (Emphasis added).

The language of ORS 656.212 clearly and unambiguously states that, in regard to TPD, the date of injury is the relevant date to determine any loss of earning power. Here, at the date of injury, claimant was able to work at least 40 hours per week. However, as of May 31, 1994, claimant was limited to working 30 hours per week due to the compensable injury. In other words, as of May 31, 1994, claimant was not released to his at-injury capacity of a 40 hour work week. Because the baseline for comparison is the date of injury, it is irrelevant that, prior to Dr. Lee's restriction to 30 hours of work per week, claimant had been reassigned to a different job (for reasons unrelated to the injury) that required 30 hours of work per week. Therefore, we find claimant entitled to TPD as of May 31, 1994, the date of Dr. Lee's restriction to 30 hours of work per week. This TPD is to be calculated pursuant to temporary OAR 436-60-030 (WCD Admin. Order 94-050), the rule in effect at the time of Dr. Lee's restriction, and Stone v. Whittier Wood Products, 124 Or App 117 (1993), rev den 318 Or 459 (1994).

OAR 436-60-030(11)(b) provides that TPD shall cease and TTD shall begin when the "job no longer exists or the job offer is withdrawn by the employer," which includes a layoff.¹ Here, claimant was laid off due to a lack of work on June 3, 1994. At the time of this layoff, claimant remained able to work only 30 hours per week. In addition, on June 7, 1994, Dr. Lee further restricted claimant to light to medium work in addition to continuing the limitation of 30 hours of work per week.

In Jose Vergara, 44 Van Natta 809 (1992), we held that former OAR 436-60-030(4)(b), which is now found at OAR 436-60-030(11)(b), was consistent with the purpose of ORS 656.268, which is to compensate workers "for wages lost because of inability or reduced earning capacity to work as a result of the compensable injury." Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987), rev den 305 Or 102 (1988) (quoting Cutright v. Weyerhaeuser Co., 299 Or 290, 296 (1985)) (Emphasis added).

Here, claimant could only perform modified work as a result of the work injury. Therefore, claimant had a reduced capacity to work. Accordingly, pursuant to OAR 436-60-030(11)(b), claimant is entitled to TTD benefits as of June 3, 1994, the date he was laid off. Jose Vergara, supra.

¹ SAIF argues that the reasoning in Dawes v. Summers, 118 Or App 15 (1993), should apply to the present case. We disagree. In Dawes, the claimant was seeking substantive temporary disability following claim closure. The claimant had been released to and returned to work following a compensable injury and was subsequently terminated for reasons not related to her injury. The court held that, because the claimant was fired for reasons not related to her claim, no wages were lost due to the compensable injury and the claimant was not entitled to temporary disability benefits. Here, unlike Dawes, the claim was in open status and the dispute involves procedural temporary disability. Moreover, claimant was not terminated; instead, the job was withdrawn through a layoff. Thus, on the facts of the case, the reasoning in Dawes is not applicable.

In summary, we find that claimant is entitled to TPD benefits from May 31, 1994 through June 2, 1994. Claimant is entitled to TTD benefits as of June 3, 1994. These benefits are to continue until SAIF may terminate them in accordance with the law.

Claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of any increased compensation as a result of this order, not to exceed \$3,800, payable directly to claimant's counsel. ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated October 25, 1994 is reversed in part and affirmed in part. That portion of the order that declined to award temporary disability benefits is reversed. Claimant is awarded temporary partial disability (TPD) benefits from May 31, 1994 through June 2, 1994. The SAIF Corporation is directed to calculate claimant's TPD as previously set forth in this order. Claimant is awarded temporary total disability (TTD) benefits from June 3, 1994 and continuing until such benefits may be terminated pursuant to law. Claimant's counsel is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed.

May 25, 1995

Cite as 47 Van Natta 919 (1995)

In the Matter of the Compensation of
CARLA J. CADY, Claimant
WCB Case No. 94-07597
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Daughtry's order that upheld the self-insured employer's denial of claimant's occupational disease claim for mental disorder. On review, the issue is compensability.

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

This case involves a confrontation between claimant and her supervisor, Phil, which occurred on April 12, 1994. In short, after an earlier disagreement on the telephone, Phil arrived at claimant's work station, and spent several minutes screaming obscenities at claimant in front of a number of other workers. Claimant first sought counseling on May 4, 1994, and was later diagnosed as having signs of post-traumatic stress disorder.

Pursuant to ORS 656.802(3), a mental disorder is not compensable unless (a) the employment conditions producing the mental disorder exist in a real and objective sense; (b) the conditions producing the mental disorder are other than those generally inherent in every working situation; (c) there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; and (d) there is clear and convincing evidence that the mental disorder arose out of and in the course of employment.

The Referee found that claimant's need for treatment, nearly three weeks after the April 12, 1994 incident, arose out of events occurring in part before, during and principally after the incident. In applying ORS 656.802, the Referee determined that claimant met the requirement for a sufficient diagnosis of a generally recognized mental disorder. The Referee also found that the April 12 incident was a real event, that Phil's actions were inappropriate, and that the event could have caused stress. The Referee concluded, however, that claimant's need for treatment had more to do with events subsequent to the April 12 incident, including Phil's discipline and claimant's inaccurate belief that the company had failed to take appropriate action, than the actual incident itself. Relying on Marilee B. Rutherford, 44 Van Natta 183 (1992), the Referee determined that claimant's condition was not compensable because the employment conditions causing claimant's stress (her perception that Phil had not been disciplined) did not exist in a real and objective sense.

On review, claimant argues that the April 12 incident itself, and not any subsequent event, was the major contributing cause of her disability and need for treatment. Claimant also argues that the April 12 incident cannot be meaningfully distinguished from the subsequent events, such as the employer's investigation and discipline of Phil. The employer argues, in contrast, that although Phil was wrong in how he confronted claimant, claimant's stress and need for treatment arose not from the April 12 incident but primarily from her inaccurate belief that the employer had "swept the matter under the rug" and did not properly discipline Phil for his actions.

In many ways, this case is analogous to Rutherford. There, the alleged triggering event of the claimant's mental disorder was an embarrassing incident with a co-worker. Yet, the claimant's statements to her treating psychiatrist and to an independent medical examiner indicated that her stress arose not from the actual incident, but from her belief that the employer did not take appropriate disciplinary action against the co-worker.

In upholding the denial of compensability, we determined that the actual incident could be distinguished from events occurring both prior and subsequent, such as the discipline of the co-worker. We found that the circumstance that triggered the claimant's condition was the claimant's perception that management did not sufficiently investigate the incident or discipline the co-worker, along with her general belief that management did not care about her. We concluded that although the co-worker incident itself was real, the claimant's belief that the co-worker was not disciplined was not based on actual events. Her employer did investigate the matter, reprimand the co-worker and document the incident in the co-worker's personnel file. The claimant therefore failed to show that real and objective stressful events were the major cause of her mental disorder and did not prove she had a compensable claim under ORS 656.802. Rutherford, supra, 44 Van Natta at 185.

As in Rutherford, we are in this case able to distinguish between the April 12 incident and the events subsequent. Although the April 12 incident was real, claimant's condition arose only after the employer allegedly failed to take appropriate action against Phil. Indeed, although upset by the incident, claimant wrote out a statement then returned to her work. She continued with her regular job for two weeks without incident.¹ (Tr. 50). She did not appear upset on April 28 when she first approached the plant manager about the incident. (Tr. 68). During the April 28 and 29 meetings among claimant, the plant manager, union and management representatives and Phil, claimant told her story and repeated her complaints. She received what she perceived as an insincere apology from Phil. Although she said she was satisfied with the plant manager's promise that there would be no more problems with Phil, claimant apparently left the meeting feeling that Phil had not been sufficiently punished. Five days later, she sought treatment, reporting anxiety arising out of the incident and subsequent events.

Specifically, in addition to describing the incident, claimant explained to Helen Herman, M.A., on May 3, 1994 that the incident had expanded into a company-wide concern involving company management and union officials. (Ex. 3). On May 19, 1994, she reported to Dr. Wagner at the occupational health clinic that she filed a formal complaint but nothing had been done about it. She stated that Phil had not apologized to her and that she felt the company was trying to "sweep the matter under the rug." (Ex. 7). Similarly, she reported to Dr. Maletzky, a psychiatrist, on May 23, 1994 that "no one has suggested Phil was in error or extreme." She indicated that management was saying that the incident was her fault. (Ex. 9-1).

As in Rutherford, claimant's belief that Phil was not properly disciplined or her perception that management was faulting her for the incident are not based on actual events. The employer investigated the matter. Phil was reprimanded and the incident was documented in his personnel file. He was placed on notice that if such an incident happened again, he would likely be terminated. A meeting was held in which claimant aired her complaints and Phil apologized to claimant. As the plant manager testified, although claimant desired that Phil be given time off without pay, time off was not an appropriate penalty because Phil is a salaried rather than hourly employee. (Tr. 73-75).

¹ Claimant sought treatment at Kaiser for an eyelid problem on April 7, 1994, before the April 12 incident. She returned to Kaiser on April 21, where her condition was described as a nonimproving skin irritation with drainage and itchiness. She did not recall discussing with anyone at Kaiser that she was having problems with her supervisor. (Tr. 90).

In conclusion, like the Referee, we find that the employment conditions producing claimant's stress and need for treatment during May 1994 arose primarily from her perception that the employer failed to properly investigate the incident and discipline her supervisor.² We find that although Phil's behavior was aberrant, the April 12 incident itself was not the major contributing cause of claimant's condition. We also find that claimant's belief concerning the manner in which her employer handled the April 12 incident is not real and objective. As such, claimant's mental disorder is not compensable under ORS 656.802(3). We therefore affirm the Referee's upholding of the self-insured employer's denial.

ORDER

The Referee's order dated October 21, 1994 is affirmed.

² In support of this conclusion, we rely on the lay testimony concerning the evolution of claimant's complaints and their relationship to the April 12 incident and the employer's response to that event. We also rely on the following medical opinion, which provides a persuasive explanation concerning the genesis of claimant's disorder. Dr. Sturges (who examined claimant at the employer's request on August 30, 1994) noted that claimant's reaction "was one of an emotional response to the processing of her claim and this would explain the time sequence of her seeing the occupational physician for the first time [on] May 19, 1994 and her focus on the allegation that 'this has been shoved under the rug.'" (Ex. 10-2).

May 25, 1995

Cite as 47 Van Natta 921 (1995)

In the Matter of the Compensation of
SALVATORE D. COCO, Claimant
WCB Case No. 94-00585
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Mongrain's order which upheld the insurer's denial of his low back injury claim. On review, the issue is compensability.

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

The Referee concluded that claimant failed to prove by a preponderance of the evidence that he sustained a low back injury on September 21, 1993. In reaching this conclusion, the Referee determined that there was no persuasive medical evidence sufficient to satisfy claimant's burden of proof under either a material or major causation standard.

On review, claimant contends that he has sustained his burden of proof, arguing that the medical opinions of his attending physician, Dr. Mather, and a consulting neurosurgeon, Dr. Dunn, are persuasive. We disagree.

In resolving a complex medical causation issue, such as that presented here, we rely on 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). In this case, we find persuasive reasons not to rely on the medical opinion of claimant's attending physician, Dr. Mather.

Claimant, a mechanic, testified that he was repairing brakes on a horse trailer on September 21, 1993, when he felt a "tug or strain" when putting wheels back on the trailer. Claimant also testified that he informed his employers that the incident had occurred. Claimant's supervisor could not recall that claimant reported an incident and a co-owner flatly denied knowledge of the incident. Claimant further testified that he did not work on September 23, 1993 because of back pain, but that his condition improved but never became totally asymptomatic. According to claimant's testimony, on October 6, 1993, his back pain increased after bending over to pick up a toy and hearing a "pop" and "strain." Claimant subsequently testified that his back pain increased significantly after picking up trash at work later that day. Claimant then sought medical treatment from Dr. Mather on October 8, 1993.

Dr. Mather's October 8, 1993 chart note states that claimant's back pain had begun two weeks previously putting tires on a horse trailer, but that it had "slowly resolved" and had "recurred" when he picked up a toy. Dr. Mather's chart note did not mention the alleged increase in back pain after claimant picked up trash. Dr. Mather diagnosed a lumbar strain and later referred claimant to Dr. Dunn, who diagnosed a herniated lumbosacral disc.

Dr. Mather agreed in a "check-the-box" report that, based on a review of medical records, the September 21, 1993 "injury" was the major contributing cause of claimant's current condition. (Ex. 26). The Referee discounted this opinion because Dr. Mather did not analyze the causation issue with consideration of his history of a resolution of symptoms followed by a recurrence of symptoms after claimant bent over to pick up a toy.

We concur with the Referee that Dr. Mather's medical opinion is unpersuasive both because it does not consider the history documented in his October 8, 1993 chart note and because it lacks any explanation of how Dr. Mather's review of the medical records led to his opinion on the causation issue. See Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of expert opinion depends on the persuasiveness of the foundation on which the opinion is based).

We now turn to Dr. Dunn's medical opinion. Dr. Dunn first evaluated claimant's low back condition on January 18, 1994. (Ex. 23A). Dr. Dunn took a history of claimant putting on tires, feeling soreness and then increased back pain over the next few days. Dr. Dunn's history does not mention the October 6, 1993 toy incident or the alleged increase of back pain due to picking up trash. Dr. Dunn wrote, however, that claimant had recently experienced another exacerbation as a result of "setting his child down."

After diagnosing a herniated disc, Dr. Dunn concluded without explanation that claimant's symptoms were "definitively, solely, and completely" the result of the September 21, 1993 work incident. (Ex. 23A-3).

In a May 4, 1994 chart note, Dr. Dunn stated that, within reasonable medical probability, claimant's symptoms and MRI findings were consistent with an injury in September 1993. (Ex. 28). Dr. Dunn recommended surgery.

The Referee found Dr. Dunn's opinion unpersuasive because he had no history of the October 6, 1993 toy incident and thus did not factor into his opinion a history of a resolution of symptoms followed by a recurrence of symptoms following the off-the-job incident. We agree with the Referee's reasoning. Dr. Dunn's history was incomplete and, in addition, it was not adequately explained. In light of the complex history of symptoms, and the existence of multiple potential injurious incidents, both on and off the job, we believe that a complete and accurate history, followed by a well-explained opinion, is necessary in order to support a conclusion that claimant's herniated disc is causally related to the September 1993 incident.

We are cognizant of claimant's testimony that his back pain never completely resolved after the September 21, 1993 incident. This could support Dr. Dunn's apparent assumption that claimant has had ongoing symptoms since the September 1993 incident. However, we do not accept claimant's testimony as accurate. Although the referee determined that claimant testified in a "straightforward and nonevasive" manner, we find the history given in Dr. Mather's contemporaneous October 8, 1993 chart note that claimant's back pain "resolved" after the September 1993 incident to be more reliable. See Steve L. Nelson, 43 Van Natta 1053, 1054 (1991) (claimant's testimony given little weight when inconsistent with the contemporaneous medical documentation); Accord Charles W. Inmon, 42 Van Natta 569, 570 (1990); Cf. Diana M. VanKerckhove, 42 Van Natta 1067 (1990) (where contemporaneous medical records supported the claimant's testimony, claimant's testimony found credible).

Inasmuch as we have found the medical opinions of Drs. Dunn and Mather unpersuasive, and because the only remaining medical opinion, that of the radiologist, Dr. Young, does not support compensability, claimant has not sustained his burden of proving medical causation. We, therefore, affirm the Referee's decision to uphold the insurer's denial of claimant's low back injury claim.

ORDER

The Referee's order dated July 13, 1994 is affirmed.

In the Matter of the Compensation of
RONALD GALLI, Claimant
WCB Case No. 92-08948
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Mongrain's order that: (1) found that claimant's neck injury claim was not time barred; and (2) set aside its denial of that claim. On review, the issues are timeliness and compensability. We affirm.

FINDINGS OF FACT

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

Claimant's motor vehicle accident (MVA) occurred on January 21, 1991, rather than in December 1990.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions, with the following supplementation concerning the timeliness issue.

An injury claim must be filed within 30 days of the date of injury. However, the claim is not time barred, even if filed more than thirty days after the injury, if the employer otherwise had actual knowledge of the injury. ORS 656.265(4)(a). For purposes of determining whether a claim is time barred, "actual knowledge of the injury" includes facts sufficient to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate. See Wilson v. Roseburg Forest Products, 113 Or App 670 (1992); Argonaut Ins. Co. v. Mock, 95 Or App 1, rev den, 308 Or 79 (1989).

Here, it is undisputed that the employer had actual knowledge of claimant's January 21, 1991 MVA. A skidder, with its blade up, hit claimant's truck and totaled it. The blade came through the driver's-side window, stopping just behind the steering wheel. The skidder drove up on the truck, bending the hood down on the engine and smashing the cab. Claimant and his passenger "bounced around in there quite a bit." (Tr. 9).

Mr. Dahl, a co-worker who was riding in claimant's truck at the time of the accident, filed a Workers' Compensation claim for injuries sustained in that accident. (Tr. 49). After the impact, Mr. Dahl testified, "I looked over at [claimant], and I could see his hands and stuff were bleeding from the glass. . . . I told him, 'the truck's on fire'. . . . And then everybody started showing up." (Tr. 45). Those present within minutes after the accident included John Owings, shop foreman, and Randy "Raimy" (phonetic), field supervisor. (See Tr. 10, 59).

Under the circumstances described, we conclude that the employer's actual knowledge of the incident was sufficient to lead a reasonable employer to conclude that workers' compensation liability was a possibility and that further investigation was appropriate. See Argonaut Ins. Co. v. Mock, supra; Marty Winn, 42 Van Natta 1013, 1014-15 (1990). Accordingly, even if the employer was prejudiced by claimant's failure to timely file his injury claim, we would conclude that the claim is not barred, because the employer had knowledge of a possible work-related injury. See ORS 656.265(4)(a); Baldwin v. Thatcher, 49 Or App 421, 425 (1980) ("Since the employer had knowledge of the injury, it is not material whether he was prejudiced by the actual filing date.").

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$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 November 9, 1994 is affirmed. For services on review, claimant's counsel is awarded a \$1,000 attorney fee.

May 25, 1995

Cite as 47 Van Natta 924 (1995)

In the Matter of the Compensation of
ADRIENE GARDNER, Claimant
WCB Case No. 94-05684
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Cummins, Goodman, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Thye's order that upheld the insurer's denial of claimant's aggravation, "new injury," or "consequential condition" claim for a right knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the "Findings of Ultimate Fact," with the following supplementation.

Claimant's compensable July 11, 1992 right knee sprain (specifically, give-way weakness resulting from permanent injury-related medial collateral ligament laxity) was the major contributing cause of claimant's disability and need for treatment for her right knee after the March 8, 1994 incident at work.

CONCLUSIONS OF LAW AND OPINIONPreliminary Matters

The Referee found that claimant failed to establish that her current right knee condition is compensable as a "new injury" or as an aggravation of her accepted right knee medial collateral ligament sprain condition.¹ The Referee also found that "claimant does not contend that the accepted [1992] claim is responsible for her need for treatment and disability after the January 26, 1994 incident." (Opinion and Order p. 5). Consequently, the Referee did not decide whether claimant's current right knee problems are a "compensable consequence" of her accepted right knee condition. The insurer argues that we should not address claimant's "compensable consequence" theory on review because she raised it for the first time in her Appellant's Brief. We disagree with the Referee's finding (and the insurer's contention) that claimant did not raise the "compensable consequence" theory at hearing.

In reaching this conclusion, we first note that the insurer's denial broadly asserted that claimant's "current condition" was not caused or worsened by her "work activities" for the employer. (Ex. 26-1). Claimant's request for hearing also raised the compensability issue. The insurer's response to that request denied claimant's contention regarding compensability and further denied "all issues raised or raisable."

In her opening remarks, claimant's counsel stated that the issue is "what is the cause" of claimant's January 26, 1994 right knee injury, specifically:

"whether it's a new injury, an aggravation of the compensable injury, or if it is related to a previous surgery claimant had in June of 1992 to her meniscus, right knee meniscus called meniscus surgery. So it's our position that based on the evidence in the file, that claimant's new injury on January 26, 1994 is -- or new incident caused new symptoms, new objective findings, new requests for treatment all related to her exposure while she was at work." (Tr. 3, emphasis added).

¹ We agree with and adopt those portions of the Referee's opinion finding that claimant has not proven her aggravation or "new injury" theories of compensability.

Considering the denial, the request for hearing, the response to the request for hearing, and claimant's broad assertion that her post-January 1994 problems are related to her work "exposure" (which necessarily includes the accepted right knee medial collateral ligament sprain condition), we find that the "compensable consequence" theory of causation was adequately raised at hearing. See Alan B. Cooper, 40 Van Natta 1915 (1988) (An alternative legal theory on the compensability issue is not a "new" issue). Because the record is adequately developed and the compensable consequence theory is argued on review, we address it.

Compensability

The medical evidence relates claimant's current right knee problems only indirectly to her compensable right knee condition. Accordingly, to carry her burden, claimant must establish that her accepted right knee medial collateral ligament sprain condition is the major contributing cause of her current disability and need for treatment for her right knee. ORS 656.005(7)(a)(A); see Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Claimant first injured her right knee on May 25, 1992, off work. Dr. Neitling, treating physician, performed arthroscopic surgery for a torn medial meniscus, stretched anterior cruciate ligament, and multiple loose bodies in June 1992. Claimant returned to modified work on July 2, 1992. On July 11, 1992, claimant's right knee gave way at work. Dr. Neitling diagnosed a medial collateral ligament strain and the insurer accepted claimant's claim for that condition. Claimant treated conservatively and returned to modified work on August 14, 1992 and to regular work on September 1, 1992. A September 20, 1993 Determination Order closed the claim and awarded 39 percent scheduled permanent disability for loss of use of the right knee. The award was based in part on grade I medial collateral ligament laxity and a chronic right knee condition. (Ex. 22-2; see Ex. 20-2).

As of the August 7, 1993 closing examination, Dr. Neitling opined that claimant would need follow-up care if "she should develop recurrent symptoms of instability, *i.e.*, giving away in the knee." (Ex. 20-2; see Ex. 1-15-16).

On January 26, 1994, claimant's right knee gave way on a stairway at work and she twisted or turned to the right in order to grab a handrail. She experienced right knee pain and sought treatment. An MRI revealed a possible strain of the posterior cruciate ligament. Claimant filed a claim, which the insurer denied.

Based on claimant's testimony and consistent reporting, we are persuaded that claimant's right knee gave out first, then she twisted it when she turned to grab the hand rail. The critical fact is that her knee gave way, just as Dr. Neitling anticipated at the August 1993 closing examination. As a result of the give-way (and the consequent twisting which occurred when claimant turned to grab a hand rail), claimant suffered a stretching or strain of her right posterior cruciate ligament. Thus, the current right knee problems are a compensable consequence of the accepted right knee collateral ligament strain condition, if the accepted condition was the major contributing cause of the give-way (which in turn caused the twisting injury, *i.e.*, the right posterior cruciate ligament strain). See ORS 656.005(7)(a)(A).

The medical evidence concerning causation is provided by Dr. Neitling, treating physician, and Drs. Mayhall and Peterson, examining physicians.

Drs. Mayhall and Peterson opined that claimant's current right knee problems result from causes other than the accepted medial collateral ligament strain condition, including claimant's age, weight, and the effects of poor rehabilitation following the June 1992 surgery for the initial (off work) injury. Drs. Mayhall and Peterson specifically opined that the current problems do not result from the accepted medial collateral ligament strain condition, because, in their view, that condition resolved before the January 1994 incident. (Exs. 25-8, 28-6).

Dr. Neitling has treated claimant since her May 25, 1992 off work injury. He performed claimant's June 1992 right knee surgery and had the advantage of observing claimant's right knee following each injury and during surgery. See Argonaut Insurance Company v. Mageske, 93 Or App 847 (1983). Dr. Neitling noted that claimant did "quite well" and failed to mention "significant problems" with her knee following the 1992 surgery, until she sustained the initial medial collateral

ligament tear (the accepted injury). (Ex. 27-1). Based on this history, and the fact the 1992 medial meniscectomy was a common procedure rarely associated with "this degree" of difficulty, Dr. Neitling opined that most of claimant's current problems result from the accepted medial collateral ligament injury.² (Ex. 27-1-2).

Considering Dr. Neitling's opinion as a whole (including his anticipation that claimant's compensable permanent ligament laxity might cause knee give-way), we find that it supports a conclusion that claimant's current right knee posterior cruciate ligament strain is an indirect consequence of her compensable right knee medial collateral ligament condition.³

In our view, Dr. Neitling's opinion is well reasoned and based on an accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986). Moreover, considering Dr. Neitling's advantageous position as claimant's treating physician and the absence of reasons to discount his opinion concerning causation, we find that opinion persuasive. See Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, based on Dr. Neitling's opinion, we conclude that claimant has established that her current right knee condition is a compensable consequence of her accepted right knee condition. See ORS 656.005(7)(a)(A).

Claimant's attorney is entitled to an assessed 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 fee for claimant's attorney's services at hearing and on review is \$3,000 payable 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 counsel may go uncompensated.

ORDER

The Referee's order dated August 30, 1994 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded a \$3,000 attorney fee, payable by the insurer.

² Dr. Neitling also opined, based on an MRI, that claimant's currently stretched posterior cruciate ligament "was intact clinically and did not appear to cause any knee laxity." (Ex. 24).

³ Specifically, we find that claimant's compensable ligament laxity caused her 1994 knee give-way, which in turn caused the current posterior cruciate ligament strain. In reaching this conclusion, we acknowledge that Dr. Neitling once opined that the major contributing cause of claimant's present need for treatment was the "twisting" injury which claimant sustained while descending stairs at work in January 1994. (Ex. 24-1). However, Dr. Neitling's opinion also establishes that the cause of the "twisting" injury was ligament laxity resulting from the accepted right knee condition. Under these circumstances, we conclude that the former statement does not obviate or weigh against our conclusion that the claimant's current right knee problems are an indirect result of her accepted right knee condition. We further find, based on Dr. Neitling's opinion, that claimant's accepted right knee condition is the major contributing cause of her current right knee problems. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991) (No incantation of "magic words" or statutory language is required); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986); Darlene L. Bartz, 45 Van Natta 32, 33 (1993), aff'd mem Jeld-Wen, Inc. v. Bartz, 123 Or App 359 (1993).

May 25, 1995

Cite as 47 Van Natta 926 (1995)

In the Matter of the Compensation of
TROY A. GASCON, Claimant
 WCB Case No. 94-07195
 ORDER ON REVIEW
 Philip H. Garrow, Claimant Attorney
 Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Baker's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a right ankle condition; and (2) declined to award penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are aggravation, penalties and attorney fees.

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

The Referee found that, while claimant's compensable right ankle injury of October 8, 1993 was a material contributing cause of his refracture six months later, the off-work incident on April 8, 1994 was the major cause of the new fracture. The Referee therefore upheld the insurer's denial of claimant's aggravation claim and did not award any penalty or attorney fees for an allegedly unreasonable denial.¹

On review, claimant argues that the Referee erred in not deferring to the opinion of claimant's treating physician that the prior industrial injury was the primary cause of the claimant's off-work refracture of the same ankle. Claimant contends he has shown that his industrial injury materially contributed to his subsequent reinjury, and the insurer has not established that the off-the-job incident was the major cause of his new fracture. We disagree.

Under ORS 656.273(1), a claimant has a compensable aggravation if he proves that his compensable injury materially contributed to his worsened condition. If he establishes that, his aggravation claim is compensable, unless it is proven that an off-the-job injury is the major cause of his worsened condition. Fernandez v. M & M Reforestation, 124 Or App 38, 42 (1993). Because the carrier is the party with an interest in establishing that an off-the-job injury was the major cause of claimant's worsened condition, it has the burden of proof on that fact. Id.

Here, the record establishes that claimant's attending orthopedist, Dr. Maloney, believes that claimant's industrial injury (unusual fractures to the lower right leg and ankle sustained in an October 8, 1993 accident), "was probably the primary cause" of the April 8, 1994 refracture of the same ankle at the same spot. (Ex. 24A). Conversely, Dr. Young, a radiologist who reviewed claimant's x-rays at the insurer's request, believes that while claimant's ankle may have been weakened as a result of the industrial injury, that weakness was only a "minor predisposing event." (Ex. 28-1). He was therefore of the opinion that the April 8, 1994 incident was the major cause of the worsened condition.

Dr. Maloney's opinion regarding the relationship between the prior industrial injury and the off-work injury was based on claimant's history of the off-work incident. Claimant reported to Dr. Maloney that, although he was doing quite well and fully using his right ankle ("he was jumping in and out of his pickup without any difficulties"), he suffered severe pain when he "stepped up onto the curb" following an "altercation of some sort with a 'cowboy.'" (Ex. 19-1). Dr. Maloney's notes reflect as follows:

"I reviewed the x-rays. There is a transverse nondisplaced fracture of the distal tibia in exactly the same place where he had a fracture from his industrial injury. In other words, he had fractured through the old fracture which must not have completely healed. I reviewed the x-rays taken when I finally removed the cast, and it certainly does look like the fracture was healed at the time. If his story is correct, it obviously wasn't completely healed." (Ex. 19-1).

Dr. Young's opinion, on the other hand, was based on his review of 14 separate x-rays of claimant's ankle, taken between October 8, 1993 and June 30, 1994. Like Dr. Maloney, Dr. Young found that the x-ray taken on February 16, 1994 (some two months before the April 8 incident) shows that the fractures from the industrial injury had completely healed.² (Ex. 25). Also, like Dr. Maloney, Dr. Young felt that the fracture identified on the April 8, 1994 x-ray was not the same fracture, but an entirely separate and different injurious event.³ (Id.)

¹ The Referee also found that claimant had not proved entitlement to additional interim compensation. Claimant does not challenge this finding. We therefore do not address the issue on review.

² In comparing the December 29, 1993 x-ray of claimant's ankle to the February 16, 1994 x-ray Dr. Young noted that "the fracture line has disappeared and there is solid bone deposition at the fracture sites." (Ex. 25-3).

³ Claimant argues that Dr. Young's opinion is erroneous since he determined all of the original fractures were non-displaced (Ex. 25), whereas Dr. Maloney found that the fractures of the distal fibula and tibia were non-displaced but the fracture of medial malleolus was minimally displaced. (Exs. 6, 7-1, 7-2). We find this discrepancy irrelevant, as the April 8 refracture occurred in the distal tibia, not the medial malleolus.

In fact, the reason for the difference in the opinions of Drs. Maloney and Young is their assumptions regarding the off-work incident on April 8. Dr. Young believes claimant must have suffered "a considerable and significant injury" to cause a refracture at the same site, whereas Dr. Maloney accepted claimant's report that the reinjury occurred as a result of "stepping up onto a curb." That version of the incident, and claimant's denial there was any actual altercation with this "cowboy," caused Dr. Maloney to reconsider his earlier assessment that the original fractures had completely healed. (Ex. 19).

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). However, we find that this case involves expert analysis rather than expert external observation. Accordingly, Dr. Maloney'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).

As did the Referee, we find the medical opinion of Dr. Young, indicating that claimant would have had to suffer a considerable and significant new injury to cause a refracture at the same spot, to be complete, well-reasoned, and therefore most persuasive. Somers v. SAIF, *supra*. We note, as did the Referee, that while the record is not developed as to the circumstances of the April 8 refracture, it is clear that from a radiological standpoint, claimant's industrial injury had completely healed two months prior. We also note claimant reported that prior to the April 8 incident, he was fully using his right ankle without any difficulties.

In addition, Dr. Maloney's assessment that the original fracture had not completely healed was premised on claimant's story that he reinjured his ankle simply stepping onto a curb. Yet, claimant previously reported to Dr. Carroll (who treated claimant in Dr. Maloney's absence on April 8) "he slipped and twisted [his ankle] and it cracked again in the same place and he has a lot of pain." (Ex. 18).⁴

Medical opinions based on incomplete or inaccurate information are not afforded persuasive force. See Somers v. SAIF, *supra*; Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Inasmuch as claimant himself reported inconsistent versions as to the actual manner in which the April 8 off work injury occurred, we also conclude Dr. Maloney did not necessarily base his reasoning on a complete and accurate history.

We therefore conclude that insurer has sufficiently shown that the off-the-job injury on April 8 was the major cause of claimant's worsened condition. See ORS 656.273(1); Fernandez v. M & M Reforestation, *supra*. Indeed, in light of Dr. Young's opinion that the original injury was only a "minor predisposing factor," it is debatable whether claimant has met the "material cause" test. However, even if he did, we are persuaded that the insurer has proven that the off-work incident was the major cause of the refracture.

In view of our decision to affirm the Referee's decision to uphold the insurer's denial, we do not address claimant's arguments concerning penalties and attorney fees for an allegedly unreasonable denial.

ORDER

The Referee's order dated October 13, 1994 is affirmed.

⁴ Claimant did not appear at the hearing or testify regarding the circumstances of the April 8, 1994 off-work incident. Instead, he relies on the statements in the medical reports. On this point, we note the rule of Zurita v. Canby Nursery, 115 Or App 330, 334 (1992), *rev den*, 315 Or 443 (1993), to the effect that a claimant who opts not to testify personally or present witnesses concerning the circumstances of his injury runs the risk that the statements contained in the medical reports may not be sufficient to carry his burden of proof.

In the Matter of the Compensation of
JUDITH W. HALL, Claimant
WCB Case No. 93-07702
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of claimant's right shoulder and right knee injury claim. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

On November 14, 1992, claimant tripped over a customer's bag at work and fell against a counter striking her left shoulder. She felt immediate pain in her left shoulder, right shoulder, right hip, and right knee. The symptoms in claimant's left shoulder, right hip, and right knee resolved within several days without medical treatment or disability. However, claimant had ongoing symptoms in her right shoulder following this fall.

Ms. Hunter, a co-worker, testified that in November 1992 claimant's arm was dangling and she was trying to work, although she was in a lot of pain. (Tr. 71).

On May 22, 1993, claimant was examined by Drs. Cronin, orthopedist, and Gancher, neurologist, on behalf of the insurer. (Ex. 8).

On August 10, 1993, claimant was examined by Dr. Burchiel, consulting neurologist. (Exs. 13, 15).

We replace the sixth finding of fact with the following. When Dr. Hartmann, treating neurologist, first examined claimant on May 4, 1993, she had a severe paralysis of the trapezius muscle with severe atrophy. (Ex. 14-6, -9). Dr. Hartmann opined that claimant sustained a traumatic injury to the right accessory nerve as a direct result of her fall at work. The fall caused a "whip lash" injury to the right accessory nerve by stretching it, which in turn caused paralysis of the trapezius muscle which is supplied by the accessory nerve. (Exs. 12, 14-6, -7, -8). The paralysis of the trapezius muscle would be immediate if the entire damage to the accessory nerve occurred at the time of the "whip lash" stretching. If claimant had complete paralysis of the accessory nerve at the time of her fall at work, she would have experienced pain with any attempted lifting and major problems with lifting thereafter. (Ex. 14-16, -19-21). Claimant had such problems after her fall. (Tr. 6-7, 18-19, 26, 65, 71).

CONCLUSIONS OF LAW AND OPINION

Despite having "no difficulty with the proposition that [claimant] tripped and injured her left shoulder and right knee on November 14, 1992 while at work," the Referee concluded that claimant had failed to prove that she injured her right shoulder at the same time. As a result of this conclusion, the Referee upheld the insurer's June 10, 1993 denial, which denied claimant's right knee and right shoulder injury claim.

On review, claimant argues that she compensably injured her right shoulder during her fall at work. In the alternative, she argues that, based on the Referee's conclusion that she injured her right knee at work, that portion of insurer's denial that denied a right knee injury should be set aside. Although we agree with claimant that she has established a compensable right shoulder injury, we disagree that she has established a compensable right knee injury.

We adopt the Referee's reasoning and conclusions that, on November 14, 1992, claimant tripped and fell at work striking her left shoulder against a counter. We agree, for the reasons expressed by the Referee, that the testimony of Ms. Alsbrook, claimant's supervisor, regarding her knowledge of that

incident is not trustworthy. Claimant told Ms. Alsbrook about the fall incident within hours of its occurrence and filled out an 801 form reporting the accident on November 18, 1992. She was unable to fill out the form earlier because the office was out of the forms. (Tr. 19). The question remains whether the work incident resulted in compensable injuries to claimant's right knee and right shoulder.

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)(a). Here, there is no evidence that claimant's right knee required medical services as a result of the fall at work. Claimant testified that, with the exception of her right shoulder symptoms, all of her symptoms, including the right knee pain, resolved several days after her fall at work. (Tr. 6). Claimant also testified that she received no medical treatment for her knee. (Tr. 32-33). In this regard, the record shows that all medical treatment was directed at claimant's right shoulder condition; no treatment was provided for her right knee, nor was the right knee even discussed in the medical reports. (Exs. 2, 3, 5, 6, 8, 13, 14, 15).

Furthermore, although claimant left work early on the day of the fall, there is no indication that the fall at work resulted in any disability due to an injury to claimant's right knee. Claimant testified that she continued working after the day of the fall. (Tr. 7). Claimant's ability to work was first restricted on April 6, 1993, when she sought treatment for her right shoulder condition. (Ex. 2). The record establishes that, when claimant became disabled, it was due to her right shoulder condition, not her right knee. (Ex. 2, 11, 14-26, -27).

Accordingly, on this record, claimant has not established a compensable injury to her right knee. ORS 656.005(7)(a).

Regarding claimant's right shoulder condition, as discussed above, the record establishes that that condition resulted in both disability and the need for medical treatment. However, the question remains whether the right shoulder condition is causally related to claimant's November 14, 1992 fall. In order to establish a compensable injury, claimant must prove, by a preponderance of the evidence, that her work injury was at least a material contributing cause of her disability or need for medical treatment. In addition, claimant must establish her compensable condition by medical evidence supported by objective findings. ORS 656.005(7)(a). Here, there is no question that the right shoulder condition displays objective medical findings, as evidenced by the atrophied trapezius muscle, the winging scapula, and the EMG testing. (Exs. 14-6, -9, -27).

Given the fact that claimant did not seek medical treatment for almost five months after the work incident and she did not directly strike her right shoulder during the fall, we find that the causation of the right shoulder condition presents a complex medical question that requires medical evidence for its resolution. See Uris v. Compensation Department, 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993).

Opinions regarding causation are presented by Drs. Cronin, examining orthopedist, and Gancher, examining neurologist, and Dr. Hartmann, treating neurologist. Drs. Cronin and Gancher examined claimant on May 22, 1993, and agreed that claimant had an injury to the accessory nerve to the right trapezius. (Ex. 8-3). They noted that they could not "directly correlate" claimant's shoulder condition with the work incident, opining that there "could be several other causes for her current presentation including an occult malignancy or an idiopathic trapezius paresis." (Ex. 8-4). They stated that they had only claimant's history linking the work incident with her condition, although they noted that they identified no other causal activities. Id.

Dr. Hartmann opined that the fall at work was the major contributing cause of claimant's right accessory nerve injury, describing the mechanism of injury as a "whip lash" injury that stretched the right accessory nerve. (Exs. 12, 14-7). In his deposition, Dr. Hartmann explained that if the entire damage to the accessory nerve occurred at the time of the stretching, the paralysis of the trapezius would be immediate. (Ex. 14-8). He did not know if any further injuries occurred afterwards with attempts to use the arm. Id. He opined that, if there was not a complete nerve injury at the time of the stretching, a series of injuries would be required to take the trapezius from partial paralysis to complete paralysis. (Ex. 14-8-9). He did not consider this to be the type of injury that progressively worsened with everyday activities. (Ex. 14-8). He opined that atrophy of the trapezius muscle after significant paralysis of the nerve would take a month or two to develop. (Ex. 14-9).

Dr. Hartmann based his opinion on: (1) the immediate onset of right shoulder pain, which he considered a crucial element; (2) claimant's history of the traumatic event; and (3) the continuation of symptoms in the right arm and shoulder from the time of the fall until claimant saw him, without letup. (Exs. 12, 14-14-15). He noted that he could not say whether the type of pain caused by the stretching of the accessory nerve would be "an excruciating type of pain or an uncomfortable feeling," but that both types of pain would be consistent with this type of injury. (Ex. 14-18). He opined that, with this type of nerve injury, pain is maximized by attempted lifting of the arm, although he did not know how much spontaneous pain without movement of the shoulder there would be. (Ex. 14-16). He stated that, if claimant had complete paralysis of the trapezius at the time of the incident, she should have had "pain rather shortly on her job with any attempted lifting because of the paralysis." *Id.* He opined that claimant would have symptoms the next day, if raising of the arm and lifting was required. (Ex. 14-21).

Dr. Hartmann explained that claimant's fall from a horse in 1991 could not have caused her current injury because she did not have any appropriate pain in the right arm and she had full range of motion of both shoulders, which would eliminate the possibility of a totally paralyzed trapezius. (Ex. 14-20). He also explained that, if one presumed the 1991 fall caused a paralysis of the trapezius muscle, claimant would have had major problems lifting from that point on and claimant had been able to perform her job "appropriately." (Ex. 14-20).

Finally, Dr. Hartmann disagreed with the opinion of Drs. Cronin and Gancher. He noted that tests performed by Dr. Burchiel, consulting neurologist, ruled out causation from tumors. (Ex. 14-9-10).

The insurer argues that claimant did not display the symptoms that Dr. Hartmann reported that she should have developed immediately after the fall at work, including "right arm paralysis" and pain with any lifting. (Respondent's Brief, page 3). We disagree with the insurer's assessment of Dr. Hartmann's opinion. Dr. Hartmann did not opine that claimant would have right arm paralysis or indicate that claimant would be totally disabled from using her right arm immediately. Instead, he opined that a complete injury to the right accessory nerve would result in immediate pain, paralysis of the trapezius muscle, subsequent atrophy of that muscle, and pain with any lifting. Furthermore, we find that the record supports a finding that claimant had these symptoms following the fall at work.

Claimant reported to the various physicians that she had immediate pain in her right shoulder at the time of the injury, with continuing pain since the injury, and increased pain with lifting. (Exs. 2, 5-1, 6-1, 8-1, -2, 12, 14-4, -5). Claimant generally reported the pain gradually worsened, with the exception of a report to Dr. Burchiel that the pain "stayed the same." (Ex. 13-2). She testified that the right shoulder was painful immediately when she fell but the pain was not that severe initially, although it became progressively worse until she could not raise her arms very well. (Tr. 6, 7, 19, 26). She testified that she had ongoing problems with the right shoulder, although she continued working.

Claimant's testimony regarding the problems with her right shoulder is corroborated by testimony from two co-workers. Ms. Hunter testified that in November 1992 claimant's arm was "dangling" and she was trying to work while she was in pain. (Tr. 71). Ms. Arguello testified that during the January 1993 inventory claimant was in a lot of pain, could not do freight, and "she wasn't lifting * * * she couldn't lift too high up * * * she just had to be within her reach." (Tr. 65).

Furthermore, Dr. Hartmann testified that the pain from the nerve injury would not necessarily be excruciating, it could also be a discomfort type of pain, which would include the aching pain claimant testified about. The important factors in Dr. Hartmann's mind were immediate and ongoing pain with increased pain with lifting. Those are the symptoms claimant displayed.

The insurer argues that the testimony of co-workers established that claimant did not remember the November 1992 fall when she discussed her right shoulder problems with them. We disagree. The fact that claimant failed to relate the cause of her right shoulder problems to the fall at work when discussing these problems with her co-workers does not indicate that claimant forgot the fall at work. Furthermore, we do not find this failure material given the fact that claimant fell at work, reported this fall to her supervisor within hours of its occurrence, and was sufficiently injured to require her leaving work early that day.

Finally, the insurer argues that claimant failed to adequately explain why she did not mention a right shoulder injury on the 801 form or why she reported to various medical providers that she was

injured in December 1992. As to her failure to report a right shoulder injury on the 801 form, claimant testified that she was most concerned about her right knee because she had previously injured it, although the right side of her body also hurt, including her right shoulder. (Tr. 6, 19, 26).

As to claimant's identifying the date of injury as occurring in December 1992 to several medical providers, claimant testified that she could not remember the exact date of the injury when she sought treatment. (Tr. 21). We do not consider this mistake material, since claimant was obviously reporting the November 1992 fall incident. (Exs. 1, 2, 3, 5-1, 6-1, 8-1, 13-1, 14-4, -7-8). In addition, the minor differences in the details of the fall are not material, i.e., whether the customer's actions in causing the fall were purposeful or not. Claimant consistently reported that she tripped and fell at work striking the counter with her left shoulder. *Id.*

Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, there are no persuasive reasons not to defer to Dr. Hartmann's well reasoned opinion. In addition, as discussed above, Dr. Hartmann's opinion is based on an accurate understanding of claimant's injury, as reflected by the record. Thus, based on Dr. Hartmann's opinion, we conclude that claimant established the compensability of her right shoulder injury claim. *See* ORS 656.005(7)(a).

Claimant's attorney is entitled to an assessed 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 fee for claimant's attorney's services at hearing and on review regarding the right shoulder claim is \$3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The Referee's order dated September 14, 1994 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of the right shoulder injury is reversed. The insurer's denial of the right shoulder injury is set aside, and the claim is remanded to the insurer for further processing according to law. For services at hearing and on review, claimant's attorney is awarded \$3,500, payable by the insurer. The remainder of the order is affirmed.

May 25, 1995

Cite as 47 Van Natta 932 (1995)

In the Matter of the Compensation of
PATRICIA E. HERRON-BURBANK, Claimant
 WCB Case No. 94-08578
 ORDER ON REVIEW
 Rasmussen & Henry, Claimant Attorneys
 Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of that portion of Referee Livesley's order that set aside its partial denial of claimant's claim for home health care services following a cervical fusion. On review, the issue is medical services.

We adopt and affirm the Referee's order.¹

¹ The insurer requests that the Referee's order be clarified to distinguish compensable services from noncompensable services. In response, we refer the insurer to our decision in *Robert P. Holloway, Sr.*, 45 Van Natta 2036 (1993). Services requested by claimant's attending physician and expressly intended to assist claimant in her recovery from surgery, such as "assisting [claimant] with personal hygiene, housekeeping, changing bandages, taking medication, use of physical therapy/mobility devices, and transporting claimant to medical appointments . . . are properly considered 'other related' medical services pursuant to ORS 656.245(1)." 45 Van Natta at 2038.

Claimant 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 counsel's services on review is \$1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 10, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the insurer.

May 25, 1995

Cite as 47 Van Natta 933 (1995)

In the Matter of the Compensation of
OATHER MESSER, Claimant
WCB Case No. 93-14785
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Herman's order that upheld the self-insured employer's denials of claimant's occupational disease claims for bilateral carpal tunnel syndrome and right hand tendinitis or synovitis conditions. On review, the issue is compensability.

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

Claimant contends that his diabetes is a predisposition and not a cause of his bilateral wrist condition. A predisposition is a condition of special susceptibility to a disease, not the disease itself. Preston v. Wonder Bread, 96 Or App 613, rev den 308 Or 405 (1989). Whether a preexisting condition represents a cause or a predisposition is a matter of fact. Liberty Northwest v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992).

Here, claimant initially sought treatment for decreased function, numbness and tingling in the left hand. Drs. Keller and Throop each noted claimant's history of left arm symptoms. Dr. Throop also noted that claimant's right wrist symptoms differed from those of the left, in being painful but not tingling. He noted that electrical studies were consistent with diffuse diabetic neuropathy in both arms, with a severe median neuropathy superimposed on the underlying diabetic neuropathy on the left, which might be related to work. Dr. Throop attributed the right arm symptoms to the diabetic neuropathy and was unable to conclude that work activities were the major cause of the median neuropathy. (Exs. A-1, 3 and 8).

Dr. Button noted that, on claimant's nondominant left side, he had paresthesias in the median nerve distribution; and on the dominant right side only minor changes revealed by electrical testing. He diagnosed bilateral carpal tunnel syndrome, severe on the left. Dr. Button opined that claimant's diabetes was the major contributing cause of claimant's bilateral carpal tunnel syndrome, explaining that, since the bulk of claimant's work is performed with the right hand, he would expect the right hand to exhibit a greater carpal tunnel involvement than the left. Dr. Button, like Dr. Throop, indicated that claimant's work activities contributed to claimant's condition, but was not the major contributing cause. (Ex. 7).

On this record, we conclude that claimant's diabetes was the cause of claimant's diabetic neuropathy, which was, in turn, a cause of claimant's symptoms. Thus, we conclude that claimant's diabetes was more than a mere predisposition to the development of carpal tunnel syndrome, and must be taken into account as a causative factor in our analysis. Spurgeon, supra.

We are not persuaded by Dr. Lewis' opinion that claimant's work activities were the major contributing cause of his bilateral carpal tunnel condition. Somers v. SAIF, 77 Or App 259, 263 (1986); Weiland v. SAIF, 64 Or App 610 (1982). Even though Dr. Lewis received detailed information about

claimant's work activities, he failed to explain the medical reasons for his change in opinion. (Compare Exs. 1, 6 and 11). We consequently conclude that claimant has failed to affirmatively prove that his work activities were the major contributing cause of his bilateral arm conditions.

ORDER

The Referee's order dated November 2, 1994 is affirmed.

May 25, 1995

Cite as 47 Van Natta 934 (1995)

In the Matter of the Compensation of
DAVID R. MORITZ, Claimant
 WCB Case No. 94-06762
 ORDER ON REVIEW
 Rasmussen & Henry, Claimant Attorneys
 David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Brazeau's order which: (1) admitted the testimony of an expert witness; and (2) upheld the SAIF Corporation's denial of claimant's injury claim for a seizure disorder. On review, the issues are evidence and compensability.

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

Evidentiary Issue

In its August 4, 1994 supplemental submission of exhibits, SAIF noted on the top of the second page that it "may be calling Robert Stearns as an expert witness." At hearing, SAIF called Mr. Stearns to testify as an accident reconstruction expert. Claimant's counsel initially objected to his testimony for lack of notice pursuant to OAR 438-07-016.¹ (Tr. 29). After verifying that SAIF had provided notice that Mr. Stearns might be called as a witness, claimant's counsel specifically withdrew her objection to Mr. Stearns' testimony. (Tr. 30).

In closing argument, claimant renewed his objection to SAIF's expert witness, arguing that SAIF's "pre-hearing" notice did not comply with OAR 438-07-016. Specifically, claimant asserted that the language "SAIF may be calling" was similar to language specifically prohibited by the rule, *i.e.*, "reserves the right." The Referee rejected claimant's contention, reasoning that the rule did not require a party who has an expert witness to actually call the witness. Moreover, the Referee noted that the "reserves the right" language in the administrative rule only applied to witnesses whose opinion had been included in the documents filed in the case. Inasmuch as Mr. Stearns' opinion had not previously been entered into the record, the Referee determined that SAIF had provided adequate notice of its intent to call Mr. Stearns as a witness.

On review, claimant renews his objection to Mr. Stearns' testimony, citing Gail L. Norris, 46 Van Natta 1450 (1994). In Norris, the employer opposed the deposition of a physician in part because the claimant's Notice of Expert Witness did nothing more than reserve the right to call the physician as an expert witness. The Referee agreed with the employer's contention. The Referee also concluded that the employer would be prejudiced by the deposition, and that the claimant had not shown good cause outweighing the prejudice. Accordingly, the Referee refused to keep the record open for the deposition.

¹ OAR 438-07-016 provides as follows:

"Within the times provided for the initial exchanges of exhibits and indexes under [OAR] 438-07-018, each party shall disclose to all the parties the identity of each expert witness the party will call to testify at the hearing. A statement by a party that the party "reserves the right," or similar language, to call as a witness any expert whose opinion has been included in the documents filed in the case is not compliance with this rule. At the hearing the referee may, in his or her discretion, allow the testimony of expert witnesses not disclosed as required by this rule. In the exercise of this discretion, the referee shall determine whether material prejudice has resulted from the time of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs the prejudice to the other party or parties."

In Norris, we recognized that the claimant's notice was somewhat vague in that it indicated that the claimant might call an expert witness. Nevertheless, we reasoned that the employer failed to timely object to the notice at the beginning of the hearing. Under such circumstances, we concluded that the employer waived any right to later claim surprise or prejudice from the deposition. Accordingly, we held that the Referee should have allowed the deposition, and that his failure to do so was an abuse of discretion.

Here, Norris supports the Referee's ruling. While claimant initially objected to the testimony of Mr. Stearns, he specifically withdrew the objection. Thus, this case is similar to the facts of Norris, where the employer failed to timely object to the expert witness' testimony. Therefore, we conclude the Referee did not abuse his discretion in admitting Mr. Stearns' testimony.

Moreover, given claimant's withdrawal of his objection to Mr. Stearns' testimony at hearing, we consider claimant's contention during closing argument that this testimony was inadmissible to be the same as raising a new issue during closing argument. Accordingly, we will not consider the issue on review. See Larry L. Schutte, 45 Van Natta 2085 (1993) (Board will not consider an issue raised for the first time during closing argument); Accord Leslie Thomas, 44 Van Natta 200 (1992).

Compensability

Claimant contended that his seizure disorder was materially related to a motor vehicle accident on February 10, 1994, in which he sustained a compensable cervical strain. See Albany General Hospital v. Gasperino, 113 Or App 670 (1992). Conceding that the case was "very close," the Referee found that claimant's seizure disorder was not compensable.

In reaching this conclusion, the Referee relied on the medical opinion of an attending neurologist, Dr. Buchholz, who concluded that it was improbable that claimant sustained an injury to the head as a result of the accident. (Exs. 17-2, 29). The Referee noted that, while claimant's family physician, Dr. Cross, and another attending neurologist, Dr. Altrocchi, had related claimant's seizures to the motor vehicle accident, they had based their conclusions on the assumption that claimant had struck his head during the accident. Concluding that there was insufficient evidence that claimant sustained head trauma in the accident, the Referee discounted their opinions.

We agree with the Referee's reasoning in this regard. In addition, we find other weaknesses in Dr. Altrocchi's and Dr. Cross's medical opinions. Specifically, we note Dr. Altrocchi's July 12, 1994 medical report in which he opined that claimant had sustained a "left frontal contusion" during his motor vehicle accident. In the same paragraph, however, Dr. Altrocchi stated that claimant had evidence of a two-inch scalp contusion, citing claimant, his wife and Dr. Cross as providing verification. (Ex. 36-4).

However, our de novo review of the medical records, particularly those contemporaneous with the accident, reveal no evidence of head trauma. (Exs. 6, 9, 10, 16, 17, 21, 29). To the contrary, Dr. Cross reported as a result of his examination on the day of the motor vehicle accident that there was "no evidence of head trauma." (Ex. 10). Although claimant testified that he discovered a painful area on the left side of his head and his wife testified that she observed a "dent" in claimant's scalp, the medical records fail to confirm these reports. Therefore, to the extent that Dr. Altrocchi based his medical opinion on objective evidence of a scalp contusion, we find that he had an inaccurate history. Thus, his medical opinion is less persuasive than that of Dr. Buchholz. See Somers v. SAIF, 77 Or App 259 (1986).

With respect to Dr. Cross, he opined in a "check-the-box" report that trauma caused by claimant's motor vehicle accident was the major contributing cause of claimant's seizure disorder. (Ex. 34-2). In that report, Dr. Cross confirmed that the history of the onset of claimant's seizure, combined with the normal objective testing, supported his belief that the auto accident caused claimant's seizure disorder.

We are not persuaded by Dr. Cross' opinion. First, Dr. Cross is a family physician. 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); Melvin L. Nelson, 46 Van Natta 2416 (1994). Therefore, we find Dr. Buchholz's opinion to be more convincing given his neurological expertise. Moreover, Dr. Cross does not explain why the fact of normal objective testing supports his conclusion

that claimant's seizures are related to the motor vehicle accident, when the opposite conclusion seems more plausible. Inasmuch as Dr. Cross' opinion is not adequately explained, we give it less weight. Somers v. SAIF, *supra*.

While the causation issue is a close one, we agree with the Referee that claimant has failed to sustain his burden of proving that his seizure disorder is materially related to his motor vehicle accident. Accordingly, we affirm.

ORDER

The Referee's order dated October 20, 1994 is affirmed.

May 25, 1995

Cite as 47 Van Natta 936 (1995)

In the Matter of the Compensation of
SANDRA MORRIS, Claimant
WCB Case No. 94-09206
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Howell's order that declined to award claimant an attorney fee under ORS 656.386(1) for her counsel's efforts in obtaining before hearing the rescission of the SAIF Corporation's medical services denial. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant challenges the Referee's refusal to award an attorney fee based on the Referee's conclusion that the only issue raised by SAIF's medical services denial was the amount of compensation. We reverse.

Claimant injured her back, neck and head in 1993 while working for SAIF's insured. SAIF accepted the injuries. (Ex. 3). Claimant subsequently developed headaches, which were attributed to the work injuries. (Exs. 5, 6, 7, 8, 16, 17). SAIF neither accepted nor denied claimant's headache condition. Dr. Andresen, treating physician, prescribed Cardizem CD for the headaches. SAIF paid for the medication.

Meanwhile, claimant continued to use Cardizem CD for her headaches. On August 10, 1994, Dr. Andresen wrote a refill prescription for Cardizem CD. On September 9, 1994, SAIF denied the billing for that prescription on the ground that it was "not related to a compensable condition." (Ex. 14A-2).

Thereafter, claimant obtained a note from Dr. Andresen, stating that the Cardizem CD had been prescribed for claimant's headache condition. (Ex. 16). Claimant's attorney sent a copy of the note to SAIF (*see id.*), and filed a hearing request contesting the medical services denial. SAIF paid the bill shortly thereafter.

Claimant seeks a fee under ORS 656.386(1) for her counsel's efforts in obtaining before hearing the rescission of SAIF's medical services denial. ORS 656.386(1) provides, in part, that "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held, a reasonable attorney fee shall be allowed." That statute applies if the issues raised by a denial are not

confined to the amount of compensation or the extent of disability. SAIF v. Allen, 320 Or 192, 218, 222 (1994). A denial that does not clearly concede the compensability of a claimant's injury or condition is not confined to the amount of disability or extent of compensation. Id. at 217, 218. Therefore, a medical services denial that fails to concede the compensability of a claimant's underlying injury or condition may serve as a basis for an attorney fee award under ORS 656.386(1). Id. at 218, 222.

Here, SAIF's denied medical services related to claimant's headache condition, which condition SAIF has neither expressly accepted nor denied. The medical services denial does not address, much less clearly concede, the compensability of the headache condition. Therefore, the denial is not confined to the amount of disability or extent of compensation and, as such, may serve as a basis for an attorney fee award under ORS 656.386(1). SAIF v. Allen, supra, 320 Or at 218, 222; SAIF v. Williams, 133 Or App 766 (1995).

To determine a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). Claimant's counsel's efforts in obtaining the rescission of SAIF's medical services denial were minimal, consisting of sending a note to SAIF and filing a hearing request regarding the denial. Under the circumstances, we conclude that a \$500 assessed attorney fee is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We have not considered counsel's services rendered subsequent to SAIF's rescission of the medical services denial. Amador Mendez, 44 Van Natta 736, 737 (1992). Further, because attorney fees are not compensation, and because the sole issue on review is attorney fees, we also have not considered counsel's services on review in determining the amount of the assessed fee. Id.

ORDER

The Referee's order dated November 23, 1994 is reversed. For services in obtaining before hearing the rescission of the SAIF Corporation's medical services denial, we award claimant's counsel \$500, payable by SAIF.

May 25, 1995

Cite as 47 Van Natta 937 (1995)

In the Matter of the Compensation of
JUAN A. SALAS, JR., Claimant
WCB Case No. 94-09960
ORDER ON REVIEW
H. Galaviz-Stoller, Claimant Attorney
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Brazeau's order that upheld the self-insured employer's denials of claimant's bilateral hand condition, thoracic strain and upper respiratory infection. On review, the issue is compensability.

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

In a handwritten response to a September 23, 1994 letter from the employer's counsel, Dr. Olson, treating physician, stated that claimant's symptoms, recounted during an earlier office visit, "could reasonably be attributed to his work." (Ex. 3A). Based on the record in this case, which does not include any explanation or analysis of causation, that language establishes, at most, the possibility, not the probability, of a causal relationship between claimant's conditions and his work. Gormley v. SAIF, 52 Or App 1055, 1060 (1981). For this additional reason, we agree with the Referee that claimant has failed to establish the compensability of any of his conditions.

ORDER

The Referee's order dated November 28, 1994 is affirmed.

In the Matter of the Compensation of
MARGARET SCOTT, Claimant
WCB Case No. 94-07763
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Myzak's order that upheld the SAIF Corporation's denial of claimant's right eye injury claim. On review, the issue is whether claimant's injury occurred in the course of and arose out of her employment. We affirm.

FINDINGS OF FACT

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

Claimant injured her right eye when, on her return to work after a break, she pivoted and "smacked" into a pillar in the employer's parking lot. (Tr. 7). The lighting around the pillar was "average." (Tr. 13). Claimant had no trouble seeing the pillar. (Tr. 13, 14).

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the Referee's opinion and conclusions of law, with the following supplementation.

Claimant asserts that her right eye injury arose out of her employment, because the parking lot in which she was injured was poorly lit and, therefore, put her in a position to be injured. See Henderson v. S.D. Deacon Corp., 127 Or App 333, 338 (1994) (elevator that stopped above floor put claimant in position to be injured).¹ We disagree.

There is no evidence that, at the time of injury, the area near the pillar that claimant struck was poorly lit; claimant testified that she had no difficulty seeing the pillar. Rather, the record shows that claimant's injury arose as a result of her actions, *viz.*, pivoting quickly in her hurry to return to work (Tr. 7) and walking abruptly into the pillar. Under the circumstances, we find no evidence that claimant's conditions of employment put her in a position to be injured.

In sum, for the reasons stated in the Referee's order, as supplemented here, we agree that claimant's right eye injury did not arise out of her employment. Accordingly, we affirm the Referee's decision upholding SAIF's denial of that injury.

ORDER

The Referee's order dated October 21, 1994 is affirmed.

¹ We reject claimant's attempt to analogize this case to Ramon M. Marin, 46 Van Natta 1691 (1994) (order on remand). There, we held that the claimant's injuries arose out of his employment when he was struck by a flower box on the employer's parking lot that had been dislodged by a co-employee's automobile. Here, there is no evidence that the pillar had become dislodged and, thereby, become a hazard to claimant.

In the Matter of the Compensation of
BETTY S. TEE, Claimant
WCB Case No. 88-11538
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Gunn.

The self-insured employer requests review of Referee Hoguet's order which granted claimant permanent total disability (PTD) benefits. On review, the issue is PTD.

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

PROCEDURAL HISTORY

This matter was before the Board on remand from the Supreme Court. Tee v. Albertson's, Inc., 314 Or 633 (1992). The Supreme Court modified the Court of Appeals' decision, 107 Or App 638 (1991), which had affirmed our order, 42 Van Natta 540 (1990), that declined to grant claimant PTD because she could perform a telemarketing job and a hotel/motel inspectress job. The Court of Appeals held that a worker who is capable of regularly performing any service for which there exists a hypothetically normal labor market can be gainfully employed and, thus, is not PTD under ORS 656.206(1)(a).

Identifying the salient issue as the definition of the term "gainful occupation," the Supreme Court reasoned that the term relates to earnings a worker can obtain by working at a "suitable occupation." The Court held that the term "gainful occupation" means "profitable remuneration." Inasmuch as we did not have the benefit of the Court's opinion in determining whether claimant's part-time employment was for profitable remuneration and since we are the appropriate fact-finding body, the Court remanded for further consideration concerning whether "both the telemarketing job and the hotel/motel inspectress jobs were gainful and suitable employments for claimant."

On remand, we found that the record concerning whether the jobs in question represent employments for "profitable remuneration" was insufficiently developed for our review. Consequently, we remanded this matter to the Referee for the parties' submission of additional evidence regarding the issue of whether the telemarketing and hotel/motel inspectress jobs constitute employments for profitable remuneration. 45 Van Natta 289 (1993).

On remand before the Referee, the parties stipulated that the hotel/motel inspectress job is no longer at issue and that the sole focus is on the telemarketing job. The parties further stipulated that, as of September 26, 1988 (*i.e.*, claimant's effective PTD date under the Referee's first Opinion and Order), claimant was able to work four to six hours per day and that telemarketing work was available as a suitable occupation. Thus, the parties framed the dispositive issue as whether, as of September 26, 1988, the part-time (four to six hours) telemarketing job constituted employment for profitable remuneration.

Finding that part-time telemarketing work would not provide claimant with profitable remuneration, the Referee concluded that such work was not a gainful occupation. Accordingly, the Referee held that claimant was entitled to PTD benefits. The employer appealed.

CONCLUSIONS OF LAW AND OPINION

The Referee interpreted the term "profitable remuneration" to require a determination of the potential gross wages/income claimant would have earned from part-time employment as a telemarketer, minus any expenditures/costs that claimant would have realized had she accepted the employment in September 1988. The Referee calculated claimant's potential gross wages as a part-time telemarketer as \$109 per week. After subtracting taxes, assessments (*i.e.*, federal and state taxes and workers' compensation and Social Security assessments) and mileage expenses of driving her private car to and from work (a total of 70 miles per day at a rate of 21 cents per mile), the Referee found that claimant would have earned a net income of \$15 per week as a part-time telemarketer in 1988. Reasoning that a profitable remuneration must be sufficient "to pay for the necessities of life and perhaps some recreational/discretionary pursuits and to hopefully save a little bit for future needs," the Referee concluded that an income of \$15 per week was not a reasonable profitable remuneration. The Referee held, therefore, that the part-time telemarketing job was not a gainful occupation and that claimant was PTD.

On review, the employer contends that the Referee erred in interpreting the term "profitable remuneration" to require the application of a "net gain" analysis, that is, gross income minus the expenses of performing the job. The employer argues that "profitable remuneration" means that a worker can regularly earn a portion of his/her income from an occupation. Because claimant can regularly earn a portion of her income as either a hotel/motel inspectress or a telemarketer, the employer maintains that both jobs are gainful occupations and that claimant is not PTD.¹ Alternatively, the employer argues that, if we applied a "net gain" analysis, we should subtract from gross income only those expenses that every employee would realize to accept employment.²

We recently interpreted the Supreme Court's Tee holding and considered the meaning of the term "profitable remuneration." In Fred D. Justice, 47 Van Natta 634 (1995), we held that an occupation is gainful, *i.e.*, represents "profitable remuneration," if the income the worker is capable of earning at that occupation exceeds the expenses that would be incurred in earning that income. Id. at 637. In so holding, we reasoned that the majority of the Tee Court had rejected dissenting Justice Graber's interpretation of "gainful occupation" to mean simply an occupation for which the worker receives a lawful wage. Id. We relied, instead, on the plain and ordinary meaning of "profitable" and "remuneration." Id. Viewing the employment relationship as a "transaction" of services for pay, we concluded that gainful employment requires that, at a minimum, the worker receive pay that exceeds the costs of performing the services necessary to earn that pay. Id. We clarified that the costs/expenses that may be deducted are only those incurred in the "transaction" or job. Id. As examples, we listed such expenses as supplies, transportation, parking and meals. Id. We declined to include personal expenses, such as mortgage or consumer debts, because they are not job-related expenses. Id.

Thus, we have adopted essentially the same "net gain" analysis applied by the Referee in this case, and implicitly rejected the analysis proposed by the employer. For the reasons stated in Justice, we continue to adhere to the "net gain" analysis. Whereas the evidentiary record in Justice was insufficient to prove that the claimant's anticipated job-related expenses would exceed his anticipated income from suitable occupations, the record in this case is more fully developed on that issue.

On review, neither party disputes the Referee's finding that the part-time telemarketing job would have paid claimant gross wages of \$109 per week but that income taxes, assessments and transportation expenses would have reduced her income to \$15 per week. Claimant further urged the Referee to subtract parking fees, estimated to be 75 cents per hour in downtown Portland in 1988 (see tr. 86), as an additional job-related expense; however, the Referee declined to consider that expense, stating that most of the telemarketing jobs were located in East Portland, rather than downtown. For the following reasons, we disagree with this portion of the Referee's opinion.

The record does not establish that most of the telemarketing jobs were located in East Portland in 1988. Ms. French, who had worked as a telemarketer and was called as a witness on remand before the Referee, testified that while working as a telemarketer in East Portland from 1985 through 1988, she had personal contacts with individuals working for all of the other telemarketing firms in East Portland. (Tr. 25-26). She did not indicate that there were more telemarketing firms in East Portland than in the downtown area in 1988. In addition, expert witnesses testified that most of the telemarketing jobs were located in downtown Portland. Ms. Nelson, a vocational rehabilitation counselor who was called as a witness on remand before the Referee, performed a survey of telemarketing jobs advertised in the Portland newspaper in September 1988. (Tr. 66). She testified that "most of the jobs" were located in downtown Portland. (Tr. 96). Ms. Gaffuri, claimant's vocational rehabilitation counselor who performed labor market surveys of telemarketing jobs in 1988 and 1993, testified most of the jobs she

¹ On remand before the Referee, the parties stipulated that part-time hotel/motel inspectress work was no longer an issue because neither party could find such jobs in sufficient quantity to constitute a suitable occupation for claimant. (Tr. 2). Therefore, we shall not consider that occupation in our review.

² On review, claimant requested oral argument. We will not ordinarily entertain oral argument. OAR 438-11-015(2). However, we may allow oral argument where the case presents an issue of first impression which could have a substantial impact on the workers' compensation system. See Jeffrey Trevitts, 46 Van Natta 1767 (1994); Ruben G. Rothe, 44 Van Natta 369 (1992).

Here, through their appellate briefs, the parties have fully addressed the "profitable remuneration" issue before the Board. Inasmuch as the parties' positions regarding this issue has been thoroughly defined and briefed, we are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. See Glen D. Roles, 45 Van Natta 282, 283 n 2 (1993).

surveyed were in downtown Portland. (Tr. 145). Ms. Nelson's and Ms. Gaffuri's testimonies were un rebutted.

Furthermore, both Ms. Nelson and Ms. Gaffuri testified that the cost of parking claimant's vehicle in Portland during work hours would have been a reasonable expense of claimant holding a telemarketing job in 1988. (Tr. 86, 148). Their testimonies are supported by the fact that claimant would have had to commute from her residence in Sandy to the telemarketing jobs in Portland. Thus, we find that the parking fees are expenses attributable to claimant's performance of the proposed telemarketer position. Therefore, contrary to the Referee's conclusion, we hold that parking fees must be deducted from claimant's potential income as a telemarketer.

Ms. Nelson and Mr. Lageman, a vocational consultant who was deposed on remand before the Referee, both estimated that the parking fee in downtown Portland in 1988 was 75 cents per hour. (Ex. 2-26, Tr. 86). Their testimonies were un rebutted. In addition, there was no evidence that parking fees in other areas of Portland would have been lower than in the downtown area. In any event, because most telemarketing jobs were located downtown, we are persuaded that the hourly parking fee for claimant's 1988 proposed telemarketing position was 75 cents per hour. Based on the Referee's undisputed finding that claimant would have probably worked 25 hours per week as a telemarketer, claimant's parking expenses in 1988 would have been over \$18 per week. After subtracting parking expenses from claimant's weekly income of \$15, we conclude that claimant would have realized no income from the part-time telemarketing job in September 1988. Indeed, she would have lost money had she accepted the job.

Accordingly, we conclude that the potential income from the part-time telemarketing job does not represent "profitable remuneration." Because there is no gainful occupation which claimant could regularly perform, we find that she is permanently and totally disabled pursuant to ORS 656.206(1)(a). Therefore, as supplemented and modified herein, we affirm the Referee's conclusions and opinion.

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

ORDER

The Referee's order dated April 15, 1994 is affirmed. Claimant's counsel is awarded an assessed attorney fee of \$1,500, to be paid by the self-insured employer.

Board Member Gunn specially concurring.

I agree with the majority's ultimate conclusion that claimant is entitled to permanent total disability benefits. However, I write separately to repeat my concerns regarding the viability of the "profitable remuneration" standard established in Fred D. Justice, 47 Van Natta 634 (1995).

As expressed in my dissenting opinion in Justice, I have serious reservations concerning a strict application of "expenses" to projected "income" for a "proposed" job. Notwithstanding my misgivings, this particular claimant has successfully met this speculative "Justice" standard. Nevertheless, for the reasons expressed in my dissenting opinion in Justice, I would surmise that this claimant will be in the decided minority of injured workers seeking permanent total disability benefits.

In conclusion, in the absence of the Justice holding, I would find claimant permanently and totally disabled based on the "profitable remuneration" standard explained in my dissenting opinion in Justice. In other words, regardless of whether claimant could establish parking expenses for her proposed job, I would not consider a weekly net income of \$15 to constitute "profitable remuneration" because such projected earnings would not prevent claimant from becoming eligible for public assistance. However, because I am constrained to follow the Justice holding, I join in the majority's decision.

In the Matter of the Compensation of
CHALEUNSAK S. XAYAVETH, Claimant
WCB Case No. 92-10686
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

The insurer requests review of that portion of Referee Baker's order which set aside its partial denial of claimant's degenerative disc disease condition. On review, the issues are the propriety of the insurer's denial and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted August 1990 injury claim for lumbar strain and L4-L5, L5-S1 right-sided disc herniations. In September 1991, claimant had surgery consisting of laminectomies and discectomies. An August 14, 1992 Order on Reconsideration awarded 22 percent unscheduled permanent disability.

In October 1992, Dr. McGirr, claimant's treating physician, reported that claimant had at least two levels of degenerative disc disease in the lumbar spine. Noting that this "illness has progressed," Dr. McGirr concluded that claimant was developing a "syndrome of painful lumbar disc degeneration and instability." Recommending an MRI, Dr. McGirr intended to continue with claimant's physical therapy and work release. (Ex. 43).

An October 1992 MRI showed no significant disc herniations. (Ex. 46-2). On October 23, 1992, noting the MRI "generous" readings of "mild to moderate spinal stenosis at L5-S1 and mild spinal stenosis at L4-5," Dr. McGirr also did not agree that claimant had "very much in the way of spinal stenosis." He thought the MRI looked fairly good considering claimant's previous significant two level disc disease. Expressing hope that further physical therapy would assist claimant in reaching his previous level of physical capacity, Dr. McGirr recommended that he seek a consultation with Dr. Kitchel. (Ex. 49).

On October 27, 1992, the insurer issued a denial of claimant's aggravation claim on the ground that his condition had not worsened.

On November 11, 1992, Dr. Duff, orthopedist, examined claimant at the request of the insurer. Dr. Duff diagnosed multilevel degenerative lumbar disc disease, status post lumbar laminectomy with disc excision at L4-L5 and L5-S1. He found that claimant had experienced an expected waxing and waning of symptoms in September 1992, but that claimant was not experiencing significant nerve root pain to warrant surgery. He did not recommend further diagnostic work-up.

Dr. Kitchel examined claimant in November 1992. Noting that claimant had some degenerative disc disease at the L4-5 level, Dr. Kitchel did not recommend further physical therapy or surgery. (Ex. 53). In December 1992, Dr. McGirr concurred with Dr. Duff's findings. Thereafter, reporting that no further physical or surgical therapy was proposed, Dr. McGirr recommended that claimant remain at his light duty work restriction.

In March 1993, Dr. McGirr responded to questions posed by the insurer's counsel concerning claimant's degenerative disc condition. Dr. McGirr described the MRI as revealing, in addition to changes of a degenerative nature, disc herniations at two levels. He related the acute herniations to claimant's August 1990 injury. However, he concluded that claimant's compensable injury did not cause the degenerative disc disease. Rather, he related the degenerative condition to a chronic process not associated in major part to any one particular incident. (Ex. 57).

On April 1, 1993, the insurer issued a denial of claimant's multilevel degenerative disc disease (DDD) as unrelated to claimant's accepted injury claim or to claimant's work exposure with the employer. Claimant requested a hearing challenging the denial.

The Referee found that since claimant had made no claim for degenerative disc disease, the insurer's denial of that condition was premature. We disagree.

An insurer may issue a "precautionary" denial, in order to avoid the appearance of having accepted an unrelated condition, when it is on notice of a possible claim. Jack Allen, 43 Van Natta 190, 191 (1991); see also Sidney M. Brooks, 38 Van Natta 925 (1986). However, the mere diagnosis of a condition by an examining physician, when no treatment is contemplated, is insufficient to make a claim for that condition. Jack Allen, *supra* (citing Sharon Evans, 42 Van Natta 227 (1990)); Alvin Despain, 40 Van Natta 1823 (1988).

Here, the specific diagnosis identified in the insurer's denial was made by Dr. McGirr, Dr. Duff and Dr. Kitchel. Although further surgery or physical therapy was initially considered, no treatment for the condition was ultimately recommended. Thus, the mere diagnosis alone would not put the insurer on notice of a potential claim.

An insurer may partially deny any condition which it reasonably believes could be a claim. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989). In Warrilow, the employer accepted the claimant's claim for an ankle, neck and shoulder injury. The employer issued a partial denial of the claimant's cervical degenerative condition, although no claim had been filed for that condition. In upholding the denial, the court stated:

"Employer's partial denial protects it from the possibility that the degenerative condition, although perhaps not compensable itself, might later be determined to be encompassed in an acceptance of the claim involving claimant's ankle, neck and left shoulder injury. * * * We know of no reason why an employer should not be permitted to deny the compensability of a condition that it reasonably interprets to be encompassed in a claim and which it believes to be noncompensable." *Id.* at 38.

Cf. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16 (1995) (denial of "then current condition" was set aside as procedurally improper because it was neither specific to a particular condition, nor did it relate to a condition that arguably could have been encompassed in the claim).

Here, as detailed in the above summary of the physicians' reports, the medical evidence could be reasonably interpreted to indicate that claimant's degenerative condition was encompassed in his back injury claim. Claimant underwent surgery to relieve nerve root compression caused by the disc herniations. Following surgery, however, claimant continued to complain of back pain. Dr. McGirr felt that the degenerative disc disease had progressed and that claimant was developing a syndrome of painful lumbar disc degeneration and instability. Dr. McGirr recommended an MRI to determine whether the DDD had progressed to instability. In the interim, he continued to prescribe physical therapy. (Ex. 43). When the MRI eventually showed no recurrent disc herniations nor any true instability, Dr. McGirr had no further medical treatment to offer.

Dr. McGirr subsequently opined that claimant's compensable injury did not cause his DDD, but rather that the degenerative disc condition was a chronic process. He based his opinion on the July 1991 MRI which showed changes of a degenerative nature and the disc herniations. (Ex. 57).

Under these circumstances, we conclude that Dr. McGirr was investigating the degenerative disc condition as a cause of claimant's pain symptoms coincidentally with the treatment of the accepted condition. The above evidence supports a conclusion that the degenerative disc disease condition was being encompassed in claimant's accepted claim. Accordingly, the partial denial of claimant's degenerative disc disease was procedurally appropriate. Weyerhaeuser Co. v. Warrilow, *supra*; see Calvin E. Bigelow, 45 Van Natta 1577 (1993) ("precautionary" partial denial proper where treating physician's report which evoked the denial was generated in the context of treatment for accepted condition); Henry Martin, 43 Van Natta 2561 (1991) (notice of possible claim where treating doctor investigates unrelated condition as possible cause of symptoms during treatment for accepted condition).

On the merits, we find that the medical evidence fails to establish a causal relationship between claimant's degenerative disc disease and his compensable injury. The only medical opinion on causation was rendered by Dr. McGirr, who opined that claimant's degenerative disc disease was not caused by his August 1990 compensable injury. Rather, Dr. McGirr stated that the degenerative condition was a chronic process that had continued, despite surgery, leaving claimant with a spine that was painful and unstable. Based on this record, claimant has failed to prove that his degenerative condition is compensable. Accordingly, the insurer's April 1, 1993 partial denial is reinstated and upheld.

ORDER

The Referee's February 9, 1994 order, as reconsidered on August 10, 1994, is reversed in part and affirmed in part. That portion of the order which set aside the insurer's April 1, 1993 denial, as premature, is reversed. The insurer's April 1, 1993 denial is reinstated and upheld. The remainder of the Referee's order is affirmed.

May 26, 1995

Cite as 47 Van Natta 944 (1995)

In the Matter of the Compensation of
TOR A. ANDERSON, Claimant
WCB Case No. 94-08129
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee Brazeau's order that awarded claimant an assessed attorney fee of \$3,000 following a hearing concerning the employer's denial of claimant's current need for treatment. On review, the issue is attorney fees.

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

The employer argues that the Referee's attorney fee award is excessive because the hearing was short (the hearing transcript was 47 pages), the exhibits were few (15) and the value of the claim was less than \$1,000. Claimant responds that the fee is reasonable based upon, among other things, the value of the interest involved, the benefit secured and the risk that his attorney's efforts might go uncompensated. Claimant argues that the value of the interest involved goes beyond the medical treatment costs incurred during 1994. Specifically, claimant contends that by overturning the denial, he has retained the right to show that future symptoms and need for treatment may be related to his compensable condition.

After considering the parties respective positions and applying the factors set forth in OAR 438-15-010(4), we find that the \$3,000 awarded by the Referee for claimant's counsel's services at hearing is reasonable. In reaching this conclusion, we have particularly considered the value of the interest involved, the benefit secured for the represented party, the time devoted to the case (as represented by the record), and the risk that claimant's counsel may go uncompensated.

Claimant's counsel is not entitled to an assessed attorney fee under ORS 656.382(2) for defending the Referee's attorney fee award. Saxton v. SAIE, 80 Or App 631 (1986).

ORDER

The Referee's order dated October 21, 1994, as reconsidered on December 1, 1994, is affirmed.

In the Matter of the Compensation of
GEANA K. CANNON, Claimant
WCB Case No. 94-08747
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Turner-Christian.

The insurer requests review of those portions of Referee Baker's order that: (1) found that it had "de facto" denied a bilateral upper extremity overuse syndrome condition and a cervical strain condition; and (2) set aside the "de facto" denials. On review, the issue is scope of acceptance and compensability. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In November 1993, claimant sought treatment for shoulder and arm pain; later, claimant also sought treatment for neck pain. In May 1994, the insurer issued a notice accepting left wrist strain and right shoulder strain. In June 1994, the insurer issued an amended notice accepting bilateral carpal tunnel syndrome and "resolved" right shoulder strain.¹

The Referee found that claimant had been diagnosed with upper extremity overuse syndrome and a cervical strain and, because the insurer had not included such conditions in its notice of acceptance, it had "de facto" denied them. Further finding that claimant's work was the major contributing cause of both conditions, the Referee ordered them to be accepted.

The insurer asserts that the medical evidence shows that the conditions ordered to be accepted by the Referee are merely different diagnostic labels for the same injurious episode accepted by the insurer as bilateral carpal tunnel syndrome and right shoulder strain. Thus, according to the insurer, it did not "de facto" deny the upper extremity overuse syndrome and cervical strain conditions.

If the carrier fails to include in its acceptance all conditions that result from the injury, we regard the omitted conditions as having been "de facto" denied. Wesley R. Craddock, 46 Van Natta 713, 714 (194). On the other hand, we do not consider a claim to have been "de facto" denied when a claimant's condition is the same as that accepted by the carrier even though different medical terminology is used to describe the condition. Leslie C. Muto, 46 Van Natta 1685, 1686 (1994); Teresa A. Olson, 46 Van Natta 1765 (1993). In determining whether the condition is the same, we examine whether the claimant sustained separate injuries or there were separate conditions resulting from the compensable injury. Id.

Claimant initially complained of shoulder blade pain and occasional pain in the arms and shoulders; she was diagnosed with rhomboid strain secondary to overuse. (Ex. 1). When claimant saw her treating physician, Dr. Lade, in January 1994, she continued to complain of pain in the right shoulder and numbness in the left hand; the diagnosis was possible carpal tunnel syndrome (CTS) with overuse phenomenon of the right shoulder. (Ex. 3-1).

¹ The Referee found that the inclusion of "resolved" in the Notice of Acceptance constituted an impermissible preclusion denial and ordered the word to be deleted. The insurer does not request review of this portion of the Referee's order. In her brief on review, claimant states that "[t]his unappealed aspect of the referee's order is an independent, additional basis for the assessment of attorney fees."

To the extent that this language suggests that claimant's attorney is entitled to an assessed fee for services on review regarding the "resolved" portion of the Referee's order, we see no merit to such an assertion. Inasmuch as the insurer did not request review concerning this issue, there is no statutory basis for awarding an assessed fee for services on review. See ORS 656.382(2).

In February 1994, following physical therapy, claimant developed neck pain and was diagnosed with a cervical strain. (Ex. 3-2). Following chiropractic treatment, claimant's neck pain essentially resolved but she continued to experience upper back and shoulder pain, as well as hand numbness. (Exs. 3-4, 16-2). After undergoing nerve conduction tests, claimant was diagnosed with bilateral CTS. (Exs. 3-5, 16-3). Claimant continued to experience hand, arm, and shoulder symptoms through the date of the insurer's amended denial. (Exs. 3-6, 18). Consulting physician Dr. Lantz diagnosed bilateral CTS and bilateral upper extremity overuse syndrome. (Ex. 18).

Dr. Lade indicated that claimant's need for treatment, including the cervical condition and "bilateral upper extremity problems," was in major part caused by her work. (Exs. 19, 23). Dr. Lade also concurred with the insurer's attorney's statement that the "various diagnostic labels used by the several practitioners dating back to November 1993 reflect the same industrial injury episode [the insurer] has accepted as bilateral carpal tunnel syndrome and right shoulder strain[.]" (Ex. 24).

We agree with the Referee that the insurer "de facto" denied the cervical condition. Because claimant's neck symptoms developed after she initially sought treatment, we consider the cervical condition to be separate from that which was initially diagnosed and treated. Leslie C. Muto, supra; Teresa A. Olson, supra. In view of the uncontested medical evidence establishing that the cervical condition was caused by claimant's work activities, we also agree with the Referee that claimant proved compensability of such condition.

We reach a different conclusion, however, with regard to the diagnosis of bilateral upper extremity overuse syndrome. The record shows that claimant's arm and shoulder complaints have been fairly constant since she first sought treatment; we find this to be proof that the condition accepted by the insurer is the same as that for which claimant sought treatment and that the diagnosis of "bilateral upper extremity overuse syndrome" merely reflects a different term for the accepted conditions. Therefore, having concluded that "bilateral upper extremity overuse syndrome" is included in the scope of the acceptance, we find no "de facto" denial for this diagnosis.

Inasmuch as our order reverses a portion of the Referee's order, claimant's attorney is not entitled to an assessed fee for services at hearing regarding the bilateral upper extremity overuse syndrome issue. Consequently, the Referee's \$1,500 attorney fee award must be modified. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the cervical condition is \$750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

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

ORDER

The Referee's order dated November 18, 1994 is reversed in part, modified in part, and affirmed in part. That portion of the Referee's order finding that the insurer "de facto" denied a bilateral upper extremity overuse syndrome is reversed. The Referee's \$1,500 assessed attorney fee award is modified to \$750 for services at hearing, to be paid by the insurer. The remainder of the order 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
GLADYS K. KYGAR, Claimant
WCB Case No. 94-10042
ORDER ON REVIEW
Aspell, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Brown's order that increased claimant's award of temporary disability benefits. On review, the issue is temporary disability.

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

The insurer argues that, because claimant's treating physician did not authorize temporary disability benefits, the Referee erred in awarding temporary partial disability benefits from July 6, 1993 through December 5, 1993. We disagree.

Although a claimant's procedural entitlement for any period during an open claim is contingent upon authorization by the attending physician of temporary disability, see OAR 436-30-036(1), there is no such requirement for determining a claimant's substantive entitlement to temporary disability benefits. Rather, a claimant's substantive entitlement to temporary disability accrues on claim closure and is based on a preponderance of the evidence in the entire record that the claimant was at least partially disabled due to the compensable injury while the claim was open. See SAIF v. Taylor, 126 Or App 658 (1994).

On November 18, 1993, examining orthopedist Hunt opined that claimant had a fractured pelvis that required further rehabilitation after July 5, 1993. As noted by the Referee, attending physician Bury concurred with the report, and attending physician Balme did not disagree. We find such evidence shows that claimant was partially disabled in that she could not at that time perform "full work." Under such circumstances, we agree that the preponderance of the evidence showed that claimant was partially disabled between July 6, 1993 through December 5, 1993, and therefore, entitled to temporary partial disability for this period.

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

ORDER

The Referee's order dated December 20, 1994 is affirmed. For services on review, claimant's counsel is awarded an \$800 attorney fee, to be paid by the insurer.

In the Matter of the Compensation of
DENNIS RAUSCHERT, Claimant
WCB Case No. 94-10724
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of that portion of Referee Neal's order which set aside its denial of claimant's right indirect inguinal hernia claim. On review, the issue is compensability.

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

The Referee found that claimant's right inguinal hernia was compensable, reasoning that a lifting incident on or about May 15, 1994 was a material contributing cause of claimant's need for treatment for this condition, including surgical repair. Claimant had a preexisting, asymptomatic congenital defect, a peritoneal sac. The Referee concluded that this defect predisposed claimant to developing a hernia, but did not constitute a "preexisting condition" warranting application of the major contributing cause standard of ORS 656.005(7)(a)(B).

On review, the insurer contends that the Referee erred in not applying the major contributing cause standard of ORS 656.005(7)(a)(B), asserting that the congenital defect is not a predisposing factor to his hernia, but rather a preexisting condition for the purposes of that statute. We disagree.

Claimant's attending surgeon for his hernia condition, Dr. Veillet, concluded that claimant had a "predisposition" to develop a hernia. (Ex. 12). Dr. Gross, a general surgeon who reviewed the medical records, testified regarding the etiology of claimant's hernia and referred to a 1953 medical treatise entitled "Anatomy and Surgery of Hernia," which Dr. Gross testified is still authoritative. The article states that an indirect hernia does not occur in the absence of a "performed peritoneal sac of congenital origin," irrespective of the amount of force or trauma to which the abdomen is subject. (Ex. 14-1). According to the article, the "sac of the peritoneum" is a "congenital predisposing factor," essential to the development of indirect inguinal hernia. Id.

Dr. Gross testified that, in general, a hernia is the "extrusion of an organ beyond the wall of the cavity in which it is contained." (Tr. 34). Specifically, Dr. Gross testified that an indirect hernia goes through the spermatic cord, rather than the cavity wall, as in the case of a "direct" hernia. (Tr. 34). Dr. Gross explained that an indirect hernia will not occur without the congenital defect, which causes an incomplete closure of the lower abdominal wall along the spermatic cord. (Tr. 35).

The insurer contends that Dr. Veillet only operated on claimant to repair the congenital defect, i.e., the opening in the abdominal wall, inasmuch as the operative report indicated that no abdominal contents were outside the abdominal wall. (Tr. 52). The insurer asserts that the congenital defect cannot be a predisposing factor since the opening in the abdominal wall was the condition being treated and the preexisting congenital defect was the major contributing cause of that condition. We disagree.

Dr. Gross's testimony, as well as the aforementioned medical treatise, supports the Referee's finding that claimant's congenital defect is a predisposition rather than a preexisting condition. Dr. Gross testified that claimant's hernia would not have occurred in the absence of the congenital defect and confirmed that the congenital defect was a predispositional requirement for an indirect hernia. (Trs. 35, 47). Dr. Gross specifically referred to the portions of the medical treatise that described the congenital defect as a predisposition to an indirect inguinal hernia. (Tr. 35).

Based on the medical explanations in the record, we conclude that the congenital perineal sac was a predisposition, a special susceptibility to an indirect inguinal hernia, but not a disease or pathological condition itself. See Rodney T. Buckallew, 44 Van Natta 358, 360 (1992), aff'd Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993); Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991). Accordingly, we conclude that the congenital defect is not a

preexisting disease or condition within the meaning of ORS 656.005(7)(a)(B). Therefore, we agree with the Referee's application of a material contributing cause standard. See John E. Perkins, 44 Van Natta 1020, 1021 (1992) (where medical evidence indicated that preexisting vasectomy was a predisposition, not a preexisting condition, ORS 656.005(7)(a)(B) not applicable; injury claim for congestive epididymitis condition found compensable under material causation standard).

Applying this standard, we conclude, as did the Referee, that claimant has sustained his burden of proving that the lifting incident at work was a material contributing cause of his need for medical treatment. Dr. Veillet attributed claimant's need for medical treatment for his hernia to the lifting incident in May 1994. (Exs. 11, 12). Dr. Gross also opined that the lifting incident contributed to claimant's need for medical treatment. (Trs. 58, 59).

Although the insurer contends that Dr. Veillet's treatment was directed toward repairing the congenital defect, Dr. Gross testified that he would not treat claimant for an indirect hernia in the absence of an extrusion such as claimant experienced and that claimant properly sought treatment once he became aware of the hernia. (Trs. 55, 58). Although neither physician expressly stated that the lifting incident was a material contributing cause of claimant's need for medical treatment, we find that, viewing the medical evidence as a whole, that standard of proof is satisfied by the medical evidence in this case. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986) (use of "magic words" not necessary to establish medical causation).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$1,250, 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 and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 13, 1994 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of \$1,250, payable by the insurer.

May 30, 1995

Cite as 47 Van Natta 949 (1995)

In the Matter of the Compensation of
ELMER F. KNAUSS, Claimant
 WCB Case No. 94-02325
 ORDER ON RECONSIDERATION
 Emmons, Kropp, et al., Claimant Attorneys
 Michael Fetrow (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 3, 1995 order that affirmed a Referee's order awarding claimant a total of 49 percent (156.8 degrees) unscheduled permanent disability for a cardiovascular condition. Specifically, SAIF challenges our reasoning that, for administrative efficiency, we would give precedential effect to prior referee and Board orders even if those litigation orders remained on appeal. Contending that our reliance on Michael S. Barlow, 46 Van Natta 1627 (1994), is inconsistent with language contained in Connie M. Johnson, 47 Van Natta 429 (1995), SAIF seeks clarification of our decision.

We disagree with SAIF's assertion that the aforementioned holdings are in conflict. In Johnson, we determined that the doctrine of res judicata was not applicable to a surgery claim because an earlier order finding claimant's initial claim to be compensable was not final. Our specific holding in Barlow is consistent with the Johnson rationale.¹ Relying on Drews v. EBI Companies, 310 Or 134, 140 (1990), we

¹ The Barlow decision does contain a statement that the prior non-final litigation order was "final for purposes of res judicata." Michael S. Barlow, supra, 46 Van Natta at page 1628. Nevertheless, the specific rationale expressed in Barlow recognizes that the prior litigation order is not final, but holds "for reasons of administrative efficiency, we conclude that it was appropriate for [the Referee] to give precedential effect to [the earlier referee's] order." Michael S. Barlow, supra. Thus, both the Barlow and Johnson holdings support the principle that res judicata is not applicable if a prior adjudication order is not final.

recognized that claim preclusion attached only if a prior adjudication order was final. Nonetheless, despite the fact that the prior adjudication of the initial claim was not final due to a party's appeal, we concluded that, for administrative efficiency, it was appropriate to give precedential effect to the prior litigation order.

Our initial decision is consistent with both the Johnson and Barlow holdings. In accordance with the aforementioned decisions, our prior order was not based on the doctrine of res judicata. In other words, because the previous Board order was not final, SAIF was not precluded from litigating the compensability of claimant's cardiovascular condition. Nevertheless, consistent with the Barlow rationale (and also not inconsistent with the Johnson statement regarding the inapplicability of the res judicata doctrine), we determined that, for purposes of administrative efficiency, we would give precedential effect to the prior litigation order. Among other reasons, we continue to believe that such an approach avoids the potential of multiple, inconsistent rulings.

In conclusion, as explained above, our prior reasoning is not contrary to the rationale contained in Johnson. Consequently, in accordance with the Barlow holding, we continue to give precedential effect to the prior non-final litigation order.

Accordingly, we withdraw our May 1, 1995 order. On reconsideration, as supplemented herein, we republish our May 1, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 31, 1995

Cite as 47 Van Natta 950 (1995)

In the Matter of the Compensation of
VIDALIA GARAY, Claimant
WCB Case No. 94-01352
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Brown's order that upheld the insurer's denial of claimant's fibromyalgia. The insurer cross-requests review of those portions of the Referee's order that: (1) affirmed an Order on Reconsideration reclassifying claimant's low back injury claim as disabling; and (2) assessed a penalty for the insurer's allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are compensability, claim classification 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

Compensability

Claimant asserts that the Referee erred in concluding that she failed to establish the compensability of her fibromyalgia. We disagree.

Claimant worked for the employer packing pears into boxes. She sustained a low back injury on October 5, 1992 when she was hit in the back by a cart that was pushed by a co-worker. The employer accepted a nondisabling low back strain. (Ex. 3).

Claimant was released to light duty work, with a 10- to 15-pound lifting restriction. (Exs. 2A, 4, 6, 7, 8, 10). In February 1993, Dr. Wedlake, who had become claimant's treating physician, diagnosed fibromyalgia (Exs. 11A-2), and limited claimant's activities to no lifting or prolonged sitting or standing. (Ex. 12). In her light duty position, claimant performed various work activities, including putting paper pads on boxes, preparing gift packs, and painting and cleaning carts and paper racks. (Tr. 29-30).

In March 1993, Dr. Dickerman examined claimant on the insurer's behalf. He diagnosed thoraco-lumbar area contusion and significant overlay and discrepant examination. (Ex. 13-8). Dr. Wedlake concurred with Dr. Dickerman's report. (Ex. 14). Claimant was laid off from her modified position on March 29, 1993.

A December 2, 1993 Determination Order directed that claimant's accepted injury claim remain classified as nondisabling. (Ex. 22). A December 28, 1993 Order on Reconsideration directed the insurer to reclassify the claim as disabling. (Ex. 25).

In May 1994, Drs. Potter and Rich examined claimant on the insurer's behalf. They concluded that claimant did not have fibromyalgia. (Ex. 27-4, -5). Dr. Potter adhered to that conclusion in deposition. (Ex. 29A-4, -35). On June 20, 1994, Dr. Wedlake signed a concurrence report agreeing with Drs. Potter's and Rich's report. (Ex. 28). The same day, however, Wedlake stated in a chart note that claimant had fibromyalgia, based on her continuing pain. (Exs. 25A-2, 29).

In deposition, Dr. Wedlake agreed that the major contributing cause of claimant's fibromyalgia was probably her accepted work injury. (Ex. 31-31). However, he also stated, "I have no idea why [claimant is] still having pain this far out from a minor injury. I don't know." (*Id.* at 10). He thought that claimant's fibromyalgia was related to her low back injury. (*Id.* at 11). When asked how claimant's fibromyalgia could have resulted from being "bumped on the rear," Wedlake responded, "I can't be sure of anything. I didn't examine her before the injury." (*Id.* at 25). Finally, he stated, alternatively, that it was conceivable, possible and/or probable that claimant's fibromyalgia was work-related. (*Id.* at 30).

We generally give great weight to the reports of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

We find persuasive reasons not to rely on Dr. Wedlake's reports. First, Dr. Wedlake does not explain why he first agreed with the examining physician's reports, and then agreed that there was a major causal connection between claimant's work injury and her fibromyalgia. See *Moe v. Ceiling Systems*, 44 Or App 429 (1980) (court discounts medical report based on unexplained change of opinion). Second, Dr. Wedlake admitted in deposition that he did not know why claimant continued to have pain long after a relatively minor work injury. Finally, Wedlake stated that it was conceivable, possible and/or probable that there was a causal link between claimant's fibromyalgia and her work injury. We find those statements inconsistent and, as a whole, insufficient to meet the medical probability standard. See *Gormley v. SAIF*, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet claimant's burden of proof).

In sum, we find Dr. Wedlake's opinions inconsistent and, therefore, neither persuasive nor well-reasoned. Consequently, we afford them minimal weight. Because they are the only opinions that even arguably support claimant's claim, we conclude that there has been a failure of proof. The Referee correctly upheld the insurer's denial of claimant's fibromyalgia claim.

Claim Classification

The insurer asserts that the Referee erred in affirming an Order on Reconsideration directing it to reclassify claimant's claim as disabling. We disagree.

When a claimant is released to modified work following a compensable injury, he or she is temporarily and partially disabled, and the injury claim is properly classified as disabling. See *Sharman R. Crowell*, 46 Van Natta 1728 (1994). Here, after she injured her low back, claimant was released to light duty; therefore, she was temporarily and partially disabled and her claim should have been classified as disabling. Because the December 28, 1993 Order on Reconsideration properly ordered the reclassification of claimant's claim as disabling, we affirm the Referee's order.

The insurer asserts that there is insufficient evidence that claimant was released to light or modified work following her low back injury. We disagree. The medical and testimonial evidence establishes that, before her injury, claimant performed strenuous, repetitive piece work (packing pears into boxes) that required her to stand most of the day. Following her injury, she was restricted from

most lifting, and prolonged sitting or standing; moreover, she actually performed lighter work, such as putting paper pads on boxes, preparing gift packs, painting and cleaning carts and paper racks, and other odd jobs. We find that evidence sufficient to establish that claimant performed light or modified work following her low back injury.

Penalties

Contending that it properly classified claimant's injury claim as nondisabling, the insurer asserts that its failure to pay temporary disability after March 30, 1993 (the day after claimant was laid-off) was not unreasonable. We agree that the insurer's failure to pay temporary disability was not unreasonable, but offer the following analysis.

In October 1992, the insurer accepted a nondisabling low back strain. (Ex. 3). As we concluded earlier, in view of claimant's release to modified employment following her work injury, that claim should have been classified as disabling. That conclusion is based on Sharman R. Crowell, supra, which issued after the insurer was directed to reclassify the claim as disabling.

In Sharman R. Crowell, supra, after suffering a compensable injury, the claimant was released to light duty work at her regular wage. The carrier accepted the claim as nondisabling. After a hearing, a referee determined that the claim should have been classified as disabling. On review, the carrier argued that under OAR 436-30-045(5)(a) and (d), which provide that a claim is "disabling" if temporary disability compensation is "due and payable," or if the worker is released to and doing a modified job at reduced wages from the job at injury, the claimant was not entitled to reclassification because she had returned to modified work at her regular wage and, therefore, she had failed to prove that temporary disability was "due and payable."

We disagreed, noting that, under Stone v. Whittier Wood Products, 124 Or App 117 (1993), temporary partial disability (TPD) is measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. Because OAR 436-30-045(5)(a) and (d) equate disability with reduction in post-injury wages, we found the rules inconsistent with Stone and declined to give them any effect. Id. at 1728. Instead, relying on cases establishing that, although a claimant is released to modified work at or above his or her regular wage, a claimant is temporarily and partially disabled, although the actual TPD rate may be zero, we concluded that the claimant's claim was disabling. Id. at 1729.

Here, the insurer reasonably relied on OAR 436-30-045(5)(a) and (d) as justification for its decision to classify claimant's claim as nondisabling. Because our holding in Crowell, which declined to give effect to those rules, did not issue until after the insurer was directed to reclassify the claim as disabling, we conclude that the employer's "pre-Crowell" claim misclassification was not unreasonable. See Joseph M. Lewis, 47 Van Natta 616 (1995) (order on reconsideration) (carrier's "pre-Crowell" claim misclassification held not unreasonable); see also Marie E. Kendall, 47 Van Natta 335 (1995) (order on reconsideration) (carrier's conduct held reasonable where case law at the time supported propriety of that conduct). Consequently, we reverse the Referee's penalty award.

Claimant's counsel is entitled to an assessed fee for services on review concerning the claim classification 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 that issue is \$750, to be paid by the insurer. In reaching this conclusion, we have 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. We have not considered counsel's services regarding the penalty issue. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The Referee's order dated October 24, 1994 is affirmed in part and reversed in part. The Referee's penalty award is reversed. The remainder of the Referee's order is affirmed. For services on review concerning the claim classification issue, claimant's counsel is awarded \$750, to be paid by the insurer.

In the Matter of the Compensation of
MARY D. GULLICKSON, Claimant
WCB Case Nos. 94-07892 & 94-05100
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of that portion of Referee Black's order that set aside its denial of claimant's occupational disease claim for a left shoulder condition. Claimant cross-requests review of that portion of the order that upheld the employer's denial of claimant's right shoulder condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Right Shoulder Condition

We adopt the Referee's reasoning and conclusion concerning claimant's right shoulder condition.

Left Shoulder Condition

The Referee concluded that claimant's left shoulder condition was due in major part to work activities. Claimant agrees with the Referee, but asserts that the material contributing cause standard applies because her left shoulder claim arises as a primary effect of employment. We disagree.

The "801 form" signed by claimant on April 4, 1994 referred to the "date of injury or occupational disease" as February 18, 1994. (Ex. 19). On the form, claimant stated that she told the employer that she was hurt when she went home on the 18th and she described "overuse," "bakery work," and "lifting, pulling, pushing." (Id.)

Claimant testified that she started having left shoulder problems when the doctor placed her on restricted work for her right shoulder.¹ (Tr. 15). Dr. Fletchall first reported a work restriction on November 4, 1993. (Ex. 4). The record contains no evidence of a specific injury to claimant's left shoulder and it does not identify a discrete period of employment which prompted her complaints. Rather, the medical records indicate that claimant's left shoulder condition was gradual in onset. Therefore, we analyze the condition as an occupational disease. See Valtinson v. SAIF, 56 Or App 184 (1982). To prove compensability of an occupational disease, claimant must show that her work exposure is the major contributing cause of the left shoulder condition or its worsening. See ORS 656.802(2).

Claimant relies on the opinion of Dr. Fletchall. On April 5, 1994, Dr. Fletchall reported that "in connection with her work at [the employer] claimant has begun to have symptoms in the left shoulder. This has been going on for about two months." (Ex. 4). Dr. Fletchall diagnosed left shoulder impingement syndrome and authorized limited duty for two weeks. (Id.; ex. 20). On April 19, 1994, Dr. Fletchall reported that claimant's left shoulder was "no longer a problem to her as long as she doesn't do much with it." (Ex. 4).

In a report summarizing a conversation with the employer, Dr. Fletchall agreed that "the left shoulder condition was caused in major part by overuse due to the inability to use the right shoulder." (Ex. 28). Dr. Fletchall based his opinion on the history given to him by claimant.

¹ We note that claimant's left shoulder condition cannot be based on a "consequential condition" theory because her right shoulder condition is not compensable. See ORS 656.005(7)(a)(A).

We are not persuaded that Dr. Fletchall had an accurate history of claimant's work activities. Although Dr. Fletchall authorized light duty on April 5, 1994 and reported that claimant was having left shoulder symptoms in connection with her work, there is no indication that Dr. Fletchall was aware that claimant was no longer working for the employer at that time. Claimant testified that she left work on February 18, 1994 because of her shoulders and had not returned to work. (Tr. 40-41). Inasmuch as Dr. Fletchall's opinion was based on an inaccurate work history, we do not find his opinion persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977).

The remaining medical opinions on causation do not support compensability of claimant's left shoulder occupational disease claim. Although Dr. Davis treated claimant, he was not clear as to claimant's left shoulder complaints and did not have any comments. (Ex. 23). Dr. Farris acknowledged that it was "possible" that claimant's work activities contributed to her left shoulder condition, but he said that claimant's activities of daily living also contributed. (Ex. 27). Dr. Farris was unable to conclude that work activities were the major contributing cause of claimant's left shoulder condition.

In sum, we conclude that claimant has failed to establish the compensability of her left shoulder condition. Accordingly, we reverse the Referee's decision setting aside the employer's denial of that condition.

ORDER

The Referee's order dated October 25, 1994 is reversed in part and affirmed in part. That portion of the Referee's order setting aside the self-insured employer's denial of claimant's left shoulder condition is reversed. The employer's denial is reinstated and upheld in its entirety. The Referee's attorney fee award is reversed. The remainder of the Referee's order is affirmed.

May 31, 1995

Cite as 47 Van Natta 954 (1995)

In the Matter of the Compensation of
DAVID SMITH HENRE, Claimant
 WCB Case No. C5-01160
 ORDER APPROVING CLAIM DISPOSITION AGREEMENT
 Hollander & Lebenbaum, Claimant Attorneys
 Safeco Insurance Co., Insurance Carrier

Reviewed by Board Members Neidig and Gunn

On April 28, 1995, the Board acknowledged receipt of the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

Here, the CDA contains signature lines for claimant, counsel for claimant, and the insurer's claims examiner. There is no signature line for counsel for the insurer, and no attorney has signed the CDA on the insurer's behalf.

ORS 656.236 provides that the "parties" to a claim, by agreement, may make such disposition of any or all matters regarding a claim. Additionally, a CDA must contain signature lines for all the "parties" to the agreement. DCBS Bulletin No. 217 (May 16, 1991).

Furthermore, ORS 9.230 provides, in part, that:

"Any action, suit or proceeding may be prosecuted or defended by a party in person, or by attorney, except that the state or a corporation appears by attorney in all cases, unless otherwise specifically provided by law." (Emphasis supplied).

We recently considered the application of ORS 9.230 to a CDA. Allen Ehr, 47 Van Natta 870 (1995). We reasoned that, whereas a contested case "hearing" is a proceeding, and the concern over

representation arises where the layperson is participating in activities such as cross-examining witnesses and making evidentiary objections, a CDA which has been submitted to the Board for approval does not constitute a hearing and is not an "action, suit or proceeding" requiring attorney representation. Thus, we held that, because the CDA did not involve a "proceeding" as contemplated by ORS 9.230, an attorney for the corporate insurer was not required to sign the proposed agreement.

No attorney for the corporation (the insurer) has signed this CDA. However, based on Ehr, we conclude that it is also unnecessary for an attorney for the corporate insurer to sign the CDA in this case. See Allen Ehr, supra.

Accordingly, we conclude that the CDA in this case is in accordance with the terms and conditions prescribed by the Director, and is not unreasonable as a matter of law. See ORS 656.236(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of \$1,000, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

May 31, 1995

Cite as 47 Van Natta 955 (1995)

In the Matter of the Compensation of
WAYNE A. MOLTRUM, Claimant
WCB Case Nos. 93-05804 & 93-05805
ORDER ON REVIEW

Royce, Swanson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Davis' order that: (1) declined to reinstate claimant's request for hearing as to Liberty Northwest Insurance Corporation's denial of his head injury claim; and (2) dismissed as untimely claimant's hearing request concerning the SAIF Corporation's denial of the same condition. On review, the issues are voluntary dismissal and timeliness of the hearing request.

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

Claimant suffered head injuries on June 27, 1989, when he fell from a ladder while installing a shade on a skylight. Rodda Paint Company (Rodda) had contracted with Paramount Interiors (Paramount) to perform the work. Paramount, in turn, had assigned the job to claimant.

After claimant filed a claim, Paramount took the position that claimant was an independent contractor. In May 1990, claimant's attorney asked the Department of Insurance and Finance (DIF) to investigate whether Paramount was a noncomplying employer. (Ex. 2). After conducting an investigation, DIF referred the claim to SAIF for processing. (Ex. 4). See former OAR 438-80-060(2) (WCD Admin. Order 4-1989). On July 18, 1990, SAIF issued a denial, stating that it had been instructed to deny the claim by DIF on the basis that claimant was not a subject employee. (Ex. 5).

In a November 9, 1992 Opinion and Order, Referee Hazelett found that an employee-employer relationship existed between claimant and Paramount, and he set aside SAIF's July 18, 1990 denial. (Ex. 6). On November 25, 1992, DIF issued a Proposed and Final Order, finding that Paramount was a noncomplying employer at the time of claimant's injury. (Ex. 9). On the same date, DIF sent claimant's claim to Liberty Northwest Insurance Corporation, insurer for Rodda, for processing. (Ex. 7). DIF also sent the claim to SAIF for issuance of a denial on the ground that Rodda was responsible for providing workers' compensation coverage in accordance with ORS 656.029. (Ex. 8).

On December 4, 1992, SAIF sent claimant a Notice of Claim Acceptance. (Ex. 11). On December 7, 1992, Referee Hazelett abated the November 9, 1992 Opinion and Order to consider Paramount's motion for reconsideration. (Ex. 12). On December 8, 1992, SAIF issued a denial, which provided, in part:

"SAIF Corporation has been instructed to deny your claim by the Department of Insurance and Finance on the basis that Rodda Paint Company, Inc. is responsible for providing workers' compensation coverage in accordance with ORS 656.029. [DIF] has submitted your claim to Liberty Northwest Insurance Corp. for processing pursuant to the Opinion and Order #90-14909 dated November 9, 1992." (Ex. 13).

On December 10, 1992, Liberty denied compensability of the claim on the basis that claimant was a non-subject worker. (Ex. 15). Liberty also issued a disclaimer of responsibility, stating that Paramount was responsible for claimant's injuries.

On December 28, 1992, Referee Hazelett issued an Order on Reconsideration that republished the November 9, 1992 Opinion and Order. (Ex. 18).

Claimant's requests for hearing on SAIF's December 8, 1992 denial and on Liberty's December 10, 1992 denial were received by the Hearings Division on May 17, 1993. (Ex. 23 and 23A). Amended requests for hearing were received on May 21, 1993. Both SAIF and Liberty sought dismissal of claimant's hearing requests on the ground that they were untimely. Referee Davis dismissed both requests for hearing.

Claimant's Request for Hearing on SAIF's December 8, 1992 Denial

In light of SAIF's December 4, 1992 acceptance of the claim, the Referee found that SAIF would have to meet the standard of proof prescribed in ORS 656.262(6) in order to prevail on its December 8, 1992 denial. See SAIF v. Mize, 129 Or App 636 (1994) (since the carrier had officially notified the claimant of the acceptance, it could not subsequently deny compensability without complying with ORS 656.262(6)). However, since claimant did not timely appeal the denial and the Referee found no good cause for claimant's failure to appeal SAIF's denial within 60 days, the Referee dismissed claimant's hearing request.

Claimant argues that SAIF's December 8, 1992 letter was a "backup" denial, which was invalid as a matter of law. Relying on Darwin G. Widmar, 46 Van Natta 1018 (1994), aff'd mem Alexis Risk Management v. Liberty Northwest Insurance Corporation, 134 Or App 414 (1995), claimant argues that SAIF had not been designated a "paying agent" under ORS 656.307 and, therefore, ORS 656.262(6) is not applicable and the "backup" denial was invalid. According to claimant, since SAIF's denial was invalid, his request for hearing was unnecessary and SAIF's December 4, 1992 acceptance should be reinstated. We disagree.

In Darwin G. Widmar, supra, we said that ORS 656.262(6) specifically allows "back-up" denials to the extent such denials are issued by a "paying agent." Citing OAR 436-60-180, we stated that "paying agents are appointed pursuant to ORS 656.307." 46 Van Natta at 1019. Since no paying agent had been appointed in Widmar, and since the carrier was not challenging the compensability of the claimant's claim, we held that ORS 656.262(6) was not applicable. Alternatively, we addressed the merits of the "backup" denial issue and concluded that the carrier did not establish by "clear and convincing" evidence that it was not responsible for payment of benefits.

After we decided Darwin G. Widmar, supra, the Court of Appeals issued SAIF v. Shaffer, 129 Or App 289 (1994). In Shaffer, the issue was whether ORS 656.262(6) applied to the carrier's denial. Relying on ORS 656.307(1) and the legislative history of the 1990 amendments to ORS 656.262(6), the court held that ORS 656.262(6) encompassed backup denials based on lack of coverage. In the court's analysis, it noted that no statute expressly defines "paying agent" for purposes of ORS 656.262(6). 129 Or App at 292 n.2. However, the court found the definition of "paying agency" in ORS 656.576 to be instructive. 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."

The administrative rules provide a similar definition. OAR 436-60-005(22) (WCD Admin. Order 1-1992) defines "paying agent" as "the insurer responsible for paying compensation for a compensable injury."

In light of SAIF v. Shaffer, *supra*, and OAR 436-60-005(22), we conclude that ORS 656.262(6) does not require that a "paying agent" has to be appointed pursuant to ORS 656.307 in order for ORS 656.262(6) to apply to the denial.¹ As the Shaffer court noted, no statute expressly defines "paying agent" for purposes of ORS 656.262(6). The language of ORS 656.262(6) does not provide that a "paying agent" has to be appointed pursuant to ORS 656.307. Moreover, OAR 436-60-005(22), which defines "paying agent," does not require that a paying agent be designated pursuant to ORS 656.307.

We reject claimant's argument that SAIF's December 8, 1992 "backup denial" was invalid as a matter of law because SAIF had not been designated a "paying agent" under ORS 656.307. Under ORS 656.054, SAIF is the "paying agent" in all claims involving noncomplying employers. SAIF's December 8, 1992 denial was issued because DIF had instructed SAIF to deny the claim on the basis that Rodda was responsible under ORS 656.029. (Ex. 13). Thus, at the time of its denial, SAIF had "evidence that the paying agent is not responsible for the claim" under ORS 656.262(6). SAIF's December 8, 1992 denial was not invalid because SAIF had not been designated a "paying agent" under ORS 656.307.

In Knapp v. Weyerhaeuser Co., 93 Or App 670 (1988), *rev den* 307 Or 326 (1989), the employer issued a "back-up denial" of the claimant's occupational disease claim after a Referee had set aside the employer's prior denial of the claim. The employer based its "backup denial" on information obtained subsequent to the prior litigation. When the claimant's hearing request from the "backup denial" was filed more than 60 days after the denial, the employer moved for dismissal of the hearing request.

The Knapp court held that the employer's denial had no basis in law and, therefore, the claimant was not required to comply with the filing restrictions of ORS 656.319(1)(a). The court reasoned that the employer had once denied the claim and had the opportunity to litigate the denial on its merits and it could not do so again.

Here, in contrast, SAIF has not had an opportunity to litigate the denial of claimant's head injury claim on the merits. Although there was prior litigation on the subjectivity issue (whether claimant was a subject worker or independent contractor), the Referee did not order SAIF to process or accept the claim in that proceeding. Under these circumstances, SAIF could issue a "backup denial." Consequently, in order to contest the denial, claimant had to timely request a hearing.²

Claimant also contends that SAIF's December 8, 1992 denial was void because SAIF did not comply with the disclaimer of responsibility requirements under ORS 656.308(2). According to claimant, SAIF had knowledge of the claim by July 18, 1990, when it issued the first denial. Claimant argues that SAIF's December 8, 1992 denial was more than 2 years late.

In Joyce A. Crump, 47 Van Natta 466 (1995), we held that the application of ORS 656.308(2) is contingent on finding a claim compensable. Inasmuch as claimant has not established compensability of his claim, we do not address whether SAIF was required to comply with the disclaimer of responsibility requirements under ORS 656.308(2) when it issued its July 18, 1990 denial. See Joyce A. Crump, *supra*.

Claimant's request for hearing on SAIF's denial was received by the Board on May 17, 1993 and was filed more than 60 days but within 180 days after claimant's receipt of the denial. Claimant argues that he has established good cause for the late filing of his hearing request. We disagree.

¹ In Darwin G. Widmar, *supra*, the Board reached three alternative holdings. The Board found that since no paying agent had been appointed under ORS 656.307, ORS 656.262(6) was not applicable. The Board alternatively concluded that the carrier did not base the "backup" denial on "later obtained evidence" under ORS 656.262(6). The Board also addressed the merits of the "backup" denial issue and concluded that the carrier did not establish by "clear and convincing" evidence that it was not responsible for payment of benefits. The Court of Appeals has affirmed our Widmar decision without opinion. Alexis Risk Management v. Liberty Northwest Ins. Corp., 134 Or App 414 (1995). The court's affirmance could have been based on any of the Board's alternative holdings. See Ruby L. Goodman, 46 Van Natta 810, 812 n.3 (1994). Therefore, we do not interpret the court's affirmance with Widmar as necessarily inconsistent with our conclusion in this case that ORS 656.262(6) does not require that a "paying agent" must be appointed pursuant to ORS 656.307 in order for ORS 656.262(6) to apply to the denial. This reasoning is further supported by the court's holding in Shaffer.

² Claimant also argues that SAIF's December 8, 1992 denial was invalid because it was not based on "later obtained evidence." We agree with SAIF that the merits of the denial can only be decided if claimant's request for hearing is found to be timely.

A request for a hearing must be filed not later than the 60th day after claimant is notified of a denial of the claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B or former ORS 18.160. Hempel v. SAIF, 100 Or App 68 (1990).

Claimant argues that his former attorney did not file a timely request for hearing on the December 8, 1992 denial because he mistakenly believed that SAIF had already been ordered to accept the claim. Claimant asserts that his former attorney's interpretation was not unreasonable under the confusing circumstances of this case.

In previous cases, we have held that confusion about the status of a claim does not constitute "good cause." See Joan C. Gillander, 47 Van Natta 391 (1995) (the claimant's belief, due to the receipt of temporary disability benefits, that her Washington claim had been accepted did not constitute good cause for her failure to timely request a hearing on the Oregon carrier's denial); Mary M. Schultz, 45 Van Natta 393, on recon 45 Van Natta 571 (1993) (receipt of interim compensation and any confusion created by that action did not constitute good cause).

Even if we assume, without deciding, that the actions of claimant's former attorney were negligent, the negligence of an attorney is not excusable neglect unless the attorney's reason for his action would be excusable had it been attributed to claimant. Sekermestrovich v. SAIF, 280 Or 723 (1977); see also Mendoza v. SAIF, 123 Or App 349 (1993) (neglect of an attorney's employee, who was responsible for filing the hearing request, was not excusable neglect), rev den 318 Or 326 (1994).

Here, the reason for the former attorney's failure to timely request a hearing on SAIF's denial was because he mistakenly believed that SAIF had already been ordered to accept the claim. Such a reason would not constitute excusable neglect if attributed to claimant. See Agatha K. Bohm, 42 Van Natta 2859 (1990) (the claimant's attorney failure to file the request for hearing because he thought the denial was issued by mistake and was invalid could not be held to be excusable neglect if it were done by claimant herself), aff'd mem 108 Or App 191 (1991); Beth M. Murdock, 42 Van Natta 580 (1990). Consequently, we affirm the Referee's determination that claimant failed to establish good cause for her failure to file a timely hearing request on SAIF's December 8, 1992 denial.

Claimant's Request for Hearing on Liberty's December 10, 1992 Denial

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

ORDER

The Referee's order dated October 12, 1994 is affirmed.

In the Matter of the Compensation of
CHRIS L. SARGENT, Claimant
WCB Case No. 94-08477
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Mongrain's order that upheld the SAIF Corporation's denial of claimant's neck injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's neck injury sustained in a motor vehicle accident was not compensable, as it did not arise out of or in the course of his employment. We disagree.

Claimant was employed as a roofer by Chris Smith, who operates his business from his home in Grants Pass. Claimant is paid on a piece-work basis.

Smith would usually call claimant the night before a job and instruct him to either come to his house the next morning or go to the designated job sites, which, with one prior exception, were located in Grants Pass. Claimant usually drove his own vehicle to the job site. He was not reimbursed for his transportation expenses.

The night before claimant's injury, Smith instructed claimant to come to his house the next morning before proceeding together in Smith's truck to an unspecified job site in Medford. Smith did not ask claimant to share the cost of gas. Two other employees followed Smith's truck in a different vehicle.

Smith and his employees stopped in Medford for breakfast. After breakfast, they left in the two vehicles, Smith leading in his because he was the only one who knew the location of the job site. At the first stop sign, Smith stopped to let the second vehicle catch up with him. The second vehicle rear-ended Smith's truck, causing claimant's neck injury.

The question presented is whether claimant was in the course and scope of his employment when he was injured while receiving a ride from the employer's premises to the job site from the employer.

To establish a compensable injury, a worker must prove that his injury arose out of and in the course of employment. Norpac Foods v. Gilmore, 318 Or 363 (1994). The first prong of the inquiry is whether the injury occurred in the course of employment, which concerns the time, place and circumstances of the injury. The second prong is whether the injury arose out of the employment, that is, whether a causal connection existed between the injury and the employment. Id. In assessing the compensability of an injury, we must evaluate the work-connection of both elements; neither is dispositive.

We begin by examining whether claimant's injury arose "in the course of" employment. Generally, injuries sustained while traveling to and from an employee's regular place of employment generally are not considered to have occurred in the course of employment. Philpott v. State Ind. Acc. Com., 234 Or 37, 40 (1963). There are, however, exceptions to this "going and coming" rule.

One exception to the "going and coming" rule is the "employer's conveyance" rule. Larson states the "employer's conveyance" rule as follows:

"When the journey to or from work is made in the employer's conveyance, the journey is in the course of employment, the reason being that the risks of the employment continue throughout the journey." 1 Larson, Workmen's Compensation Law 4-209, §17.00 (1994).

"If the trip to and from work is made in a truck, bus, car, or other vehicle under the control of the employer, an injury during that trip is incurred in the course of employment." 1 Larson, supra, 4-209, §17.11 (1994); Giltner v. Commodore Con. Carriers, 14 Or App 340 (1972).

The reason for this rule depends on the extension of risks by the employer's control of the conditions of transportation. 1 Larson, supra, 4-215, §17.11 (1994).

In Giltner, the claimant was a truck driver who leased his truck to the employer. The claimant lived in Portland and picked up mobile homes in Roseburg, where the employer's manufacturing plant was located, for delivery. The claimant was injured while driving his truck to Roseburg. The court relied on Larson's "employer conveyance" rule to find that that injury occurred in the course and scope of employment. It reasoned that the claimant was required to use his own truck, and pursuant to the lease, the employer had exclusive control of the truck. 14 Or App at 346-347.

Here, claimant was injured while a passenger in a truck owned and operated by the employer, who arranged that claimant would ride with him to a destination in Medford that only he knew. Providing the ride from his business headquarters to the job site expanded the range of risks assumed by the employer and was under the employer's control, such that claimant was within the course of employment.

Moreover, because the employer expected his four employees to gather together at his business premises, eat breakfast together and then continue on to the job location, which only he knew, and to which he was leading the second vehicle, the risk that claimant would be injured while traveling to the job site was a risk of his employment. See Henderson v. S.O. Deacon Corp., 127 Or App 333, 338-39 (1994) (causal relationship shown between injury and employment if job put the worker in a position to be injured); Roy J. Johnson, 46 Van Natta 1117 (1994). Accordingly, we conclude that claimant has established that his injury arose out of and in the course of employment.

Claimant's attorney is entitled to an assessed 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 fee for claimant's attorney's services at hearing and on review is \$3,000, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The Referee's order dated November 7, 1994 is reversed. The SAIF Corporation's denial is set aside and the claim remanded to SAIF for processing according to law. Claimant's attorney is awarded \$3,000 for services at hearing and on Board review, to be paid by SAIF.

In the Matter of the Compensation of
KRISTIN MONTGOMERY, Claimant
WCB Case No. 93-14375
ORDER ON REVIEW
Olson Law Firm, Claimant Attorney
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of her occupational disease claim for left upper extremity (wrist and shoulder) myofascial syndrome and left thumb deQuervain's tenosynovitis. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

Claimant began suffering right wrist, shoulder and arm symptoms in 1987 while working as a chef for Liberty Northwest's insured. (Tr. 14). Her claim was accepted. Claimant underwent right carpal tunnel release surgery in 1987 and right thoracic outlet surgery in 1989. Claimant received an award of 15 percent scheduled permanent disability for the right forearm and 12 percent unscheduled permanent disability for the right shoulder. (Ex. 16).

Claimant has changed employers several times. After she left Liberty's insured, she worked at Mexicali Rose and a small seafood market. (Tr. 20). Claimant worked at Prima Vera Catering from March 1990 to September 1991. (Tr.12). Claimant worked as the coffee house manager at Bloomsbury Books from August 1991 to September 1992. (Tr. 11). After working at Bloomsbury, claimant was the night supervisor at the Red Baron restaurant for approximately six months. (Tr. 10). She was a dinner cook and night supervisor at Black Sheep from April 1993 until August 7, 1993. (Tr. 10). From August 7, 1993 to October 1, 1993, claimant worked as an assistant chef for SAIF's insured. (Tr. 3).

Claimant's treating physician since 1987 has been Dr. MacKinnon. (Tr. 17). Dr. MacKinnon has been treating claimant for right upper extremity symptoms since that time. On November 13, 1990, Dr. MacKinnon noted a positive Finkelstein test on the left, no swelling. (Ex. 3-13). On January 15, 1991, Dr. MacKinnon reported that claimant "does note a limited ulnar motion to her left wrist that I was not aware of last visit." (Ex. 3-13). The Finkelstein test revealed "somewhat limited ulnar deviation of her wrist and some slight tenderness proximal to the thumb extensor." (Id.) On February 14, 1991, Dr. MacKinnon reported that claimant's left hand had been bothering her at work and an injection was administered to decrease inflammation and fibrosis. Claimant was subsequently diagnosed with left upper extremity (wrist and shoulder) myofascial syndrome and left thumb deQuervain's tenosynovitis.

Claimant left work at SAIF's insured on October 2, 1993 because her wrist hurt very badly. (Tr. 9; ex. 32). She has not worked since that time. On November 10, 1993, claimant filed a claim against SAIF's insured for bilateral carpal tunnel syndrome and tenosynovitis of the left wrist. (Ex. 32). On December 1, 1993, SAIF issued a disclaimer of responsibility and claim denial, which notified claimant that six other employers could be responsible for her condition, including Rogue Valley Art Association, Bloomsbury Books, Prima Vera Catering, Black Sheep, the Red Baron restaurant and Liberty's insured. (Ex. 35).

Claimant testified that she had filed workers' compensation claims against the Red Baron restaurant, PrimaVera and Bloomsbury Books. (Tr. 21). Claimant did not file claims against the Black Sheep restaurant or the Rogue Valley Art Association. (Tr. 21-22). On November 22, 1993, claimant entered into a Disputed Claims Settlement (DCS) with Bloomsbury Books in regard to her claim for bilateral upper extremity conditions. (Ex. 33).

At hearing, the Referee upheld SAIF's denial on the basis that the medical evidence indicated that claimant's work at SAIF's insured did not cause a worsening of her condition.

CONCLUSIONS OF LAW

Compensability

In order to establish the compensability of her current condition, claimant must show that work activities were the major contributing cause of her disease or its worsening. See ORS 656.802(2). Citing Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), claimant relies on the last injurious exposure rule to prove that she has a compensable occupational disease.

In Bennett, supra, the claimant had filed occupational disease claims for hearing loss against two employers and later entered into a DCS with the first employer. The court reasoned 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 responsible employer remained in the case. Id. at 77. Since the DCS with the first employer neither demonstrated an election by the claimant to prove actual causation against the remaining employer nor established a lack of contribution to the claimant's condition from the claimant's work exposure with the first employer, the Bennett court found that the claimant was entitled to rely on the last injurious exposure rule to establish the compensability of his claim.

In other words, the Bennett court held that if the claimant could show that employment conditions, which could include conditions to which the claimant was exposed at the first employer, were the major contributing cause of the occupational disease, the claimant could rely on the last injurious exposure rule to prove the compensability of the claim against the later employer by showing that employment conditions there could have caused the condition.

Here, claimant entered into a DCS with Bloomsbury Books in regard to her claim for bilateral upper extremity conditions. (Ex. 33). Based on Bennett, we must examine the language in the DCS to determine whether claimant agreed that her work at Bloomsbury did not contribute in any way to her condition.

In the DCS, claimant agreed that Bloomsbury Books' denial as supplemented by its contentions in the agreement "shall remain in full force and effect." (Ex. 33). The DCS further provided that Bloomsbury Books contended that claimant's bilateral upper extremity conditions were not the result of any job related activities while employed by Bloomsbury Books. In addition, Bloomsbury Books contended:

"If claimant has [a] bilateral upper extremity condition, it is either the result of a pre-existing condition; the result of non-work activities, or a combination of both. Nothing during claimant's employment caused the conditions, the need for treatment for the conditions, nor a symptomatic or pathological worsening of any pre-existing conditions." (Ex. 33).

Based on Bennett v. Liberty Northwest Ins. Corp., supra, we find that claimant's DCS with Bloomsbury Books evidenced an agreement by claimant that her work with Bloomsbury Books "did not contribute in any way" to her current left upper extremity condition. See Lola K. Springer, 46 Van Natta 2213 (1994). In other words, the aforementioned provisions establish that claimant elected to prove actual causation against the remaining employers for her conditions. Therefore, claimant cannot rely on her employment exposure with Bloomsbury Books from August 1991 to September 1992 to establish the compensability of her condition.

Although claimant worked for at least six employers during the time that she has been experiencing left upper extremity symptoms, she has apparently not filed claims with all of those employers. In this case, she is arguing that SAIF's insured is responsible and she has not joined any other carriers. In Mary A. Kelley, 47 Van Natta 822 (1995), we held that employment conditions while in the employ of an insured who has not been joined in the case may be considered to prove compensability. See also Silveira v. Larch Enterprises, 133 Or App 297, 302-03 (1995) (the court held that "for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws"). We reach the same conclusion here. We find that claimant may use the last injurious exposure rule to prove compensability of her occupational disease claim, except that she may not rely on her employment with Bloomsbury Books. See Lola K. Springer, supra.

We generally 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). Here, we find no persuasive reasons not to do so.

The chart notes of Dr. MacKinnon, claimant's treating physician, document that claimant's left upper extremity symptoms were caused by her work activities. (Ex. 3). Dr. MacKinnon concluded that claimant's work activities over the years were the major contributing cause of her current left upper extremity condition, including her left shoulder, wrist and hand. (Exs. 38 & 39).

Dr. MacKinnon's opinion that claimant's condition is work-related is supported by the April 24, 1993 report from Drs. Snodgrass and Perry, who examined claimant on behalf of Liberty Northwest. Although they opined that claimant's work exposure at the Red Baron was not the major contributing cause of her left upper extremity condition, they recommended that claimant change her occupation to something that required less active use of her hands and upper extremities. (Ex. 23). They believed that when claimant resumed her regular work she would have a worsening of symptoms and become disabled again.

In contrast, Dr. Dickerman opined that claimant's condition was related to her off work activities. (Ex. 21). He reported that claimant's left upper extremity complaints were not related to her original right upper extremity complaints and he noted that her left sided complaints developed significantly later than those on the right, after employment at other jobs and significant off work activities. Dr. Dickerman reported that claimant liked to cross country ski and that she attended a gym, worked out with weights and rode a stationary bicycle. He concluded that if any treatment was necessary for the left upper extremity, it would be due to claimant's off work activities.

At hearing, claimant testified that she had cross country skied once, in 1986, and she did not belong to a gym or lift weights. (Tr. 15). Claimant testified that she had previously lifted weights when she had been involved in a work hardening program. In light of claimant's testimony, we find that Dr. Dickerman had an erroneous impression of claimant's off work activities and we do not find his opinion persuasive. Rather, we are persuaded by Dr. MacKinnon that claimant's work activities over the years were the major contributing cause of her current left upper extremity condition. Therefore, we conclude that claimant's left upper extremity condition is compensable. In making this determination, we did not rely on claimant's work activities at Bloomsbury Books from August 1991 to September 1992.

Responsibility

In determining which carrier is responsible for claimant's condition, we must first decide whether this case is governed by ORS 656.308 or the last injurious exposure rule. Since there is no accepted left upper extremity claim in this case, we do not apply ORS 656.308. When ORS 656.308(1) does not apply, the last injurious exposure rule applies to assign responsibility. SAIF v. Yokum, 132 Or App 18 (1994).

SAIF opposes the application of the last injurious exposure rule and assignment of liability on the ground that the record establishes that the major contributing cause of claimant's condition was her work activities at Prima Vera Catering. We disagree.

The last injurious exposure rule is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. On the other hand, where actual causation is established with respect to a specific employer, the last injurious exposure rule is not applied. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Rick C. Wertman, 47 Van Natta 340 (1995).

Here, claimant relies on the last injurious exposure rule. In contrast, SAIF argues that the medical evidence indicates that claimant's left upper extremity condition was caused in major part by her work activities in 1990 and 1991 with Prima Vera Catering. SAIF relies on a "check-the-box" summary of a conversation between Dr. MacKinnon and claimant's attorney. (Ex. 31). However, Dr. MacKinnon did not entirely concur with the summary and wrote extensive notes on the report. Since it is impossible to determine precisely which portions of the type-written letter Dr. MacKinnon agreed with, we rely solely on her handwritten notes. There is nothing in Dr. MacKinnon's handwritten notes to support SAIF's argument that claimant's left upper extremity condition was caused in major part by her work activities in 1990 and 1991 with Prima Vera Catering. Since there is no other medical evidence that establishes actual causation with Prima Vera, we reject SAIF's argument that claimant's left upper extremity condition was caused in major part by her work activities in 1990 and 1991 with Prima Vera Catering. Because actual causation has not been established, it is necessary to rely on the last injurious exposure rule to determine responsibility.

The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

The parties dispute the triggering date for the assignment of responsibility. SAIF argues that initial responsibility lies with Prima Vera Catering because claimant first sought treatment for her condition while she was working for Prima Vera. Although claimant acknowledges that she first sought treatment for her condition while working at a prior employer, she argues that the key event for assigning responsibility is the date of disability. Claimant contends that SAIF's insured is responsible because she first became disabled while working for SAIF's insured. We disagree with claimant's contention.

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received 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, 401 (1993), rev den 319 Or 81 (1994). The dispositive date is the date the 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).

Here, Dr. MacKinnon noted a positive Finkelstein test on the left without swelling on November 13, 1990. (Ex. 3-13). On January 15, 1991, Dr. MacKinnon reported that claimant "does note a limited ulnar motion to her left wrist that I was not aware of last visit." (Ex. 3-13). The Finkelstein test revealed "somewhat limited ulnar deviation of her wrist and some slight tenderness proximal to the thumb extensor." (Id.) On February 14, 1991, Dr. MacKinnon reported that claimant's left hand had been bothering her. Dr. MacKinnon explained:

"[Claimant] has been relying more on her left hand during her saute work and has had to do a lot of sideways motion with her wrist. She did notice it back in October and I have it documented in my note that she had a positive Finkelstein's test back in January. This limited motion has persisted. In addition, a positive Finkelstein's test was noted in mid November on the left. She started work again on the 18th and is having difficulty at work." (Ex. 3-14).

An injection was administered to decrease inflammation and fibrosis.

Based on Dr. MacKinnon's chart notes, we conclude that claimant first sought medical treatment related to her compensable left upper extremity symptoms on January 15, 1991. At that time, claimant was employed at Prima Vera Catering. (Tr. 12). Therefore, we would ordinarily assign presumptive responsibility for claimant's condition to Prima Vera Catering. Although SAIF's disclaimer notified claimant of a potential claim against Prima Vera (Ex. 35), and claimant testified that she filed a claim against Prima Vera, (Tr. 21), Prima Vera was not a party to this hearing.

Claimant has chosen to pursue the claim for her left upper extremity condition with SAIF's insured. Since SAIF issued a proper disclaimer pursuant to ORS 656.308(2), it "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." Although claimant apparently has not pursued her claim with Prima Vera, SAIF can still assert as a defense that actual responsibility lies with Prima Vera, even though claimant has not joined Prima Vera in this litigation. SAIF bears no responsibility for the fact that claimant did not join Prima Vera in this proceeding. See Connie A. Martin, 42 Van Natta 495 (1990) (insurer not precluded from using the last injurious exposure rule defensively where the claimant withdrew hearing request challenging the denials of other potentially responsible carriers); see also William R. Tompsett, 45 Van Natta 1266 (1993); Ronald L. Schilling, 42 Van Natta 1974 (1990).

In the usual situation, since Prima Vera is presumptively responsible for claimant's left upper extremity condition, Prima Vera could attempt to shift responsibility to an earlier or later carrier. Here, however, claimant has chosen not to pursue her claim against Prima Vera Catering. Consequently, Prima Vera cannot be held responsible for claimant's condition since claimant did not join Prima Vera in the litigation.¹

¹ For purposes of our analysis, we emphasize that Prima Vera Catering is only presumptively responsible for claimant's condition. Since claimant is only pursuing a claim with SAIF's insured, our review is limited to addressing whether SAIF's insured is responsible for claimant's condition.

Since claimant has chosen to advance her claim against SAIF, she can attempt to shift responsibility to SAIF's insured. In order to shift responsibility to SAIF's insured, claimant must show that a later employment "actually contributed to a worsening of the condition." Oregon Boiler Works v. Lott, 115 Or App 70 (1992). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 134 Or App 245 (1995); see Bracke v. Bazar, *supra*, 293 Or at 250 ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer.").

Here, claimant worked at SAIF's insured from August 7, 1993 to October 1, 1993. (Tr. 3). In a "check-the-box" summary of a conversation with SAIF, Dr. MacKinnon agreed that she treated claimant during and after her employment at SAIF's insured for the same diagnosed conditions that preexisted her employment. (Ex. 37). Dr. MacKinnon opined that claimant's work at SAIF's insured did not contribute to a worsening of her underlying condition. (Exs. 37 & 39). Dr. MacKinnon testified that claimant's symptoms worsened temporarily during her employment at SAIF's insured, but her condition returned to the same baseline condition she had prior to her work for SAIF's insured. (Ex. 39-22). Dr. MacKinnon doubted that there was any pathological worsening. (Exs. 39-9, 39-22).

We conclude that claimant's work at SAIF's insured did not actually contribute to a worsening of her left upper extremity condition.² Therefore, SAIF is not responsible for claimant's condition.

ORDER

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

² In claimant's brief, she relies on a medical report (Exhibit 29) that allegedly states that the worsening of the symptoms represented a worsening of her condition. (Appellant's brief at 3). Since Exhibit 29 is not part of the record and was withdrawn at hearing, (Tr. 1), we do not consider it.

June 1, 1995

Cite as 47 Van Natta 965 (1995)

In the Matter of the Compensation of
SCOTT TURO, Claimant
WCB Case No. TP-92012
THIRD PARTY DISTRIBUTION ORDER ON REMAND
Pierce & Stoddard, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Turo v. SAIF 131 Or App 572 (1994). The court has reversed our prior order, Scott Turo, 45 Van Natta 995 (1993), which, in determining a "just and proper" distribution of proceeds from a third party settlement under ORS 656.593(3), held that the SAIF Corporation was entitled to receive full reimbursement for the \$15,000 Claim Disposition Agreement (CDA) payment it had previously paid to claimant for the release of his past, present and future "non-medical service" benefits. Relying on ORS 656.593(1)(c), the court concluded that a paying agency is not entitled to recover "any compensation which may become payable under ORS 656.273 or 656.278." Inasmuch as a portion of the CDA payment was designed to release claimant's rights to future compensations under ORS 656.273 and 656.278, the court determined that we had erroneously given SAIF recovery for a type of claim cost to which it was not statutorily entitled. Consequently, the court has remanded for a redetermination of a "just and proper" distribution of the third party settlements specifically concerning what portion of the CDA payment is properly reimbursable to SAIF.

The facts have been recited in our prior order, as well as the court's decision. Turo v. SAIF, *supra*; Scott Turo, *supra*. We incorporate those findings into this order.

The court agreed with that portion of our previous order which determined that CDA payments constituted "compensation" under ORS 656.005(8). Turo v. SAIF, *supra*. Nevertheless, the court disagreed with that portion of our decision which concluded that the entire \$15,000 CDA payment was

reimbursable. Reasoning that future compensation payable under ORS 656.273 and 656.278 are not reimbursable under ORS 656.593(1)(c), the court has remanded for reconsideration of what portion of the CDA payment is properly reimbursable. Consistent with the court's mandate, we proceed with our reconsideration.

To begin, it is well-settled that attorney fees payable from compensation retain their identity as compensation. Steiner v. E. J. Bartells Co., 114 Or App 22, 25 (1992). Consistent with the Steiner rationale, we conclude that the \$3,375 attorney fee payable from the \$15,000 CDA payment is compensation. Moreover, since this compensation does not pertain to future compensation payable under ORS 656.273 and 656.278, the prohibitions contained in ORS 656.593(1)(c) are not applicable. Under such circumstances, we find it "just and proper" for SAIF to receive reimbursement for this \$3,375 claim cost.

The prohibitions of ORS 656.593(1)(c) do apply to a portion of the remaining \$11,625 from the \$15,000 CDA payment. Nevertheless, based on the following reasoning, we conclude that the statutory prohibition is not applicable to the entire remaining balance of the CDA payment.

The CDA pertained to past, present, and future rights to temporary disability, permanent disability, vocational services, aggravation rights under ORS 656.273 and "Own Motion" rights under ORS 656.278. At the time of CDA approval, the claim was in closed status. Since most "post-closure" benefits are payable under ORS 656.273 and 656.278, those portions of the CDA payment attributable to such future compensation is not reimbursable. Nonetheless, as persuasively established by claimant's affidavit and petition for third party relief, the CDA did not solely pertain to his rights to such future compensation. Instead, the CDA was also designed to release his rights to vocational assistance, a benefit to which claimant was entitled at the time of the CDA without further reopening of his claim under ORS 656.273 and 656.278.¹

Consequently, to the extent that the CDA payment involved settlement of claimant's existing rights to vocational services arising from the original claim closure, that portion of the payment is not subject to the statutory reimbursement prohibition of ORS 656.593(1)(c). Thus, we find it "just and proper" for SAIF to recover that portion of its CDA payment which pertained to such vocational assistance costs.

To determine what portion of the CDA payment involved vocational assistance costs arising from the original claim closure, we turn to SAIF's actual claim costs at the time of the CDA. SAIF's actual "non-CDA / non-medical services lien" totalled \$27,703.36 (consisting of \$13,141.63 in temporary disability, \$6,851.25 in permanent disability, and \$7,710.48 in vocational assistance). Thus, 28 percent of SAIF's actual "non-CDA / non-medical services" claim costs were composed of vocational assistance costs. Applying that ratio to the \$15,000 payment, we find that \$3,255 of the payment pertained to vocational assistance.

Accordingly, we find it "just and proper" for SAIF to receive a total of \$6,630 (\$3,375 in attorney fees and \$3,255 in vocational assistance benefits) from the \$15,000 CDA payment. See ORS 656.593(3). Claimant's attorney is directed to pay this amount (in addition to the other claim costs previously found reimbursable in our initial order) to SAIF. The remainder of the third party settlement proceeds shall be distributed to claimant.

IT IS SO ORDERED.

¹ As is apparent from his petition for third party relief, as well as his accompanying affidavit, claimant's primary (if not sole) reason for entering into the CDA was to resolve the ongoing dispute regarding his personally unsatisfactory attempts to receive vocational assistance. In light of claimant's clear and unambiguous intentions and considering that additional vocational services were available to him without reopening of his claim under ORS 656.273 and 656.278, we find it reasonable to apportion the entire "vocational assistance" portion of the CDA payment to such claim costs arising from his original claim closure. We consider this approach to be particularly appropriate since at the time of the execution and approval of the CDA, eligibility for future vocational assistance arising from a subsequent claim closure was contingent on the likelihood of permanent disability. See former OAR 436-120-040(2). Since claimant was releasing his future aggravation rights (as well as further entitlement to permanent disability), the potential for him receiving additional vocational services resulting from a later claim closure was virtually nonexistent. Thus, any value for "post-aggravation" vocational assistance would be negligible.

Board Member Gunn dissenting.

Because I disagree with the majority's determination of a "just and proper" distribution of the third party settlement proceeds, I must respectfully dissent. I base my disagreement with the majority's conclusion on the following reasoning.

As I stated in my dissenting opinion in Scott Turo, 45 Van Natta 995 (1993), the parties' Claim Disposition Agreement (CDA) represents their compromise for "peace and resolution" of claimant's injury claim. As such, the disposition is composed of many aspects (generically termed "benefits"), which claimant is releasing and SAIF is relieved from providing. Neither the CDA itself, nor this accompanying record, lends any guidance whatsoever as to what portions of the CDA proceeds were designed to compensate claimant for his past, present, or future "non-medical service" benefits. Thus, any attempt by this Board to discern an intention from this record is indulging in pure speculation.

In conclusion, as the party seeking to enforce its asserted lien as a paying agency, it is SAIF's burden to establish that it is "just and proper" for it to receive reimbursement for its claim expenditures attributable to payment of the CDA proceeds. Since this record is devoid of any direct evidence demonstrating that any portion of those proceeds were designed to compensate claimant for benefits other than those which are not lienable under ORS 656.593(1)(c), I submit that SAIF has failed to prove entitlement to reimbursement for its claim costs related to the CDA payment.

Consequently, I would hold that claimant can retain the entire \$15,000 CDA payment.

June 1, 1995

Cite as 47 Van Natta 967 (1995)

In the Matter of the Compensation of
DALE A. WECKESSER, Claimant
 WCB Case No. 93-10648
 ORDER ON REMAND
 Pozzi, Wilson, et al, Claimant Attorneys
 Kenneth P. Russell (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995). The court reversed our prior order which adopted a Referee's order that affirmed an Order on Reconsideration award of 3 percent (4.05 degrees) scheduled permanent disability for loss of use or function of the left ankle. The court agreed with our conclusion that a claimant's chronic condition "impairment" must be rated or concurred in by the attending physician. Nevertheless, interpreting our decision to be erroneously based on a determination that a medical opinion must expressly use the term "chronic" in order for claimant to receive a "chronic condition" award, the court has remanded for a determination as to whether the relevant medical opinions support a finding that claimant is unable to repetitively use a body part "due to a chronic and permanent medical condition" as required by former OAR 436-35-010(6). In accordance with the court's mandate, we proceed with our reconsideration.¹

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

¹ SAIF's request for supplemental briefing was previously granted. Pursuant to the supplemental briefing schedule, claimant's opening brief was due 21 days from the court's March 24, 1995 appellate judgment. SAIF's response was due 21 days from the date of mailing of claimant's brief. In the event that claimant did not file a brief, SAIF's brief was due 42 days from the court's appellate judgment. Claimant has not filed a supplemental brief. Since more than 42 days has expired since the court's March 24, 1995 appellate judgment, we have proceeded with our reconsideration without the submission of supplemental briefs.

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. Weckesser v. Jet Delivery Systems, *supra*; Donald E. Lowry, 45 Van Natta 1452 (1993).

On April 15, 1990, claimant injured his left ankle. On June 23, 1993, the claim was closed by a Notice of Closure that awarded temporary disability, and 3 percent scheduled permanent disability for loss of strength. As a result of his injury, claimant has weakness and easy fatiguability in his left foot, and is required to wear high top shoes with orthotic correction.

In his April 2, 1993 closing report, Dr. Wisdom, claimant's attending physician, stated that claimant has permanent impairment in his foot that will take the form of "easy fatiguability in the foot and leg with long standing and walking, probable discomfort in the foot and ankle with same * * * ." (Ex. 8).

On May 18, 1993, Dr. Hunt examined claimant for the SAIF Corporation. Dr. Hunt concluded that claimant has impairment, but not based on lost motion. Dr. Hunt found 4/5 weakness of the invertors of the left ankle which would result in loss of motor strength causing a 10 percent impairment in claimant's lower extremity. (Ex. 9-5). On June 4, 1993, Dr. Wisdom concurred with Dr. Hunt's opinion. (Ex 10).

After considering Dr. Wisdom's opinion that claimant has permanent impairment due to easy fatiguability with long standing and walking, in conjunction with Dr. Hunt's finding of approximately 10 percent impairment due to loss of motor strength, we conclude that claimant is unable to repetitively use his left foot due to a chronic and permanent medical condition. Accordingly, claimant is entitled to 5 percent for a chronic condition for his left foot. Former OAR 436-35-010(6). Therefore, claimant's scheduled permanent disability award for loss of use or function of the left foot is increased from 3 percent to 8 percent.

Claimant has finally prevailed on the extent of permanent disability issue. 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 876, on recon 43 Van Natta 1314 (1991). This fee shall be in addition to the "out-of-compensation" award granted by this order for claimant's counsel's successful efforts in obtaining an increased scheduled permanent disability award.

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, and before the court is \$3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by 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. Finally, we have also taken into consideration the fact that claimant's counsel shall also receive an "out-of-compensation" attorney fee payable from claimant's increased permanent disability award.

Accordingly, on reconsideration, the Referee's order dated December 30, 1993 is modified. In addition to the Notice of Closure, Order on Reconsideration and Referee awards totaling 3 percent (4.05 degrees) scheduled permanent disability, claimant is awarded 5 percent (6.75 degrees), for a total award to date of 8 percent (10.8 degrees) scheduled permanent disability for loss of use or function of the left foot. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney. In addition, for services at hearing, on Board review, and before the court, claimant's attorney is awarded \$3,000, payable by the SAIF Corporation.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAUL AYALA-ARROYO, Claimant
WCB Case No. 93-06543
ORDER ON REVIEW
Law Offices of Michael B. Dye, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Hall and Turner-Christian.

The insurer requests review of Referee Michael Johnson's order that: (1) set aside its denial of claimant's left rib injury claim on the basis that claimant was not employed by its insured; and (2) assessed a penalty for allegedly unreasonable claims processing. On review, the issues are subjectivity and penalties.

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

On April 6, 1993, claimant fell out of a tree he was pruning on the "Rome" apple section of the insured's orchard, breaking several ribs. Citing Dykes v. SAIE, 47 Or App 187, 190 (1980), and BBC Brown Boveri v. Lusk, 108 Or App 623, 626 (1991), the insurer contends that claimant was injured during a pre-employment "try out," and, therefore, was not a subject worker. We disagree.

In Dykes and BBC Brown, each claimant was injured while taking a preemployment test required as a prerequisite for being considered for employment. We agree that these cases stand for the proposition that the mere possibility of future employment does not constitute "remuneration." Here, however, the record indicates that claimant was not "trying out" as a prerequisite for being considered for future employment, but that he and the employer had agreed that claimant was hired to prune a section of the employer's orchard after he finished a job he was doing for a different employer. Claimant and the employer, who was in financial straits, had not settled on a price for the pruning, so the employer and claimant agreed that claimant would appear at the pruning site and prune some trees to mutually establish the rate of payment. (Tr. 18, 36, 37, 38, 39, 42, 25, 26, 55, 68, 71, 74, 83, 84, 85, 87, 98).

Under such circumstances, we conclude that there was a valid contract for hire. Consequently, we affirm the Referee's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the subjectivity issue is \$1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated October 14, 1994 is affirmed. For services on review, claimant's attorney is awarded \$1,500, payable by the insurer.

In the Matter of the Compensation of
MICHELLE K. DIBRITO, Claimant
WCB Case No. 91-13969
ORDER ON REMAND
Black, Chapman, et al., Claimant Attorneys
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. Dibrito v. SAIF, 319 Or 244 (1994). In our prior order, Michelle K. Dibrito, 45 Van Natta 150 (1993), we upheld the SAIF Corporation's denial of claimant's colitis/stress claim. 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). Citing Mathel v. Josephine County, 319 Or 235 (1994), the Court has remanded for further proceedings, reasoning that claimant's episode of colitis, alleged to be caused by stress, should be analyzed as an accidental injury under ORS 656.005(7)(a).

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Here, claimant filed claims for colitis and for a personality disorder condition, both of which SAIF denied. The Referee found the conditions compensable as an industrial injury. On review, we reversed, citing SAIF v. Hukari, supra, which had issued subsequent to the Referee's order. Following the Hukari decision, we concluded that we were required to analyze the claim pursuant to ORS 656.802(3), as 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 an occupational disease under ORS 656.802.

Because we found that claimant's psychological condition was due, in major part, to factors other than work conditions, we concluded that claimant failed to establish by clear and convincing evidence that her psychological condition arose out of and in the course of her employment. See ORS 656.802(3). Accordingly, we concluded that claimant had not proven a compensable psychological condition pursuant to ORS 656.802, and neither claimant's mental condition nor her physical symptoms resulting from on-the-job stress were compensable.

The Court of Appeals affirmed our order without opinion. Dibrito v. SAIF, 124 Or App 680 (1993). The Supreme Court, however, reversed in part, citing Mathel v. Josephine County, supra. In Mathel, the Court considered whether the claimant's claim for a heart attack was properly analyzed as an occupational disease or an accidental injury. 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.

Consequently, based on its Mathel holding, the Court found that the present case involves a worker seeking compensation for an episode of colitis and a personality disorder. The Court agreed with our application of ORS 656.802 to the claim for the personality disorder. However, citing Mathel, the Court further held that we erred in not analyzing separately the claim for colitis under ORS 656.005(7). Specifically, the Court reasoned that, whether caused by physical factors, job stress, or both, the episode of colitis was an "event" constituting an accidental injury. Therefore, the Court reversed the portion of our order that upheld SAIF's denial of claimant's colitis episode, and remanded. We proceed with our reconsideration.

Here, the medical evidence shows that, prior to claimant's May 14, 1991 episode of colitis, claimant had had a longstanding history of abdominal distress "including acute and chronic colitis..." (Ex. 31-1). Furthermore, claimant's treating physician, Dr. Marx, opined that the stress of the work meeting on that day made claimant's preexisting colitis symptomatic. Accordingly, the evidence shows that the work "event"/injury did combine with claimant's preexisting abdominal condition to prolong disability or the need for medical treatment. SAIF's position is therefore, that claimant's colitis condition must be analyzed as a "resultant condition" under ORS 656.005(7)(a)(B), which 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."

Claimant responds that SAIF has waived application of the "resultant condition" standard of proof because it did not argue that standard prior to this remand proceeding. We disagree.

It is the worker's burden to prove that an injury is compensable. See ORS 656.266. ORS 656.005(7)(a) defines "compensable injury," in part, as "an accidental injury...arising out of and in the course of employment requiring medical services or resulting in disability or death." The "arising out of" portion of the definition encompasses the concept of medical causation, Rogers v. SAIF, 289 Or 633, 641 (1980), the test ordinarily being whether an event at work was a material contributing cause of the injury. See Olson v. State Ind. Acc. Com., 222 Or 407 (1960); Destael v. Nicolai Co., 80 Or App 596 (1986). The "compensable injury" definition is subject, however, to the statutory limitations in subparagraph (A), which applies to "consequential conditions," and subparagraph (B), which applies to "resultant conditions." Errand v. Cascade Steel Rolling Mills, Inc., 320 Or 509, 516 (1995); Tektronix, Inc. v. Nazari, 117 Or App 409, 412 (1992), mod 120 Or App 590 (1993). In order to establish that a consequential or resultant condition is a "compensable injury," the worker has the burden of proving that the work event was the major contributing cause of the condition. Errand v. Cascade Steel Rolling Mills, Inc., supra, 320 Or at 518-19; Tektronix, Inc. v. Nazari, supra.

Hence, ORS 656.005(7)(a)(B) does not set forth an affirmative defense; rather, it defines a "compensable injury" under circumstances where disability or a need for treatment is due to the combination of an injury and a preexisting, noncompensable condition. When an injury claim is denied under those circumstances (as we find them to exist), it is the worker's burden to prove compensability under the "major contributing cause" standard of proof, whether or not the insurer specifically asserts that standard.¹

Our conclusion is consistent with the Court of Appeals' opinion in Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995). There, the insurer denied the claimant's condition on the basis that it was unrelated to work conditions. The claimant filed a hearing request from the denial and, at hearing, raised the issue of whether her condition was the result of work, but she did not specify whether her condition was compensable under an occupational disease or an accidental injury theory. Citing Dibrito v. SAIF, supra, the court stated that, inasmuch as the Board's first task is to determine which provisions of the Workers' Compensation Law are applicable, it was proper for the Board to analyze the claimant's claim under the occupational disease provisions, even though the claimant did not label the claim as one for an occupational disease. Id.

Just as the claimant in Renalds was not required to specify whether her condition was compensable under an occupational disease or an accidental injury theory, the insurer was not required to specifically assert the "major contributing cause" standard under ORS 656.005(7)(a)(B). Rather, it is our task to determine whether or not ORS 656.005(7)(a)(B) applies to the facts of this case.

Here, it is undisputed that claimant filed an injury claim for colitis which SAIF denied. Therefore, she has the burden of proving that her colitis was a "compensable injury" within the meaning of ORS 656.005(7)(a). Inasmuch as we found that the work event/injury (with SAIF's insured) combined with a preexisting, noncompensable condition to prolong disability or a need for treatment, we conclude that claimant's injury claim is subject to the "resultant condition" limitation in ORS 656.005(7)(a)(B).

Our application of ORS 656.005(7)(a)(B) is consistent with the Supreme Court's instructions in this case: "The Board erred...in not analyzing separately, under ORS 656.005(7), claimant's episode of colitis, alleged to have been caused by the stress of the May 14, 1991, meeting at work. Claimant is

¹ Parties are not precluded, however, from stipulating to the application or non-application of the "resultant condition" limitation under ORS 656.005(7)(a)(B). That is, our decision in this matter should not be read as prohibiting parties from stipulating, either expressly or impliedly, that a work-related injury combined with a preexisting condition to cause or prolong disability or a need for treatment.

entitled to the Board's review of that portion of her claim under the standards that apply to injuries." 319 Or at 249 (Emphasis supplied.) The Court's use of "standards" (in the plural form) implies that our review of claimant's colitis claim should include consideration of all applicable standards in ORS 656.005(7)(a), including those set forth in subparagraphs (A) and (B).² On remand, we are bound by the Court's instructions, and we decline to take any action inconsistent with its opinion. See, e.g., Richard A. Colclasure, 46 Van Natta 1246, 1248-49 (1994)(order on remand). Therefore, we apply the "resultant condition" standard, and conclude that claimant has the burden of proving that the May 14, 1991 injury is and remains the major cause of her disability or need for treatment.

Because claimant has had an extensive history of abdominal diseases and a preexisting colitis condition, we find that causation of claimant's resultant condition 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).

There are several medical reports which discuss claimant's resultant condition. Dr. Marx, claimant's treating physician, reported that the stress of the May 1991 work meeting made claimant's preexisting colitis symptomatic. He also concluded that claimant's need for treatment and disability was in major part caused by the stress she suffered at work.

Dr. Herbert, who reviewed the medical records on behalf of SAIF, was doubtful that claimant had experienced a recurrence of colitis. This opinion was based on the following findings in the record: nonspecific gastritis revealed by a gastroscopy, and a normal barium enema. If no documentation regarding claimant's condition (i.e., such as a biopsy) could be obtained, Dr. Herbert supported a diagnosis of irritable bowel syndrome. He opined that the "usual cause" of worsening symptoms of irritable bowel syndrome is stress. However, whether the work environment was responsible for this claimant's worsened symptoms was a determination that Dr. Herbert found would "perhaps be made by the psychiatrist who will be seeing (claimant.)"

Dr. Thompson, the psychiatrist who examined claimant, stated that the cause of claimant's physical symptoms was in question. Dr. Thompson believed that claimant had symptoms due to a colitis flareup following the May 1991 meeting at work, but he had hoped that a gastroenterologist would clarify that point. However, when asked whether he felt that the work incident was the major cause of claimant's irritable bowel syndrome and the reason for her subsequent hospitalization, Dr. Thompson replied in the negative.

Dr. Thompson explained that claimant's case was more complicated than merely making a temporal connection between the meeting and the onset of the condition. Dr. Thompson found that claimant could have been stressed from her job, but her symptoms could have come about because of either her faulty perceptions or as the result of preexisting "neurotic problems." Finally, although Dr. Thompson found that claimant had a diagnosable mental disorder, he attributed the primary cause of her current disability and need for treatment to non-work factors. (Ex. 45).

After reviewing the medical evidence, we find that claimant has failed to show that the May 1991 injury (the work meeting) is and remains the major cause of her resultant abdominal/colitis condition. For the following reasons, we decline to grant deference to claimant's treating physician, Dr. Marx. First, although a treating physician's opinion is entitled to deference in cases where expert external observation gives the physician an advantage over other medical experts, see Weiland v. SAIF, 64 Or App 810, 814 (1983), this is not such a case. Rather, this is a case which turns on expert analysis; in such cases, the treating physician's opinion is entitled to no greater deference. Hammons v. Perini, 43 Or App 299, 301 (1979).

Furthermore, Dr. Marx's opinion is not persuasive because, although he opined that the stress of the meeting made a preexisting condition symptomatic, there is no indication that Dr. Marx assessed the

² SAIF specifically argued to the Supreme Court that if claimant's claim was characterized as an accidental injury, rather than an occupational disease, it was subject to the "major contributing cause" standard under ORS 656.005(7)(a)(B). (Resp. to Pet. 28-30). Claimant did not object to that argument. The Court presumably considered the argument when it directed us to review the claim "under the standards that apply to injuries." We decline claimant's invitation now to ignore the Court's mandate to apply all the applicable standards under ORS 656.005(7)(a), including the limitation in subparagraph (B).

relative contribution of different causes of claimant's condition. See Dietz v. Ramuda 130 Or App 397 (1994); see also Stacy v. Corrections Division, 131 Or App 610 (1994) (Because a determination of major contributing cause requires the assessment of the relative contribution of different causes, it is necessary to consider the effect of all possible causes of a condition, including the contribution of the underlying preexisting condition). In particular, Dr. Marx has not discussed claimant's other "off work" contributors noted by Dr. Thompson. Absent such a discussion, we have no basis for assuming that Dr. Marx properly weighed all non-work-related causes against work-related causes in forming his opinion. Finally, Dr. Marx has failed to explain why the gastroscopy and barium enema tests provided no findings in support of a diagnosis of colitis.

Although Dr. Herbert offered an opinion concerning causation of worsening symptoms of irritable bowel syndrome in general, he declined to comment on causation of this claimant's condition, and instead, deferred to a psychiatrist for that determination. Additionally, Dr. Thompson, the only psychiatrist to examine claimant, did consider the contribution of different causes of claimant's condition, but he could not conclude that work was the major contributing cause of claimant's condition or the need for treatment following the May 1991 incident. We note that, at one point, Dr. Thompson was asked to assume that all of the stress claimant had at work was work related. (Ex. 45-10). As we discussed above, inasmuch as claimant had faulty perceptions and preexisting "neurotic problems" which contributed to her stress, that assumption was incorrect.

Under the circumstances, we find that claimant has failed to establish that the May 1991 work injury is and remains the major contributing cause of her disability or need for treatment for her resultant colitis condition. Therefore, we uphold SAIF's denial of claimant's injury claim for her colitis condition.

Accordingly, on reconsideration, we reverse the Referee's order dated April 13, 1992. SAIF's denial of claimant's colitis condition is reinstated and upheld. The Referee's \$6,000 attorney fee award is reversed.

IT IS SO ORDERED.

June 2, 1995

Cite as 47 Van Natta 973 (1995)

In the Matter of the Compensation of
JOHN S. BARNA, Claimant
WCB Case No. 94-03793
ORDER ON REVIEW
Swanson, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Referee Crumme's order that affirmed that portion of an Order on Reconsideration that awarded 10 percent (32 degrees) unscheduled permanent disability for claimant's allergic contact dermatitis condition. On review, the issue is extent of unscheduled permanent disability.

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

Claimant contends that his skin condition should be rated under OAR 436-35-440, instead of OAR 436-35-450. However, claimant's compensable condition is allergic contact dermatitis, resulting from exposure to photochemicals. (See Ex. 2). Under these circumstances, OAR 436-35-440(1), by its terms, provides that the condition must be rated under OAR 436-35-450. Finally, because claimant has returned to his regular work teaching photography, with restrictions against exposure to photochemicals, we agree with the Referee that claimant's permanent impairment prevents some, but not most, of his regular work related activities. Consequently, claimant's condition is properly rated under OAR 436-35-450(1)(b) and his permanent impairment is 8 percent, as provided by the aforementioned rule.

ORDER

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

In the Matter of the Compensation of
SCOTT D. MURDOCK, Claimant
WCB Case No. 94-02134
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Hall and Turner-Christian.

The insurer requests review of those portions of Referee Black's order that: (1) found that claimant had good cause for his untimely filed request for hearing; and (2) set aside its denial of claimant's injury claim for a left inguinal hernia. Claimant cross-requests review of that portion of the order that denied his motion to postpone the hearing. On review, the issues are timeliness (good cause), postponement, and compensability.

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

In Barnett v. SAIF, 122 Or App 279 (1993), the court reversed a Board order that upheld a back injury denial because no physician had offered a medical opinion relating the claimant's back condition to her work activities. Citing Uris v. Compensation Dept., 247 Or 420 (1967), 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.

In Barnett, the claimant had not experienced low back pain previously, had suffered immediate low back pain after the injury, and had reported the incident to her employer the next day. In addition, there was no medical evidence which indicated that the injury did not cause the back condition. Under those circumstances, the court held that the claimant was not required to introduce expert medical testimony to prove causation.

In this case, claimant experienced immediate symptoms at work and reported them promptly to his supervisor. He was previously free of such symptoms and there is no evidence that the pushing incident at work did not cause his hernia. In addition, because there is no evidence of a potential cause other than the pushing incident¹, we conclude that this case does not present a complicated question of medical causation. Accordingly, we agree with the Referee that medical evidence regarding causation is not required.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the insurer's appeal is \$1,000 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues raised by the insurer's request for review (as represented by claimant's respondent's brief and his attorney's statement of services), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for his counsel's efforts expended in connection with claimant's cross-request for review.

¹ In support of its contention that there are two potential explanations for claimant's hernia, the insurer asserts that the medical evidence identifies coughing as the only evidence of intraabdominal pressure. We disagree.

Dr. Hoversten's chartnote, (Ex. O), does mention that claimant experienced left groin pain with coughing and that claimant had a cold on September 15, 1993. However, the same note documents the previous onset of sudden groin symptoms at work, and there is no evidence that claimant coughed (or had a cold) at that time. Moreover, because there is no evidence of an "off-work" contribution to claimant's hernia condition, the insurer's contention that claimant's reporting varied regarding his pushing activities at the time of injury does not alter our conclusion that this is a medically uncomplicated case and the facts establish that claimant's hernia is work related.

ORDER

The Referee's order dated June 16, 1994 is affirmed. Claimant's counsel is awarded a \$1,000 attorney fee, payable by the insurer.

June 2, 1995

Cite as 47 Van Natta 975 (1995)

In the Matter of the Compensation of
WILLIAM G. RANKIN, Claimant
WCB Case No. 93-10894
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of that portion of Referee Nichols' order that upheld the self-insured employer's "de facto" denial of claimant's injury claim for temporomandibular joint (TMJ) dysfunction condition. On review, the issue is compensability.

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

We do not find that claimant had preexisting conditions which "predisposed" him to develop TMJ. Instead, we find that claimant had preexisting conditions and habits which actually contribute causally to his current problems. These noncompensable contributing causes include degenerative osteoarthritis of the right and left condyle and parafunctional habits of clenching, bruxing, and lip chewing. (See Ex. 40-4; see also Ex. 46).

In addition, we acknowledge the employer's contention that claimant's November 24, 1993 request for hearing should have been dismissed, because claimant did not appeal its November 30, 1993 written denial. However, because we agree with the Referee that the TMJ claim was "de facto" denied when claimant requested a hearing (before the written denial issued), the written denial was merely duplicative and no additional request for hearing was necessary to place the matter before the Referee. See Jean M. Bates, 43 Van Natta 2280, 2284 (1991), aff'd mem Digger O'Dells Steakhouse v. Bates, 115 Or App 757 (1992).

ORDER

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

In the Matter of the Compensation of
DARCY L. BORGERDING, Claimant
WCB Case No. 94-05241
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Hazelett's order that set aside its denial of claimant's "current condition." On review, the issue is the propriety of the denial and, if proper, compensability of claimant's current condition.

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

The Referee concluded that the employer issued a procedurally improper "backup" denial. The employer contends that the Referee erred in categorizing its denial as an improper "backup" denial. Instead, citing Zora A. Ransom, 46 Van Natta 1287 (1994), the employer argues that the denial was a proper preclosure denial of a condition different from the accepted condition.¹ We disagree.

In October 1990, claimant began working for the employer doing planer relief and cleanup. In the spring of 1991, she developed a rash on her face and neck. In June 1991, she experienced a rash on her face, neck, hands and other exposed areas, breathing difficulty, and swelling of the tongue and face, while sweeping out wood dust from a pit under machinery. Claimant sought treatment from Dr. Thornfeldt, dermatologist, who diagnosed claimant's condition as allergies to red spruce and fir. The employer accepted "allergies to red spruce and fir." Claimant continued to treat with Dr. Thornfeldt for her condition.

On February 28, 1994, claimant was examined for the employer by Dr. Bardana, Head of the Division of Allergy and Clinical Immunology at the Oregon Health Sciences University. Dr. Bardana opined that Dr. Thornfeldt had misdiagnosed claimant's condition as allergy to red spruce and fir. Dr. Bardana diagnosed claimant's condition from the time of its onset as chronic urticaria/angioedema², which, he opined, was idiopathic, preexisted claimant's work with the employer, and was not related to her work exposures. (Ex. 17-16 and 17-17).

On April 24, 1994, the employer issued the following denial:

"[The employer has] received Dr. Bardana's report regarding your allergy condition and [has] completed [its] review of it. [The employer has] determined that your current condition is not related to your accepted workers' compensation claim. Therefore, we cannot accept further responsibility for treatment of this condition. We must respectfully issue this partial-denial of your current condition."

Thereafter, on June 24, 1994, the employer closed the claim with no award of permanent disability. (Ex. 20A).

We agree with the Referee's findings that the employer denied claimant's claim for the same, not a different, condition. (See Exs. 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 15, 16; compare 17).

¹ At hearing, the employer noted that it had accepted the original claim for an allergy to red spruce and Douglas fir. The employer requested to amend its denial to specify the denied current conditions as chronic idiopathic urticaria and angioedema. (Tr. 8). The Referee disallowed the amendment request. On review, the employer contends that the Referee should have ruled on the denial as amended and that he erred in concluding that the denial was a "backup" denial of the accepted condition. Like the Referee, we find that the "urticaria" and "angioedema" diagnoses merely describe the same condition/symptoms which the employer accepted under the original claim. Because the employer sought to deny responsibility for the accepted condition, it was properly set aside as an invalid "backup" denial.

² Angioedema is also known as angioneurotic edema, a condition characterized by the sudden appearance of temporary edematous areas of the skin or mucous membranes and occasionally of the viscera, often associated with dermatographia, urticaria, erythema, and purpura, which may be of allergic, neurotic, or of unknown origin. Dorland's Illustrated Medical Dictionary, 25th Edition, 1974, at 90 and 494. Urticaria is commonly known as hives. Id. at 1682.

A carrier may issue a partial denial of an unrelated condition while an accepted claim is in open status. Tattoo v. Barrett Business Service, 118 Or App 348, 353-354 (1993); Zora A. Ransom, *supra*. Assuming without deciding that the employer's denial was a partial denial of a specified condition, but see Altamirano v. Woodburn Nursery, Inc., 133 Or App 16 (1995) (denial of "then current condition" set aside as procedurally improper because denial was neither specific to a particular condition nor did it relate to a condition that arguably could have been encompassed in the claim), the denial is still invalid. First, claimant's accepted allergy claim was still in open status when the denial issued. Second, the denial is denying the same condition as claimant's accepted condition. Consequently, in addition to being an invalid "backup" denial, it is an impermissible preclosure denial of an accepted condition. See Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989) (an employer may not deny its future responsibility for payment of benefits relating to a previously accepted claim, unless it follows the statutory procedure for claim closure); Roller v. Weyerhaeuser Co., 67 Or App 743, amplified 68 Or App 743, rev den 297 Or 601 (1984) (an employer may not terminate future responsibility for a claim before the extent of claimant's disability has been determined).

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,200, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 19, 1994 is affirmed. Claimant's attorney is awarded \$1,200 for services on Board review, to be paid by the self-insured employer.

June 6, 1995

Cite as 47 Van Natta 977 (1995)

In the Matter of the Compensation of
JOHN T. CAYLOR, Claimant
 WCB Case No. 94-15663
 ORDER OF DISMISSAL
 Kevin L. Mannix, Defense Attorney

The insurer requested review of Referee Nichols' order that set aside its denial of claimant's occupational disease claim for a bilateral wrist and arm condition. The parties have submitted a proposed "Disputed Claim Settlement Stipulation and Order as to Denial of Claim," which is designed to resolve all issues raised or raisable, in lieu of the Referee's order.

Pursuant to the settlement, claimant agrees that the insurer's denial "shall remain in full force and effect and shall become final." The agreement further provides that the Referee's order "is set aside." Finally, the parties stipulate that this matter "is dismissed with prejudice."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of the Referee's order.¹ Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

¹ In granting this approval, we note that the agreement provides that claimant resigns his position with his employer and waives his rights to reemployment and reinstatement. Inasmuch as our authority is confined to workers' compensation matters under ORS Chapter 656, our approval of the parties' settlement is limited to such matters and does not extend to issues pertaining to employment rights.

In addition, the settlement does not include a list of medical service provider billings in the possession of the insurer on the settlement date or an acknowledgment that the proposed distribution complies with the reimbursement formula prescribed in

ORS 656.313(4)(d). See OAR 438-09-010(2)(g). Nevertheless, the agreement provides that the insurer shall pay all medical service provider billings pursuant to the Director's fee schedule through the settlement date in addition to the settlement proceeds. Since such payment of medical service provider billings exceeds the statutory reimbursement scheme, compliance with the "list / acknowledgment" requirements are not necessary. Robert E. Wolford, 46 Van Natta 522 (1994).

Finally, claimant, who is now appearing without legal representation, directs the insurer to pay his former attorney 25 percent of the \$6,000 settlement proceeds (\$1,500) for services previously rendered at the hearings level. Since such a provision is neither unlawful, unreasonable, nor contested, it has been approved.

June 6, 1995

Cite as 47 Van Natta 978 (1995)

In the Matter of the Compensation of
CALVIN H. HACKLER, Claimant
WCB Case No. 94-07695
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Robert Yanity (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Menashe's order that affirmed that portion of an Order on Reconsideration finding that claimant's right tibia-fibula fracture claim was not prematurely closed. On review, the issue is premature closure.

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

This claim was closed based on the medical evidence and the fact that, several months before claim closure, claimant had not sought medical treatment for his fracture. Claimant asserts that there is insufficient documentary evidence to support an administrative claim closure and insufficient medical evidence to support claim closure substantively. We need not address the first argument, because we agree with the Referee that the preponderance of the medical evidence substantively supports claim closure.

In August 1993, Dr. Bowman, treating physician, issued a report stating, "[Claimant] has really done quite well. He has full range of motion. No pain. He complains of some weakness in his right leg. I obtained repeat radiographs that showed healed fractures. Recommend aggressive rehabilitation program now. Discussed this with him and he will get this set up on his own. Follow-up PRN." (Ex. 12).

Claimant did not seek treatment for several months. The claim was closed by a December 1993 Determination Order, which was affirmed by a June 1994 Order on Reconsideration. In May 1994, claimant's claim was reopened for additional surgery. In August 1994, Dr. Bowman issued a report stating that claimant would require one and one-half to two years of conditioning before he would be considered stationary. (Ex. 32).

Claimant asserts that Dr. Bowman's August 1993 and August 1994 reports establish that, at the time of claim closure, material improvement was expected in claimant's condition with time and further care. We disagree.

Although Dr. Bowman's August 1993 report recommended further "aggressive rehabilitation," it did not indicate whether the proposed treatment would reasonably be expected to result in further material improvement in claimant's condition. Indeed, claimant's full range of motion, lack of pain, healed fracture site and Bowman's release of claimant to follow-up "PRN" -- as necessary -- suggest the contrary. Accordingly, we agree with the Referee that the August 1993 report does not preclude a finding that claimant was medically stationary. See Bill H. Davis, 45 Van Natta 773, 774 (1993) (physician's recommendation of pain management program did not support the claimant's contention that he was not medically stationary, because physician did not indicate whether, as of the date of claim

closure, the program would reasonably be expected to provide further material improvement in the claimant's condition); see also Maarefi v. SAIF, 69 Or App 527, 531 (1984) ("medically stationary," does not mean that there is a lack of need for continuing medical care).

We reach a similar conclusion regarding Dr. Bowman's August 1994 report. Evidence that was not available at the time of claim closure may be considered to the extent the evidence addresses the condition at the time of closure. Scheuning v. I.R. Simplot & Co., 84 Or App 622, 625 (1987), rev den 303 Or 590 (1987). Here, we find that the August 1994 report addressed claimant's condition after the second surgery, not at the time of claim closure. Accordingly, we have not considered that report in evaluating claimant's medically stationary status when the December 1993 Determination Order issued.

In sum, for the reasons stated in the Referee's order, as supplemented here, we agree that claimant's claim was not prematurely closed. Accordingly, we affirm the Referee's order affirming the Order on Reconsideration.

ORDER

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

Board Member Hall specially concurring.

I agree that claimant has failed to establish that his right tibia-fibula fracture claim was prematurely closed. I write only to note that, at first blush, Dr. Bowman's recommendation of an "aggressive rehabilitation program" in August 1993 suggests that he expected further material improvement in claimant's condition at that time. However, when that statement is taken in context, I agree that the evidence does not preponderate in claimant's favor. Therefore, I concur with this decision.

June 6, 1995

Cite as 47 Van Natta 979 (1995)

In the Matter of the Compensation of
CHRISTINE M. HASVOLD, Claimant
WCB Case No. 93-04460
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Niedig and Hall.

Claimant requests review of those portions of Referee Podnar's order that: (1) declined to reclassify claimant's cervical strain claim as disabling; (2) upheld the insurer's denial of claimant's injury claim for left carpal tunnel syndrome; and (3) declined to assess a penalty for the insurer's allegedly unreasonable denial. On review, the issues are claim classification, compensability and penalties.

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

The Referee declined to reclassify claimant's claim on the grounds that claimant was never disabled from work. On review, claimant argues that her claim is disabling if she is entitled to an award of permanent disability or will likely be entitled to such an award. See OAR 436-30-045(7).

At the outset, we note that the insurer accepted claimant's cervical strain claim as nondisabling more than a year after the compensable injury. Thus, through no fault of her own, claimant was precluded from seeking reclassification of her claim by the Department. Under such circumstances, claimant was entitled to request a hearing seeking reclassification of her claim pursuant to ORS 656.283(1). Donald R. Dodgin, 45 Van Natta 1642 (1993).

Under OAR 436-30-045(7), a claim is disabling:

* * *

"(b) If the worker is medically stationary within one year of the date of injury and the worker substantial likelihood that the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726;

"(c) The worker is not medically stationary, but there is a substantial likelihood that the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726 when the worker does become medically stationary
* * *"

Claimant argues that her claim should be reclassified as disabling because she has established that she will be entitled to an award of permanent disability for a chronic condition and lost ranges of motion in her cervical spine. We disagree.

Examining physicians, Drs. Colletti and Phipps opined that claimant was medically stationary from the October 20, 1992 compensable injury, but believed that claimant's lost range of cervical motion was related to claimant's noncompensable motor vehicle accident in 1990. (Ex. 35-3,4). Dr. Corrigan, a consulting physician, opined that claimant was medically stationary without any measurable impairment secondary to the October 20, 1992 injury. (Ex. 38-3).

Dr. Puziss, an orthopedist who treated claimant, noted that claimant had decreased ranges of motion in her cervical spine. (Ex. 45-4). However, Dr. Puziss did not indicate whether he believed that claimant was medically stationary or whether the impairment he noted was permanent or was due to the compensable injury. Claimant also cites a physical therapist's report which finds reduced ranges of motion. (Ex. 48). That report likewise does not address whether the findings of lost range of cervical motion are due to the injury or are permanent.

Claimant previously injured her neck in a 1990 noncompensable motor vehicle accident and also had two prior compensable injuries which involved neck symptoms. There is some evidence that claimant may have previously had reduced ranges of cervical motion. (Exs. 8-1; 9-1; 35-3). Given claimant's prior injuries, and the contrary evidence from Drs. Corrigan, Colletti and Phipps, we are not persuaded, without more explanation, that the lost ranges of cervical motion found by Dr. Puziss and the physical therapist constitutes findings of permanent impairment which are due to the October 1992 compensable injury. In addition, we find no evidence in the record that claimant is unable to repetitively use her neck due to a chronic and permanent medical condition.

Thus, on this record, we are unable to conclude either that claimant will be entitled to an award of permanent disability or that there is a substantial likelihood that claimant will be entitled to an award of permanent disability. Accordingly, we agree with the Referee that claimant is not entitled to reclassification of her October 1992 injury claim.

ORDER

The Referee's order dated September 7, 1994 is affirmed.

In the Matter of the Compensation of
LISA R. ANGSTADT, Claimant
WCB Case No. 94-03657
ORDER ON REVIEW
Terrance J. Slominski, Claimant Attorney
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Bethlahmy's order which: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral hand and wrist condition; (2) declined to award claimant interim compensation; and (3) declined to award penalties and attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are compensability, interim compensation, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, who was initially hired as a receptionist in September 1993, was transferred to a typing position in mid-November 1993. Claimant sought treatment from her long-time family physician, Dr. Eubanks, on December 4, 1993, at which time she gave a history of a painful left thumb for the previous three days. She also reported that her right extremity was painful the prior night and that all her joints hurt, especially her wrists. Dr. Eubanks initially diagnosed right wrist tendonitis. (Ex. A-20). Claimant filed a form 801 on December 15, 1993 for bilateral "carpal tunnel."

The employer's office manager then referred claimant to an osteopath, Dr. Witczak, who reported claimant's onset of bilateral hand pain as on or about November 27, 1993. Dr. Witczak diagnosed bilateral hand tendonitis and median nerve neuritis bilaterally. (Ex. 3). Dr. Witczak would later characterize the diagnosis as a bilateral hand and wrist "overuse syndrome." (Ex. 12-1). Claimant was also evaluated by examining physicians, Drs. Nathan and Podemski.

Claimant was fired for reasons unrelated to her claim on January 7, 1994. At the time, claimant was released for her regular duties except that Dr. Witczak had advised against using a heavy date stamper. (Ex. 5). Dr. Witczak subsequently restricted claimant to light duty on January 17, 1994. (Ex. 6). SAIF denied claimant's "tendonitis" claim on February 25, 1994.

The Referee described the issue as the compensability of claimant's "tendonitis claim." Noting that claimant had been diagnosed with tendonitis in the left arm in 1991, the Referee concluded that claimant's left tendonitis claim was not compensable because the medical evidence did not support a finding that her employment worsened the tendonitis condition.

With respect to claimant's right extremity, the Referee also determined that claimant failed to sustain her burden of proof. Finding that Dr. Witczak had been provided an inaccurate and incomplete history, the Referee declined to rely on his medical opinion that claimant's employment was the major contributing cause of claimant's hand and wrist condition.

Finally, the Referee determined that claimant was not entitled to interim compensation because she was not taken off work due to the alleged injury and her employment ended because of reasons unrelated to the alleged injury. Given this conclusion, the Referee further found that claimant was not entitled to penalties or attorney fees for failure to pay interim compensation.

Compensability

On review, claimant initially contends that her bilateral wrist condition is compensable. She asserts that the medical opinions of Drs. Witczak and Podemski establish that her condition is compensable. We disagree.

Dr. Witzcak opined that claimant's employment was the major contributing cause of her hand and wrist overuse condition. (Ex. 12). However, we are not persuaded by his opinion. First, Dr. Witzcak provided no explanation of how claimant's typing activities caused her overuse condition. Inasmuch as it is conclusory, we find that Dr. Witzcak's opinion is entitled to little weight. See Marta L. Gomez, 46 Van Natta 1654 (1994) (least weight given to conclusory, poorly analyzed opinions), citing Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Second, we agree with the Referee that Dr. Witzcak did not have a complete and accurate history. Dr. Witzcak was unaware that claimant had received treatment in 1991 from Dr. Eubanks for her left arm. At that time, claimant reported sharp pains that radiated from her left wrist to the elbow and left arm pain from the fingers to the shoulder. (Ex. A-1). Claimant was diagnosed with left forearm tendonitis. We recognize that claimant did not receive any treatment for this condition after February 1991. Given the fact that claimant reported symptoms in the hand and wrist, we, nevertheless, believe that the weight of Dr. Witzcak's opinion on the causation of claimant's current left hand and wrist condition should be reduced.¹ See Somers v. SAIF, 77 Or App 259 (1986) (persuasiveness of medical opinion depends on accurate and complete history).

More important, however, is the fact that Dr. Witzcak was unaware that claimant had called Dr. Eubanks in October 1993, before she transferred to the typist position, and reported right elbow and wrist pain. We conclude that this gap in Dr. Witzcak's history is significant given Dr. Witzcak's express acknowledgment that, based on the history claimant gave to him, she did not experience hand or wrist problems prior to becoming a typist in November 1993.

For the foregoing reasons, we conclude that Dr. Witzcak's opinion is not persuasive. For similar reasons, we discount Dr. Podemski's opinion. Dr. Podemski opined that it is medically probable that claimant's need for treatment was due to her work. (Ex. 13). Like Dr. Witzcak, however, Dr. Podemski was unaware of claimant's reporting of right wrist symptoms in October 1993. In addition, while Dr. Podemski was apparently generally aware of claimant's left elbow and shoulder problems in 1991, there is no indication that he reviewed Dr. Eubanks' chart notes. Moreover, Dr. Podemski also did not explain how claimant's typing duties caused her overuse syndrome. Moe v. Ceiling Systems, *supra*. Instead, he appeared to rely on a temporal relationship between the reported onset of symptoms and claimant's work as a typist. See Allie v. SAIF, 79 Or App 284 (1986). For these reasons, we do not find his opinion to be persuasive.

In summary, we find that there is insufficient persuasive medical evidence that claimant's typing activities are the major contributing cause of her bilateral hand and wrist condition. Accordingly, we affirm the Referee's decision to uphold SAIF's denial.

Interim Compensation

Claimant argues that, even if her claim is not compensable, she is entitled to interim compensation from the time she was terminated from her employment on January 7, 1994 until the February 25, 1994 denial. SAIF responds by arguing that claimant was never taken off work because of her claim and that, when she was terminated for reasons unrelated to employment, claimant was performing her regular work. Thus, according to SAIF, claimant was not entitled to interim compensation.

A claimant who has been fired from work, but otherwise is in the work force, is entitled to interim compensation if the worker has "left work," *i.e.*, either been absent from work or sustained diminished earning power, for such period as is attributable to work-related disability. Randel G. Jensen, 45 Van Natta 898 (1993), (citing Bono v. SAIF, 298 Or 405 (1984); Nix v. SAIF, 80 Or App 656, 659 (1986); and Weyerhaeuser Company v. Bergstrom, 77 Or App 425 (1986)), *aff'd* RSG Forest Products v. Jensen, 127 Or App 247 (1994).

¹ We do not necessarily agree with the Referee that claimant's left arm condition in 1991 constituted a "pre-existing condition," inasmuch as claimant received no treatment after February 1991. We need not definitively decide the issue in order to conclude that Dr. Witzcak's history was incomplete.

When claimant was terminated, no physician had restricted her from performing her regular work. Although she had been advised to avoid using a date stamper, claimant was doing substantially the same job she held when she developed her hand and wrist symptoms. Cf. OAR 436-35-270(3)(c) (under the disability "standards," "regular work" means "substantially the same job held at the time of injury."). Therefore, we do not find that claimant had sustained diminished earning power at the time she was fired. Thus, we do not find that she was then entitled to interim compensation.

However, Dr. Witczak subsequently restricted claimant to light duty on January 17, 1994. (Ex. 6). At that point, claimant suffered diminished earning power. Thus, we conclude that claimant was entitled to interim compensation, consisting of temporary partial disability, as of that date. See Stone v. Whittier Wood Products, 124 Or App 117 (1993); 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); Cf. Theo Heintz, 46 Van Natta 2188 (1994) (where there was no evidence that work restrictions had been in effect prior to denial, the claimant suffered no loss of earnings related to his alleged injury prior to the insurer's denial); Randel G. Jensen, supra. Claimant's temporary partial disability rate shall be calculated based on her proportionate loss of earning power at any kind of work. OAR 436-60-030; Stone v. Whittier Wood Products, supra.

Claimant's attorney is entitled to a fee of 25 percent of the amount of interim compensation, not to exceed \$3,800, payable directly to claimant's counsel. See ORS 656.386(2); OAR 438-15-055(1); Lee R. Jones, 46 Van Natta 2179, 2182 (1994).

Penalty

Claimant also contends that SAIF's failure to pay interim compensation was unreasonable, thus entitling her to a penalty. We agree.

Refusal to pay interim compensation is a claims processing decision that necessarily assumes the risk of assessed penalties and attorney fees if that decision is later found to have been unreasonable. See Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984).

Since claimant was terminated for reasons unrelated to her claim and was performing her regular work at the time of the termination, we do not find that SAIF's failure to pay interim compensation was unreasonable at that time. However, SAIF offers no reason why it did not address claimant's entitlement to interim compensation prior to its denial after she was restricted to light duty on January 17, 1994. We, therefore, find SAIF's conduct to have been unreasonable. Jerilyn Hendrickson, supra at 1890. Thus, we assess a 25 percent penalty pursuant to ORS 656.262(10), to be based on the interim compensation granted as a result of this order. The penalty is to be shared equally by claimant and her attorney.

ORDER

The Referee's order dated July 14, 1994 is affirmed in part and reversed in part. That portion which declined to award interim compensation and a penalty for SAIF's failure to pay interim compensation is reversed. SAIF is directed to calculate claimant's temporary partial disability rate and pay claimant temporary partial disability from January 17, 1994 until February 25, 1994. Claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the interim compensation granted by this order, not to exceed \$ 3,800, payable directly to claimant's attorney by SAIF. SAIF is assessed a penalty equal to 25 percent of the interim compensation granted by this order. This penalty is to be shared equally by claimant and her attorney. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DARLENE L. BARTZ, Claimant
WCB Case No. 94-08692
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Referee Holtan's order that: (1) directed it to pay temporary total disability (TTD) benefits awarded by a prior referee's order; (2) assessed a penalty for the employer's allegedly unreasonable failure to pay TTD compensation; and (3) awarded claimant's counsel an assessed attorney fee under ORS 656.382(1) for the employer's allegedly unreasonable refusal to pay compensation due under an order of a referee. On review, the issues are propriety of the Referee's decision "enforcing" a prior referee's TTD award, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On October 30, 1993, the employer issued a Notice of Closure declaring claimant medically stationary on September 10, 1992 and granting claimant TTD through September 9, 1992. (Ex. 3-1). The employer paid that TTD, but did not pay the TTD that had earlier been awarded by Referee Michael Johnson's October 18, 1993 order, "commencing January 14, 1993 and continuing until lawfully terminated." (Ex. 2).

Claimant brought this case to hearing, seeking payment of TTD under Referee Johnson's order.

CONCLUSIONS OF LAW AND OPINION

Propriety of Referee's TTD "Enforcement" Decision

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

On January 13, 1993, the Board issued its order reversing another referee's order (which had upheld the employer's denial of claimant's bilateral carpal tunnel syndrome condition) and remanding the claim to the employer for processing according to law.¹ The employer appealed the Board's order. While that appeal was pending, the employer neither closed the claim nor paid temporary disability subsequent to the Board's January 13, 1993 "compensability" order. See ORS 656.313(1)(a)(A).

Thereafter, claimant requested a hearing, seeking an order directing the employer to pay the "post-Board order" temporary disability. On October 18, 1993, Referee Johnson ordered the employer to pay claimant TTD "commencing January 14, 1993 and continuing until lawfully terminated." (Ex. 2). We affirmed that order on review.

The employer asserts that it has complied with Referee's Johnson's order. It has not. Rather, in accord with its October 30, 1993 Notice of Closure, which found claimant medically stationary on September 10, 1992, it paid claimant TTD through September 9, 1992. (Ex. 3-1). The Notice of Closure did not vitiate the employer's statutory obligation to continue paying "post-litigation order" temporary disability benefits during its appeal of the Board's January 13, 1993 order, until claim closure. Lela K. Mead-Johnson, 45 Van Natta 1754 (1993); see ORS 656.313(1)(a)(A);² Anodizing, Inc. v. Heath, 129 Or

¹ The Court of Appeals affirmed that order without opinion. Jeld-Wen, Inc. v. Bartz, 123 Or App 359 (1993).

² ORS 656.313(1)(a)(A) obligates a carrier to continue paying temporary disability compensation during a carrier appeal from the date of the order appealed from until claim closure or until the appealed order is reversed, whichever occurs first. Here, the appealed order was affirmed, see note 1, supra; therefore, the Notice of Closure necessarily occurred first.

The employer analogizes this case to Dean L. Watkins, 44 Van Natta 1006 (1992). That case concerned the effect of a Board decision upholding one Determination Order on a carrier's obligation to pay TTD benefits pursuant to a subsequent referee's decision setting aside a second Determination Order. That case did not address the carrier's obligations to continue paying TTD benefits under ORS 656.313(1)(a)(A); this case does. Accordingly, we find Watkins inapposite.

App 356 (1994). Accordingly, we affirm the Referee's decision "enforcing" Referee Johnson's award of TTD benefits and ordering the employer to pay claimant TTD from January 14, 1993 (the day after the Board's "compensability" order) through October 30, 1993 (the date of the employer's Notice of Closure).

Penalties

We adopt and affirm the Referee's penalty analysis and conclusions.

ORS 656.382(1) Attorney Fees

The employer asserts that, because the factual basis for the Referee's penalty under ORS 656.262(10)(a) and the assessed attorney fee under ORS 656.382(1) are identical, there is no basis for awarding the assessed fee. We agree.

If a carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for a penalty in the form of an additional amount up to 25 percent of the amounts then due. ORS 656.262(10)(a). ORS 656.382(1) allows for a penalty-related attorney fee for an unreasonable resistance to the payment of compensation if there are no "amounts then due" on which to base a penalty and the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10)(a). Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992).

Here, there were "amounts then due" on which to base a penalty: the unpaid TTD benefits. Moreover, the employer's unreasonable resistance that served as a basis for the attorney fee under ORS 656.382(1) is the same conduct on which the Referee's penalty award was based; viz., the employer's refusal to pay TTD compensation as ordered by Referee Johnson. Accordingly, we reverse that portion of the Referee's order that awarded an assessed attorney fee pursuant to ORS 656.382(1).

Claimant's attorney is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the TTD enforcement issue is \$1,000, to be paid by the employer. In reaching that conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have not considered services related to the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated December 1, 1994 is affirmed in part and reversed in part. The Referee's \$2,500 attorney fee award pursuant to ORS 656.382(1) is reversed. The remainder of the Referee's order is affirmed. For services on review, claimant's attorney is awarded \$1,000, payable by the self-insured employer.

In the Matter of the Compensation of
JAMES E. CLEMONS, Claimant
WCB Case Nos. 93-01095, 93-04939, 93-09915 & 93-09916
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Cowling, Heysell, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee McWilliams' order that: (1) set aside its denial of claimant's January 1993 aggravation claim for a left shoulder condition; and (2) awarded claimant's attorney a \$3,500 assessed attorney fee for his efforts in setting aside the January 1993 aggravation denial. On review, the issues are aggravation and attorney fees. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

Aggravation/Extent of Permanent Disability

We adopt the Referee's reasoning and conclusion concerning the aggravation issue.

The Referee found that claimant had suffered a compensable aggravation between the date of the Notice of Closure and the Order on Reconsideration. We agree with the Referee that the baseline for determining whether or not claimant's compensable condition worsened is his medically stationary status, up to and including, the October 13, 1992 Notice of Closure. See Lindon E. Lewis, 46 Van Natta 237 aff'd mem Morgan Manufacturing v. Lewis, 131 Or App 267 (1994).

Extent of Permanent Disability

Because claimant's claim was in open status as a result of the aggravation, we likewise agree with the Referee's decision to defer rating of the extent of claimant's unscheduled permanent disability. See Steven P. Grossaint, 46 Van Natta 1737 (1994); Wanda N. Hainey, 44 Van Natta 674 (1992) (permanent disability should not be rated where the claimant was medically stationary when the claim was initially closed, but where the claim was open at the time of hearing or where the claimant was not medically stationary due to a subsequent aggravation).

Although we agree that the Referee properly deferred the extent issue, we do not agree with the Referee's decision to set aside the January 22, 1993 Order on Reconsideration. Based on the following reasoning, we reinstate the Order on Reconsideration.

First, we recognize that the medical arbiter's examination was performed three days after claimant had been restricted from work for his aggravation. We are also aware that the extent of permanent disability is rated as of the date of the Order on Reconsideration. See ORS 656.283(7). Because claimant's aggravation occurred prior to the medical arbiter's examination, the medical arbiter's impairment findings may not be persuasive evidence regarding claimant's disability resulting from the initial closure of his claim. Nevertheless, neither party contended at hearing that the claim had been prematurely closed and we are unaware of any other precedent or authority for setting aside the Order on Reconsideration. Second, in the absence of a reconsideration order, the Board and its Hearings Division generally do not have jurisdiction to consider a request for hearing arising from a Notice of Closure or Determination Order. See ORS 656.268(4)(e), (5) and (6)(b); Larry R. Hudnall, 44 Van Natta 2378 (1992); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

Thus, the existence of the January 22, 1993 Order on Reconsideration is a prerequisite for claimant's hearing request on the extent of permanent disability arising from the initial closure of his claim. Under the circumstances, we conclude that the Order on Reconsideration should not have been set aside. Accordingly, we reinstate the January 22, 1993 Order on Reconsideration.

In the event that the closure of claimant's aggravation claim results in another hearing request, that request shall be consolidated with WCB Case Number 94-07535 (the case to which the Referee assigned the "extent" issue). See Wanda N. Hainey, supra at 676. Should no subsequent hearing request be filed after the closure of claimant's aggravation claim, the parties shall so notify the Hearings Division, at which time WCB Case No. 94-07535 will be scheduled for a hearing. Thereafter the parties will be entitled to litigate the extent of claimant's permanent disability based on claimant's hearing request filed on the January 22, 1993 Order on Reconsideration.

In addition to deferring the extent of disability issue, the Referee also deferred the June 1993 aggravation claim for litigation. An aggravation is a worsened condition occurring after claim closure and can only become an issue once a valid claim closure has been accomplished. ORS 656.273; Jack I. Ford, Jr., 44 Van Natta 1493 (1992). Here, in light of our conclusion that the claim is in open status as a result of the January 1993 aggravation, there could be no June 1993 aggravation. Thus, we conclude that the July 1993 aggravation denial is moot. Accordingly, since it was unnecessary for the Referee to defer the moot June 1993 "aggravation" claim for later litigation, we modify that portion of the order which deferred the June 1993 "aggravation."

Attorney Fee/Hearing Level

The employer contends that the Referee's \$3,500 attorney fee award regarding the aggravation issue is excessive. We disagree.

A reasonable amount for an attorney fee is determined based on the following factors: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorney; (5) the nature of the proceeding; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. OAR 438-15-010(4).

After review of the record at hearing and considering the above factors, we conclude that the Referee's award is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the aggravation issues, including the January and August 1993 aggravation claims (as represented by the record), the complexity of the issues, the benefit secured for claimant and the risk that counsel's efforts might go uncompensated. We further note that claimant's counsel is not entitled to an attorney fee for services at the hearing level devoted to the extent of permanent disability issue.

Attorney Fee/Board Review

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the aggravation issue is \$750, payable 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. Claimant is not entitled to an attorney fee for services on review concerning the Referee's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated June 30, 1994 is reversed in part, modified in part and affirmed in part. The January 22, 1993 Order on Reconsideration is reinstated and deferred for hearing under WCB Case No. 94-07535. The employer's denial of claimant's June 1993 aggravation claim is set aside as moot. For services on review, claimant's attorney is awarded \$750, payable by the employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MARSHA K. FLANARY, Claimant
WCB Case No. 90-15238
ORDER ON REMAND
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

This matter is before the Board on remand from the Court of Appeals. Flanary v. Holladay Park Hospital, 124 Or App 206 (1993). The court has reversed our prior order, Marsha K. Flanary, 44 Van Natta 392 (1992), which held that the Hearings Division lacked jurisdiction to address claimant's request for hearing on the self-insured employer's "de facto" denials of her medical services claims for a back corset and pain center treatment. Citing Jefferson v. Sam's Cafe, 123 Or App 464 (1993), and Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court has remanded for reconsideration of the claims for medical treatment.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable low back strain in 1989. She continued to experience low back pain the following year. In April 1990, claimant was evaluated by Dr. Steinhauer, who stated that, if medical examinations did not indicate a need for surgery, then claimant should participate in rehabilitation, such as pain center treatment.

On April 16, 1990, claimant's treating physician, Dr. Treible, prescribed a lumbosacral corset. Claimant was initially unable to obtain the corset. However, on June 8, 1990, the employer's representative authorized the purchase of the corset.

Dr. Treible referred claimant to Dr. Misko for a neurosurgical consultation. An MRI showed small disc protrusions at L4-5 and L5-S1, and spondylolysis at the L5-S1 level. On May 24, 1990, Dr. Misko requested authorization to perform a lumbar laminectomy and fusion surgery.

Dr. Misko subsequently withdrew his recommendation for surgery. On August 31, 1990, Dr. Steinhauer recommended either pain center treatment or claim closure. Dr. Steinhauer stated that pain center therapy would be appropriate if claimant agreed that the treatment would be directed at "functional improvement and return-to-work." Dr. Steinhauer added that if claimant was not interested, he would not recommend the program.

On October 1, 1990, the employer denied claimant's current condition and treatment, on the ground that her current condition was not related to the October 22, 1989 injury. Claimant requested a hearing.

The Referee set aside the employer's denial of claimant's current condition. The Referee also found that there had been no denial of the pain center treatment, as claimant had never requested such treatment. Additionally, the Referee found that there had been no "de facto" denial of a back corset, as the employer authorized the corset, even though claimant did not know about the authorization.

On review, we reversed that portion of the Referee's order which set aside the employer's denial of claimant's current condition. Marsha K. Flanary, supra. We also vacated that portion of the Referee's order that purported to address the medical services issues. In so doing, we reasoned that the Director had exclusive jurisdiction over the medical services issues. Marsha K. Flanary, supra. Claimant appealed.

The court affirmed that portion of our order which upheld the employer's current condition denial. However, the court reversed and remanded for reconsideration on the medical services issues, in light of its decision in Meyers v. Darigold, Inc., supra. Flanary v. Holladay Park Hospital, supra.

In Meyers, the court held that the Board has jurisdiction to consider medical treatment disputes if no party has requested that the Director resolve the dispute. Accordingly, because no party has requested Director review, we find that we have jurisdiction over this matter, and we reconsider our prior decision.

Pain Center Treatment

The Referee found that claimant had not requested pain center treatment until the date of hearing. Consequently, the Referee concluded that there had been no "de facto" denial of pain center treatment. We find that there has been a "de facto" denial. However, we are not persuaded that the claim for pain center treatment is compensable.

A claim is a "written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which the subject employer has notice or knowledge." ORS 656.005(6). A physician's report requesting or prescribing medical treatment constitutes a claim. See ORS 656.005(6) and (8); see also Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992). A claim is denied "de facto" if the insurer fails to accept or deny the claim within 90 days of notice or knowledge of the claim. See ORS 656.262(6); SAIF v. Allen, 320 Or 192 (1994); Barr v. EBI Companies, 88 Or App 132 (1987); Betti A. Haley, 46 Van Natta 205, on recon 46 Van Natta 520 (1994).

Here, on July 31, 1990, Dr. Steinhauer recommended claimant for pain center therapy. Dr. Steinhauer stated that, if pain center treatment was felt to be a viable treatment option, he would be happy to meet with claimant and discuss her "return-to-work situation." Dr. Steinhauer also reported that he would be willing to try to rehabilitate her "contingent on her agreement to go back to work at her job-at-injury."

Subsequently, on August 31, 1990, Dr. Steinhauer wrote to the employer stating that pain center therapy would be appropriate if claimant was in agreement that treatment would be directed at functional improvement and "return-to-work." Dr. Steinhauer clarified that he would not recommend the program for claimant if she was not interested, and he noted that there would need to be authorization for the treatment. Finally, Dr. Steinhauer stated that, if the employer "was willing to offer her the program," then her doctors would meet with claimant to discuss treatment goals and to verify her interest in returning to work.

Under the circumstances, we conclude that Dr. Steinhauer's August 31, 1990 letter was a claim for pain center treatment, as the letter is a physician's written request, on claimant's behalf, requesting the employer's authorization for pain center therapy. See Safeway Stores, Inc. v. Smith, supra. In reaching this conclusion, we acknowledge that the request was, arguably, "contingent" on claimant's interest in such treatment. However, by his letter, Dr. Steinhauer had put the issue/request before the employer. In other words, if the employer was willing to authorize the treatment, Dr. Steinhauer was willing to talk to claimant. Consequently, we find that Dr. Steinhauer's request on claimant's behalf constituted a claim. Additionally, because the employer did not deny the claim prior to the December 1990 hearing, the claim was "de facto" denied, as the employer had not accepted or denied the claim within 90 days of notice or knowledge of the claim.

Having determined that there has been a "de facto" denial, we proceed to an examination of the merits of claimant's medical services claim for pain center treatment. To establish the compensability of the claim, claimant must prove that the proposed treatment is reasonable and necessary. West v. SAIF, 74 Or App 317 (1985).

Dr. Steinhauer has sought the employer's authorization of the proposed treatment. However, in doing so, Dr. Steinhauer placed a qualification on the propriety of such treatment. Specifically, Dr. Steinhauer only recommended pain center therapy if claimant met with him to discuss treatment goals and to verify her interest in returning to work.

The record neither contains evidence establishing that such a meeting occurred nor claimant's testimony that she was willing to meet with Dr. Steinhauer or undergo such treatment. Because there is no evidence that claimant has satisfied the express contingency placed upon the pain center treatment

recommendation of Dr. Steinhauer, we are unable to find that claimant's pain center treatment claim advanced at the December 1990 hearing was appropriate.¹

Back Corset

The Referee also found that there had been no "de facto" denial of a back corset, as the employer authorized the back corset, even though claimant was not aware of that authorization. We agree.

Claimant contends that her treating doctor prescribed the back corset for her on April 16, 1990. Claimant took the written prescription to an orthopedic company and the company declined to provide her with the back corset. Thereafter, on June 8, 1990, the employer wrote a letter to the company authorizing the purchase of a corset for claimant.

Claimant argues that, because she was never provided with a copy of the employer's June 1990 letter authorizing the corset purchase, and she never did receive the corset, the back corset has been "de facto" denied by the employer. We disagree.

As we previously stated, a claim is "de facto" denied if an employer has neither accepted nor denied the claim within 90 days of notice or knowledge of the claim. Here, the corset was prescribed on April 16, 1990, and it is undisputed that the employer authorized the corset on June 8, 1990. The June 8, 1990 authorization constituted an acceptance of the claim for the corset. Therefore, notwithstanding claimant's apparent failure to receive notice of the employer's acceptance, we agree with the Referee that there has been no "de facto" denial of the back corset.

Accordingly, on reconsideration, as supplemented and modified herein, we affirm those portions of the Referee's order dated December 26, 1990 that declined to grant claimant's request for pain center treatment and declined to find that the employer had denied claimant's back corset request.

IT IS SO ORDERED.

¹ In the alternative, claimant suggests that this case be remanded to the Hearings Division for further development of this issue. The request is denied. Other than asserting that the hearing was held some 4 1/2 years ago and that this case could be consolidated with another hearing which is presently stayed awaiting resolution of this dispute, claimant offers no reasoning to support a conclusion that the present record is insufficiently developed and, even if it was, that additional evidence exists which could not have been obtained with the exercise of due diligence at the time of the initial hearing. See ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In the absence of a persuasive reason for granting claimant's belated request, we do not find remand to be warranted.

In the Matter of the Compensation of
EULALIO M. GARCIA, Claimant
WCB Case No. 94-07701
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Myzak's order that found that claimant was not entitled to temporary disability for periods subsequent to the date of a prior referee's order. On review, the issue is temporary disability.

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

In this proceeding, claimant seeks enforcement of Referee Howell's June 6, 1994 order which found that the SAIF Corporation had improperly unilaterally terminated payment of temporary total disability benefits and ordered SAIF to pay unpaid temporary disability from the date of the compensable injury to "the present."

Subsequent to the date of the Referee's order, we issued our order on review of Referee Howell's order. In Eulalio M. Garcia, 47 Van Natta 96 (1995), we agreed with Referee Howell's conclusion that SAIF was not entitled to unilaterally terminate claimant's TTD. However, we modified Referee Howell's award of temporary total disability benefits to award temporary partial disability benefits during the period that claimant received unemployment benefits. We affirmed the remainder of Referee Howell's order and did not alter that portion of Referee Howell's order awarding temporary disability to the "present." Our order was not appealed and has become final.

The Referee concluded that Referee Howell's order was not currently enforceable because temporary disability compensation awarded for periods prior to Referee Howell's order was stayed pending appeal under ORS 656.313(1). The Referee further found that the order did not award any compensation for periods after the date of Referee Howell's June 6, 1994 order. We agree with the Referee's conclusions.

At the time the present Referee issued her order, Referee Howell's order was on appeal to the Board pursuant to SAIF's request for review. Thus, as the Referee correctly concluded, compensation awarded by Referee Howell's order for periods prior to the date of the order was stayed pending the appeal. See ORS 656.313(1).

Under ORS 656.313(1)(a)(A), temporary disability benefits which accrue from the date of the order appealed until closure or until the order is reversed cannot be stayed pending appeal. However, neither Referee Howell's order, nor our order, awarded temporary disability compensation payable after the date of Referee Howell's June 6, 1994 order.

Specifically, in his June 6, 1994 order, Referee Howell directed SAIF to pay unpaid temporary disability benefits from the date of injury "to the present." On Board review, we affirmed that portion of Referee Howell's order and our order has become final. Claimant argues that the phrase "to the present" is a standard workers' compensation term and means that the insurer must pay the benefits until closure. We disagree that the phrase "to the present" means continuing into the future, as claimant contends. Rather, we interpret the words literally to mean that SAIF was ordered to pay the benefits through the date of Referee Howell's order. If claimant disagreed with the periods for which temporary disability benefits were awarded, his remedy was to request reconsideration of that order or appeal that portion of Referee Howell's order to the Board. Claimant did not do so and we have affirmed that portion of Referee Howell's order. Accordingly, for the reasons set forth in this order, the relief requested by claimant is denied.

Should SAIF fail to comply with our order affirming Referee Howell's order (but modifying his award of temporary total disability to temporary partial disability for periods during which claimant received unemployment compensation), claimant may request a new hearing seeking enforcement of that order.

ORDER

The Referee's order dated October 21, 1994 is affirmed.

Board Member Hall specially concurring.

This is a proceeding to enforce Referee Howell's order which concluded that SAIF had improperly unilaterally terminated claimant's temporary disability benefits and directed SAIF to pay temporary disability benefits from the date of injury "to the present." The parties have stipulated that SAIF has paid no temporary disability after June 6, 1994, the date of Referee Howell's order.

ORS 656.268(3) sets out the circumstances under which temporary total disability benefits may be terminated. None of the circumstances authorizing unilateral termination of temporary disability occurred either before or after Referee Howell's order.¹ Thus, SAIF was not authorized under ORS 656.268(3) to terminate procedural temporary disability on June 6, 1994.

Nevertheless, Referee Howell ordered SAIF to pay temporary disability benefits "to the present." By "to the present," Referee Howell must have meant what he said, i.e., through the date of his order. When ordering a carrier to pay temporary disability in circumstances such as this, the Board and referees generally use language which directs the carrier to pay the temporary disability benefits "until termination is authorized by law," or some similar language. The only issue before us is the enforcement of Referee Howell's order. Here, by the plain meaning of his order, Referee Howell did not award any temporary disability after the date of his order.

Claimant's remedy was to move for reconsideration of Referee Howell's order and seek clarification of the language "to the present" or to appeal that portion of Referee Howell's order to the Board. Although SAIF appealed Referee Howell's order, claimant did not cross-appeal that portion of the order awarding benefits "to the present" and we did not modify that language in our January 26, 1995 order on review of Referee Howell's order. Eulalio Garcia, supra. Our Order on Review of Referee Howell's order was not appealed to the court and has now become final by operation of law. Under the circumstances, we are unable to grant the relief claimant seeks.

Although I do not believe that ORS 656.268(3) authorized SAIF to cease paying benefits on June 6, 1994, Referee Howell's order does not award any benefits after that date. For the reasons given above, I concur that Referee Howell's order must continue to be interpreted and enforced according to its terms.

¹ I note that the claim was subsequently closed on July 22, 1994.

June 7, 1995

Cite as 47 Van Natta 992 (1995)

In the Matter of the Compensation of
COLIN J. McINTOSH, Claimant
 WCB Case No. 94-08299
 ORDER ON REVIEW
 Coons, Cole & Cary, Claimant Attorneys
 Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee McWilliams' order that: (1) set aside its denial of claimant's injury claim for a psychological condition; and (2) assessed a 25 percent penalty against the insurer for an allegedly untimely denial. On review, the issues are compensability and penalties.

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

The Referee concluded that claimant had a preexisting mental condition as evidenced by his prior treatment for post-traumatic stress disorder (PTSD). Applying the major contributing cause standard, the Referee concluded that claimant had established compensability of his depression under ORS 656.005(7)(a)(B).

On review, the insurer argues that the Referee erred in relying on the opinion of Dr. McDonald, a psychologist, over that of Dr. Parvaresh, a psychiatrist. Specifically, the insurer contends that Dr. McDonald did not have a complete history of claimant's prior treatment for PTSD. The insurer further argues that the Referee erred in not considering the opinion of Michael Hendricks, a clinical social worker.

We are not persuaded that Dr. McDonald had an inaccurate history of claimant's preexisting PTSD. Dr. McDonald's reports reveal that he had an accurate history of claimant's preexisting problems related to military service as well as claimant's prior alcohol dependence.

Dr. McDonald concluded that, although claimant's preexisting problems may have contributed to his present psychological condition, they were not the major contributing cause of his depression. Dr. McDonald further concluded that claimant's major depression and subsequent anxiety were directly attributable to his February 1993 work injury. For the reasons given by the Referee, we agree that Dr. McDonald's causation opinion is more persuasive than that of Dr. Parvaresh. See Somers v. SAIF, 77 Or App 259 (1986).

Consideration of Mr. Hendricks' opinion does not change this result. In the report cited by the insurer, Mr. Hendricks does not directly address the causation of claimant's depression. However, much of Mr. Hendricks' report focuses on claimant's work injury. Hendricks noted that claimant had never been hospitalized before and that claimant spoke about "being drove [sic] crazy * * * to the bridge [sic] of suicide and basically was just tremendously frustrated and angry " over his injury and work situations. Mr. Hendricks indicated that claimant's work injury and problems "seem to genuinely have impacted him a lot."

Mr. Hendricks' report also discussed claimant's prior treatment for post-traumatic stress disorder (PTSD) stemming from claimant's service during the Viet Nam War. Hendricks' report notes that claimant was not a combat veteran and had no traumatic events/ triggers related to the war. Rather, Hendricks noted that claimant's military service was spent on an aircraft carrier and that claimant's military stressors "were not out of the normal for most any serviceperson, he may have had less tools to adopt [sic] to any level of stress in his life." Hendricks also noted that claimant's family of origin was "dysfunctional" and that Hendricks suspected that "things have been worse than one imagines" for a long time. Hendricks characterized the compensable back injury as the "frosting on the cake." (Ex. 81).

After our review of Hendricks' report, we are not persuaded that it weighs against compensability of claimant's depression. To the contrary, the report supports a conclusion that the compensable injury "impacted" claimant significantly and that claimant's military stressors were minimal.

Finally, although Mr. Hendricks stated that the compensable injury was the "frosting on the cake," Hendricks never directly stated whether he believed the injury was a mere precipitating event or was the major contributing cause of claimant's depression. Given that portions of Mr. Hendricks' report tend to support compensability, we are unable to interpret the report as indicating that claimant's preexisting condition was the major contributing cause of his depression.

Accordingly, consideration of Mr. Hendricks' report does not change our conclusions concerning compensability. We continue to believe that Dr. McDonald's report, which is based on an accurate history and which directly addresses the causation issue, is the most persuasive medical opinion.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding compensability is \$1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated November 10, 1994 is affirmed. For services on review, claimant's attorney is awarded \$1,000, payable by the insurer.

June 7, 1995

Cite as 47 Van Natta 994 (1995)

In the Matter of the Compensation of
CARMEN C. NEILL, Claimant
WCB Case No. 93-04858
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of that portion of Referee Daughtry's order which set aside its denial of claimant's aggravation claim for a neck and left shoulder injury. In her brief, claimant contests that portion of the Referee's order which declined to reclassify claimant's claim as disabling. On review, the issues are aggravation and reclassification. We vacate in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Finding that claimant had sustained a compensable aggravation, the Referee concluded that the reclassification issue was moot. We disagree.

Pursuant to ORS 656.277, a claimant has one year, from the date of injury, in which to seek reclassification of his or her claim. See Donald R. Dodgin, 45 Van Natta 1642 (1993). If a request for reclassification is not made within the one year time period, the claim cannot be reclassified and a claimant must make a claim for aggravation pursuant to ORS 656.273. ORS 656.277(1) and (2); Charles B. Tyler, 45 Van Natta 972 (1992). However, claimant must be notified of the classification of the claim, as well as the right to challenge that classification, within a sufficient time period that would allow the status of the claim to be challenged. ORS 656.262(6)(b) & (c); Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993).

Claimant sustained a neck and left shoulder injury on December 15, 1989. The injury was accepted by the employer by letter dated February 2, 1990, which informed claimant that her claim was nondisabling. (Ex. 2). However, the letter did not provide claimant with notice of her right to seek reclassification of her claim within one year of the date of injury as required by ORS 656.262(6). In fact, claimant was not informed of her right to object to her claim classification until the employer issued its June 7, 1993 Notice of Acceptance following Referee Brown's Opinion and Order. (Exs. 33, 34).

At the time the employer accepted claimant's claim, former ORS 656.262(6)(b) (now (6)(c)) provided that a notice of acceptance "shall: Inform the claimant of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury is nondisabling by requesting a determination thereon pursuant to ORS 656.268."

As noted above, the employer's acceptance did not conform with former ORS 656.262(6)(b) and therefore claimant was not informed that she could challenge the classification of her claim. Given the mandatory language of the provision, we conclude that a carrier's failure to comply with the provision has the effect of precluding a claimant, through no fault of her own, from seeking reclassification within the statutory time period. Consequently, since an objection to claim classification is a matter "concerning a claim," ORS 656.283(1) allows claimant the opportunity to object to her claim

classification. Dodgin, supra at 1645. Therefore, the Hearings Division has authority to entertain claimant's objection to her initial claim classification. We now turn to the merits of claimant's request for reclassification.

At the outset, the employer argues that claimant is precluded from objecting to her claim classification, because that issue was raisable at the time of the prior litigation before Referee Brown. We disagree.

The issues before Referee Brown were compensability of claimant's then-current condition and penalties. The status of claimant's claim classification was not at issue. Moreover, the first time that claimant was notified that she could object to her claim classification was the employer's June 7, 1993 letter of acceptance which was issued approximately 1 1/2 months after the hearing before Referee Brown. Under these circumstances, we conclude that the issue was not properly raisable at the time of the litigation before Referee Brown. Therefore, the prior litigation does not preclude claimant from now raising the issue of claim classification.

On December 28, 1989, Dr. Vranna, claimant's treating physician, released claimant to light duty work with restrictions including no repetitive overhead activity and no lifting greater than 20 pounds. (Ex. 1A-2). These restrictions continued until January 30, 1990 when Dr. Vranna released claimant to regular work. (Ex. 3). During that time period, claimant performed her normal work duties and there is no evidence in the record that claimant was paid less than her normal wage.

In Sharman R. Crowell, 46 Van Natta 1728 (1994), we held that a claimant's receipt of regular wage for her modified employment did not preclude a finding that 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 must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than a proportionate loss of pre-injury wages. Therefore, even though a claimant's rate of temporary partial disability benefits 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.

Here, because claimant was released to modified work, we conclude that her claim was disabling, notwithstanding the fact that she may receive temporary partial disability at rate of zero. Crowell, supra; George I. May, 46 Van Natta 2499 (1994).

Accordingly, claimant has established that her claim is disabling. Because of this finding, the aggravation issue is moot. Since the aggravation issue is rendered moot by our decision that claimant's claim should be reclassified as disabling, it follows that claimant's counsel is not entitled to the assessed attorney fee awarded by the Referee for prevailing over the employer's aggravation denial. Consequently, we vacate the Referee's award of an assessed attorney fee. However, claimant's counsel is entitled to an "out-of-compensation" attorney fee, payable from the increased compensation created by this order, not to exceed \$3,800, to be paid directly to claimant's attorney. ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated November 23, 1994, as republished November 28, 1994 is vacated in part and reversed in part. That portion of the Referee's order which set aside the self-insured employer's denial of claimant's aggravation claim is vacated as moot and the Referee's award of a \$3,800 assessed attorney fee is also vacated. The self-insured employer 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 created by this order, not to exceed \$3,800, payable directly by the self-insured employer to claimant's attorney.

In the Matter of the Compensation of
GUILLERMO RIVERA, Claimant
WCB Case No. 94-00923
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of those portions of Referee Hoguet's order that: (1) awarded claimant 19 percent (60.8 degrees) unscheduled permanent disability for his cervical and lumbar strains; (2) awarded an assessed attorney fee of \$2,200 for prevailing against the insurer's "de facto" denial of the cervical and lumbar strains; and (3) awarded an assessed fee of \$350 for the insurer's allegedly unreasonable "de facto" denial of claimant's cervical strain. Claimant cross-requests review of those portions of the order that: (1) declined to assess a penalty for the insurer's issuance of two Notices of Closure; and (2) affirmed the Order on Reconsideration that did not award permanent disability for claimant's right wrist and elbow sprain. Alternatively, claimant cross-requests review of that portion of the order that found that claimant was medically stationary on November 30, 1993. On review, the issues are extent of scheduled and unscheduled disability, penalties and attorney fees, and alternatively, premature claim closure.

We adopt and affirm the Referee's order, except that we reverse that portion of the order that awarded an assessed fee of \$350 for the insurer's allegedly unreasonable "de facto" denial of claimant's cervical strain.

The Referee found that all medical bills and time loss had been paid and therefore, there were no amounts due. Nevertheless, the Referee awarded an assessed attorney fee of \$350 because there was no reasonable basis for the insurer's refusal to accept/deny claimant's cervical strain condition in a timely manner.

The insurer argues that the Referee erred in awarding an assessed attorney fee of \$350 for its allegedly unreasonable "de facto" denial of claimant's cervical strain. We agree.

In SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993), SAIF did not accept the claimant's injury-related psychological condition within 90 days of notification of treatment, although SAIF had paid all medical bills for the claimant's psychological treatment. The court reversed our attorney fee award under ORS 656.382(1), finding that there could be no unreasonable resistance to the payment of compensation when all compensation had been paid. 119 Or App at 196; see also Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991).

Likewise, in this case, all compensation for claimant's cervical strain condition had been paid. 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, supra; Aetna Casualty Co. v. Jackson, supra. Consequently, we reverse that portion of the Referee's order that awarded claimant an assessed attorney fee of \$350.¹

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of unscheduled permanent disability 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 issue, and the value of the interest involved. (Claimant is not entitled to an attorney fee for services on review concerning the attorney fee and penalty issue in this case. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986)).

¹ Although a signatory to this order, Board Member Hall directs the parties' attention to his dissenting opinion in Patricia L. Row, 46 Van Natta 1794 (1994).

ORDER

The Referee's order dated September 6, 1994 is reversed in part and affirmed in part. We reverse that portion of the order that awarded an assessed fee of \$350 for the insurer's allegedly unreasonable "de facto" denial of claimant's cervical strain. The remainder of the Referee's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the insurer.

June 7, 1995

Cite as 47 Van Natta 997 (1995)

In the Matter of the Compensation of
DORA ROSALES, Claimant
WCB Case No. C5-01125
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
H. Galaviz-Stoller, Claimant Attorney
Raymond T. Smitke (Lundeen, et al), Defense Attorney

Reviewed by Board Members Hall and Haynes

On April 26, 1995, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The original agreement provided that the consideration is a lump sum payment of \$6,000. On June 1, 1995, the Board received an addendum to the original CDA, amending item 13 to read as follows:

"Pursuant to ORS 656.236, in consideration of the payment of \$8,000.00 by the insurer/employer, and lump sum payment of claimant's permanent disability award, claimant releases her rights to the following workers' compensation benefits: temporary disability, permanent disability, vocational rehabilitation and survivor's benefits. The insurer's employer's obligation to provide these benefits is also released." (Emphasis supplied, identifying new material).

The amount of the permanent disability award to be paid in a lump sum is not specified. However, the proposed CDA indicates that claimant has been awarded 30 percent (96 degrees) unscheduled and 5 percent (9.6 degrees) scheduled permanent disability. (Pg. 2, item 8). Moreover, accelerated lump sum payment of permanent disability is now permitted as part of a CDA. Norman E. Nixon, 46 Van Natta 2503 (1994).

We have previously disapproved a proposed CDA where we were unable to determine the "amount to be paid the claimant" as required by OAR 436-60-145(3)(j). See e.g., Kenneth Hoag, 43 Van Natta 991 (1991) (sole consideration was carrier's reduction of its third party lien, but proposed CDA contained no information concerning a third party settlement or judgment). In Hoag, we reasoned that, because allocations of a third party recovery to the claimant's attorney and the claimant precede any distribution to the carrier, the "value" of any consideration flowing to claimant as a result of the CDA where no third party recovery was achieved was "presently not ascertainable."

Although the CDA in this case, as amended by the parties' addendum, does not indicate the amount of the lump sum permanent disability payment, we find this case distinguishable from Hoag. In Hoag, the entire amount of consideration consisted of the carrier's reduction of its lien. Here, because the CDA provides for a payment of \$6,000, the agreement contains an "amount to be paid claimant" that is "presently ascertainable." In other words, at a minimum, the consideration is \$6,000. Compare Opal M. Smith, 45 Van Natta 6 (1993) (consideration not ascertainable where ultimate permanent disability award contingent on future claim closure and potential litigation of that closure). As such, we conclude that, regardless of the amount claimant receives in a lump sum payment for permanent disability, the proposed disposition is not unreasonable as a matter of law. See ORS 656.236(1)(a).

We conclude that the CDA, as amended by the June 1, 1995 addendum, is in accordance with the terms and conditions prescribed by the Director. ORS 656.236(1). Therefore, the parties' CDA is approved as amended. An attorney fee of \$2,000, payable to claimant's counsel, also is approved.

IT IS SO ORDERED.

June 7, 1995

Cite as 47 Van Natta 998 (1995)

In the Matter of the Compensation of
STEVEN J. ROSSMAN, Claimant
WCB Case No. 94-08276
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee Bethlahmy's order that set aside its denial of claimant's injury claim for a lumbosacral/sacroilic strain. On review, the issue is compensability.

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

Applying ORS 656.005(7)(a), the Referee found that claimant suffered a compensable lumbosacral strain on June 8, 1994. In so finding, the Referee acknowledged claimant's long-standing preexisting back problems, but determined that those preexisting problems were unrelated to the June 8 incident, where claimant strained his back pulling a dough troll out of a hoist at work as a bakery divider operator.

On review, the employer challenges claimant's credibility, based on purported discrepancies between his testimony and the medical evidence concerning his preexisting back problems, and argues that claimant did not establish a material relationship between his low back strain and his work activities. We disagree.

We note that, despite accepting claimant's testimony, the Referee made no express credibility findings based upon claimant's demeanor. Accordingly, we are in as good a position as the Referee to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

After evaluating the substance of claimant's testimony in light of the other witnesses' testimony and the medical evidence, we are persuaded that claimant testified in a credible manner. He testified to having preexisting back problems and soreness. He indicated that these preexisting problems did not preclude him from working or engaging in the recreational activities he enjoyed. The medical records following the June 8, 1994 incident indicate that claimant provided consistent histories regarding the circumstances of the incident and that he disclosed his preexisting back condition. The fact that the June 8 incident was unwitnessed or that claimant failed to recall at hearing that he had experienced radiating leg pain prior to the June 8 incident does not cause us to doubt the veracity of claimant's testimony. Further, like the Referee, we are not persuaded by the employer's speculation concerning the motivating factors for claimant's claim.

We agree that although claimant has preexisting low back problems, ORS 656.005(7)(a)(B) does not apply to this claim. See Susan A. Michl, 47 Van Natta 20, on recon 47 Van Natta 162 (1995) (ORS 656.005(7)(a)(B) inapplicable without medical evidence establishing a "combination" of conditions). The medical evidence does not establish that claimant's preexisting spondylolisthesis combined with his June

8, 1994 lumbosacral strain to prolong disability or need for treatment.¹ Accordingly, claimant must show that his work injury was a material contributing cause of his need for treatment or disability. Mark N. Wiedle, 43 Van Natta 855 (1991).

Claimant went for more than six months without medical treatment prior to June 8, 1994. During his shift on that day, he reported to a co-worker and his supervisor that he had wrenched his back pulling out the dough troll. He immediately sought medical attention. Dr. Shawler, the emergency room physician, diagnosed low back strain with sciatica of both legs, and referred claimant to another doctor. Two days later, Dr. Snow recorded claimant's history and diagnosed a lumbosacral strain. When claimant returned to Dr. Snow on June 14, the doctor determined that claimant's current "injury" (with its symptoms primarily at L2-4) was unrelated to his preexisting spondylolisthesis of L5 on S1. Dr. Snow was aware claimant had injured his low back 10 years prior and that claimant had experienced low back pain about a year ago. (Ex. 23-2). Dr. Snow then referred claimant to Dr. Brett, a neurosurgeon, to rule out disc herniation.

As noted above, Dr. Brett concluded (based on an MRI) that claimant had suffered a slight worsening of his preexisting condition, based on his misunderstanding that claimant had not experienced any radicular pain in the legs prior to the June 8 work incident. Dr. Brett also noted that claimant's present discomfort was a "direct result" of his work injury, not the preexisting condition. Dr. Lysook, who examined claimant in August in Dr. Snow's absence, noted a continuing lumbosacral strain, and recommended that claimant not return to his former duties as a divider operator.

Although each treating physician diagnosed claimant's injury, we note that with the exception of Dr. Brett, none expressly addressed the causation of claimant's disability or need for treatment. However, it is well-settled that medical opinions need not mimic statutory language or use "magic words." See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Here, after reciting claimant's work history, Drs. Shawler, Snow and Lysook diagnosed a lumbar strain and limited claimant's duties. Other than referring to claimant's work activities, these physicians offered no other cause for claimant's current complaints. Under such circumstances, we find that the medical evidence satisfies claimant's burden of proof. Each treating physician accepted (without qualification) that the June 8, 1994 work injury was the reason claimant was seeking treatment. Consequently, we conclude claimant has established the compensability of his claim for lumbosacral strain.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,300, payable 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 and his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 28, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,300, to be paid by the self-insured employer.

¹ We note that Dr. Brett found that the June 8 injury caused a slight worsening of claimant's spondylolisthesis, due to his misunderstanding that claimant had not previously experienced right leg radicular pain. Dr. Brett did not, however, indicate that this worsening would prolong claimant's disability or need for treatment. In any event, like the Referee, we decline to rely on Dr. Brett's opinion, as it was based on an inaccurate history. Instead, we rely on the opinion of Dr. Snow that claimant's June 8, 1994 injury was in a different location and not related to the preexisting spondylolisthesis. (Ex. 23). Dr. Snow's opinion is complete, well reasoned and based on an accurate history.

In the Matter of the Compensation of
ANTHONY P. THEXTON, Claimant
WCB Case No. 94-04485
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of those portions of Referee Herman's order that: (1) set aside its partial denial of claimant's injury claim for an upper back, neck and headache condition; and (2) awarded a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

Compensability

In order to prevail under an injury theory, claimant must establish, by medical evidence supported by objective findings, that his work activities were a material contributing cause of his disability or need for medical treatment. ORS 656.005(7)(a). Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991).

The Referee found that claimant's work injury was a material contributing cause of claimant's upper back, neck and headache condition, and set aside the employer's partial denial. The employer argues that this finding of compensability is inconsistent with the Referee's finding that claimant was not a credible witness. It contends that no evidence supports claimant's version of the work incident, *i.e.*, that he was knocked to the ground and rendered unconscious by the falling sheet of plywood.

The Referee specifically found that claimant's testimony about his travel excursions after the injury was not credible. Despite this negative credibility finding, the Referee concluded that claimant's February 1, 1994 industrial injury was a material contributing cause of his upper back, neck and headache condition and related need for treatment, based on the remainder of the record and the undisputed circumstances of claimant's accident: he was struck in the face with a 4 x 4 sheet of plywood.

As the Referee noted, even if the claimant is not a credible witness, it does not necessarily follow that he did not prove his claim. See Taylor v. Multnomah School District No. 1, 109 Or App 499, 501 (1991); Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984). A claimant who lacks credibility in certain matters can still meet his burden of proof if the remainder of the record supports his version of how he was injured. Michael S. Plybon, 46 Van Natta 1099 (1994).

In this case, regardless of whether claimant actually hit the ground, lost consciousness or bled profusely at the time of his February 1, 1994 injury, the record supports the conclusion that claimant's neck, back and headache condition arose directly from being hit in the face with the falling sheet of plywood.¹ After conducting an examination of claimant and considering claimant's report that his neck and back pain began two days after the injury, Dr. Versoza concluded that the February 1, 1994 incident was the major contributing cause of claimant's condition.² (Ex. 17). There is no persuasive medical or other evidence to the contrary. Even the panel from Medical Consultants Northwest stated that it was not inconceivable that claimant could have sustained a cervical and/or thoracic strain from the incident. (Ex. 23-6).

¹ Dr. Frank, who examined claimant on February 3, 1994, found objective evidence of these injuries and determined that he had suffered a concussion. (Ex. 10). On February 7, Dr. Frank again saw claimant and diagnosed cervical strain associated with the on-the-job injury. (Ex. 11). Dr. Versoza, who became claimant's attending physician on March 18, 1994, diagnosed cervicothoracic strain and post concussion headache. (Ex. 16, 17).

² Dr. Versoza's notes reflect only that claimant reported a piece of plywood fell on his face while his neck was extended. (Ex. 16, 17-1). Thus, Dr. Versoza's opinion as to the cause of claimant's condition is not based or dependent on whether claimant actually hit the ground or lost consciousness.

Accordingly, we agree with the Referee that claimant's upper back, neck and headache condition was materially caused by the February 1, 1994 work incident. Therefore, the claim is compensable.

Penalty

The Referee found that the medical evidence overwhelmingly supports compensability, and assessed a 25 percent penalty against the employer. We affirm.

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the employer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

The employer makes several arguments in support of its contention that it had a legitimate doubt about its liability when it denied the claim. Specifically, it notes that: (1) claimant did not immediately report, nor did his 801 claim refer to, headaches or back pain; (2) claimant did not tell the emergency room physician that he had lost consciousness; and (3) according to the assessment of claimant's supervisor, Mr. Stoneking, claimant's accident contradicted claimant's version of what occurred. After comparing these contentions with the medical opinions supporting a causal relationship between claimant's complaints and the work accident, we find that the employer did not have a legitimate doubt regarding its liability for the claim when it issued its denial.

At the time of the employer's denial (which issued some 50 days after the accident), no medical evidence suggested that claimant's neck and back condition was not directly related to the February 1 work accident. To the contrary, Dr. Versoza's report supported a work connection. Under such circumstances, the fact that claimant reported headaches and back pain two days following the work incident, did not tell the emergency room physician that he had lost consciousness or did not report headaches or back pain on his February 3, 1994 801 form does not cause us to conclude that the employer had a legitimate doubt regarding its liability for claimant's neck, back and headache condition. Likewise, in light of the countervailing medical evidence, Mr. Stoneking's "lay" assessment regarding the work accident (which was based on his own reconstruction, not observation of, the incident) is insufficient to constitute a legitimate doubt.

In conclusion, based on the medical and lay evidence existing at the time of its denial, we conclude that the employer's partial denial was unreasonable. Consequently, we affirm the Referee's penalty assessment.

Attorney Fee

Claimant is entitled to an assessed fee for his counsel's services on Board review. ORS 656.382(2). After considering the factors recited in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services on review concerning the compensability issue is \$1,300, to be paid by the employer. In reaching that conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services devoted to the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated August 9, 1994 is affirmed. For services on Board review, claimant's attorney is awarded \$1,300, to be paid by the employer.

In the Matter of the Compensation of
TAMERA A. FORCIER, Claimant
 WCB Case No. 94-10815
 ORDER ON REVIEW
 Burt, et al, Claimant Attorneys
 Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee Holtan's order that found claimant to be a subject worker at the time of her left hand injury. On review, the issue is whether claimant is a subject worker.

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

Relying on the "dual capacity doctrine" established in Erzen v. SAIF, 40 Or App 771, rev den 287 Or 507 (1979), the Referee found that claimant, a partner in a business, was a subject employee because she was performing the duties of a woodshop worker (rather than her normal duties as a partner) at the time of injury. On review, SAIF argues that claimant was not a covered employee. Specifically, SAIF argues that Kenneth G. Mize, 45 Van Natta 477 (1993), dismissed SAIF v. Mize, 129 Or App 636 (1994), was wrongly decided.¹ We decline SAIF's invitation to disavow Mize.

Alternatively, SAIF argues that, even if the dual capacity doctrine has been resurrected in the corporate context, the doctrine has no application in the partnership context under ORS 656.027(8). SAIF reasons that because the 1990 legislature did not similarly modify ORS 656.027(8), the Board's rationale in Mize concerning the changes to ORS 656.027(9) has no application in the instant case. SAIF's argument overlooks the fact that the legislature did not insert "post-Erzen" changes into ORS 656.027(8) that could be later modified.

More importantly, we find the Erzen court's reasoning equally applicable to partnership business entities. The claimant in Erzen, a corporate officer, was injured while performing the duties of a security patrolman. The court held that, because the claimant was injured while performing duties as an ordinary employee not associated with his function as a corporate officer, he was entitled to coverage as a worker.

Here, claimant was injured while performing the duties of a woodshop worker, rather than while performing her duties as a partner. While the claimant in Erzen was both a worker and a corporate officer, the statute the court construed concerned "sole proprietors, partners and officers of corporations."² We find nothing in the Erzen court's discussion that leads us to conclude that the court

¹ In Kenneth G. Mize, supra, we construed ORS 656.027(9), and found that although the 1981 legislature enacted statutory changes that eliminated the dual capacity doctrine regarding corporate officers established by Erzen v. SAIF, supra, the 1990 legislature "resurrected" the doctrine. SAIF notes that the issue raised in Mize, the continuing viability of the dual capacity doctrine, is pending review before the Court of Appeals. Since it filed its brief, the court has rendered a decision in the case cited by SAIF. The court did so, however, without reaching the merits of SAIF's argument. See SAIF v. Cox, 133 Or App 666 (1995) (Reversed and remanded on other grounds). Thus, Mize is still good law.

² When Erzen v. SAIF, supra, was decided in 1979, the then-pertinent statute, ORS 656.027(7), Or Laws 1981, ch 535, §3, provided that all workers were subject to workers' compensation laws except those non-subject workers described as:

* * * * *

"(7) Sole proprietors, partners and officers of corporations."

Under the pertinent version of ORS 656.027, Or Laws 1989, ch 762, §4, all workers are subject to workers' compensation laws except those non-subject workers described as:

* * * * *

"(7) Sole proprietors.

"(8) Partners. . . .

"(9) Corporate officers. . . ."

intended to restrict application of its newly enunciated dual capacity doctrine to the corporate context. Thus, we find no persuasive reason to depart from the court's holding to treat a partner who performs duties as an ordinary employee different from a corporate officer who performs duties as an ordinary employee. Consequently, we agree with the Referee that claimant was a subject worker when she was injured.

Claimant's counsel 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 counsel's services on review is \$1,000, payable 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 January 11, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,000, payable by the SAIF Corporation.

June 8, 1995

Cite as 47 Van Natta 1003 (1995)

In the Matter of the Compensation of
CHERYL K. MENG, Claimant
WCB Case Nos. 93-09097 & 93-12318
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee McWilliams' order that: (1) set aside its denials of claimant's degenerative disc disease; (2) set aside the SAIF Corporation's compensability denial of the same condition; and (3) upheld SAIF's responsibility denial of the same condition. Claimant cross-requests review of that portion of the Referee's order that declined to assess a penalty for Liberty's and SAIF's allegedly unreasonable denials. On review, the issues are compensability, responsibility and penalties.

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

Claimant asserts that the Referee erred in failing to assess a penalty for Liberty's¹ untimely compensability denial. Liberty first denied compensability at hearing, nine months after claimant filed this claim and after the issuance of an order pursuant to ORS 656.307. To the extent that claimant asserts that a carrier's rescission or withdrawal of a "307" order at hearing is per se unreasonable, we reject that argument.

The issuance of a "307" order does not preclude a carrier from subsequently denying compensability. Ronnie E. Taylor, 45 Van Natta 905, on recon 45 Van Natta 1007 (1993), aff'd Taylor v. Masonry Builders, Inc., 127 Or App 230, rev den 319 Or 281 (1994). When a carrier issues a compensability denial after a "307" order has issued, a penalty may be assessed if the denial is unreasonable; that is, at the time of denial, the carrier must have had no legitimate doubt as to the compensability of claimant's claim. Bonita J. Olson, 46 Van Natta 1731, on recon 46 Van Natta 1892 (1994); see Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

¹ Claimant asserts that the responsible carrier should pay a penalty; because we have concluded that Liberty is responsible, we consider claimant's penalty argument only to the extent that it applies to Liberty.

Here, when Liberty issued its compensability denial, the treating physician supported compensability, while the consulting and examining physicians either did not address compensability, or concluded that claimant's degenerative disc condition was not work-related. Therefore, we find that Liberty had a legitimate doubt about its liability for claimant's claim. Consequently, we agree with the Referee's decision not to assess a penalty against Liberty.

Claimant's counsel is entitled to an assessed fee for prevailing over Liberty's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable 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 considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues and the value of the interest involved. We have not considered counsel's services regarding the penalty issue. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The Referee's order dated October 1, 1994 is affirmed. For services on review, claimant's counsel is awarded \$1,000, to be paid by Liberty Northwest Insurance Corporation.

June 8, 1995

Cite as 47 Van Natta 1004 (1995)

In the Matter of the Compensation of
JOEL RODRIGUEZ, Claimant
 WCB Case No. 94-09981
 ORDER ON REVIEW
 Willner & Heiling, Claimant Attorneys
 Robert J. Yanity (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Referee Bethlahmy's order which awarded claimant's counsel an assessed attorney fee under ORS 656.386(1) for his services in allegedly obtaining compensation without a hearing. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant an assessed attorney fee for obtaining SAIF's November 9, 1994 amended acceptance without a hearing, pursuant to ORS 656.386(1). Because we conclude that claimant's request for hearing was premature, we reverse.

Claimant sustained compensable injuries when he was thrown from a company vehicle, which had been hit by another vehicle, on June 22, 1994. Claimant received emergency treatment the same day, which included a cranial CAT scan but no chest x-ray. The same day claimant filed a claim indicating the affected body part as "head." (Ex. 4). The claim was accepted on July 7, 1994 for elbow and knee abrasions and a scalp laceration. (Ex. 5).

On July 19, 1994, claimant again sought emergency treatment, complaining of chest pain. His condition was diagnosed as "right pleural effusion vs. pleural thickening," with an unknown etiology that could be due to inflammation, trauma, or surgery. (Exs. 6-2, 7). The medical records did not mention the June 22, 1994 accident.

On August 4, 1994, claimant was treated by Dr. Kelly for right pleural effusion. Dr. Kelly noted that claimant's problem began when he was thrown from the vehicle on June 22, 1994. (Ex. 9-1). SAIF received this medical record on August 15, 1994.

On August 16, 1994, claimant's counsel filed a request for hearing, identifying the issues as "failure to accept all conditions," as well as penalties and attorney fees. On November 9, 1994, SAIF accepted the claim for pleural effusion. (Ex. 13).

A "claim" is a "written request for compensation. . . or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). A carrier is not obligated to accept or deny a claim until it has notice or knowledge prompting a reasonable belief that workers' compensation liability is a possibility. Hubert R. Graves, 46 Van Natta 1032, 1033 n.1 (1994).

Here, we find that SAIF first had notice or knowledge of claimant's claim for pleural effusion on August 15, 1994 when it received Dr. Kelly's report. At that time, SAIF had notice that claimant's pleural problem might possibly be related to the June 22, 1994 work injury. From August 15, 1994, SAIF had 90 days within which to accept or deny the claim. ORS 656.262(6). It accepted the claim on November 9, 1994, less than 90 days after it received notice of the claim. SAIF never issued a denial of the claim for pleural effusion.

Claimant's counsel requested a hearing on August 16, 1994, well before the 90 days to accept or deny the claim for pleural effusion had expired. A prematurely filed request for hearing is ineffective and void. Syphers v. K-W Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981). Inasmuch as no denial had issued (either written or "de facto"), it follows that claimant's hearing request was premature. See Michael A. Dipolito, 44 Van Natta 981 (1992).

The Referee awarded a fee pursuant to ORS 656.386(1), which provides that "[i]f 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." However, this statute has no application when the hearing request did not pertain to a denial (either written or "de facto") and, thus, there was no denial to withdraw after the hearing request and before the hearing. Dipolito, supra; O'Neal v. Tewell, 119 Or App 329, 333 (1993). Accordingly, claimant is not entitled to an attorney fee under ORS 656.386(1).

ORDER

The Referee's order dated December 13, 1994 is reversed. Claimant's attorney fee award is reversed.

June 8, 1995

Cite as 47 Van Natta 1005 (1995)

In the Matter of the Compensation of
DALE A. WARREN, Claimant
WCB Case No. 94-07798
ORDER OF ABATEMENT
Dobbins, et al, Claimant Attorneys
James Moller (Saif), Defense Attorney

The SAIF Corporation requests reconsideration and abatement of our May 24, 1995 Order on Review. In that order, we found claimant entitled to temporary partial disability benefits from the date of his treating physician's restrictions until the date of his lay off from work, at which time we found claimant entitled to temporary total disability benefits. With its request for reconsideration, SAIF argues that we erred in our reasoning and that claimant is not entitled to any temporary disability.

In order to consider SAIF's motion, we withdraw our May 24, 1995 order. Claimant is granted an opportunity to respond by submitting a response within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Complying Status of
ORRIN L. GROVER, Noncomplying Employer
WCB Case Nos. 94-10995 & 94-08570
ORDER OF DISMISSAL

Orrin L. Grover (hereafter "Grover"), an alleged noncomplying employer, has requested Board review of Referee Nichols' January 25, 1995 order which dismissed Grover's request for hearing from the Director's order finding Grover to be a noncomplying employer. Contending that appellate jurisdiction does not rest with this forum, the Director seeks dismissal of Grover's request for Board review. We grant the motion.

FINDINGS OF FACT

In July and August 1994, Grover requested hearings concerning May 27, 1994 and August 10, 1994 Director orders finding him to be a noncomplying employer. In October 1994, a scheduled hearing was postponed based on an announcement that Grover and the Director had settled their dispute. Thereafter, the case was placed in deferred status.

On January 5, 1995, when no further correspondence was received from the parties, the Referee issued orders to show cause why Grover's hearing requests should not be dismissed. Specifically, Grover was given 15 days to explain why his hearing requests should not be dismissed as abandoned under OAR 438-06-071(1).

On January 25, 1995, when no response from Grover had been received, the Referee dismissed Grover's hearing request. The Referee's order contained a statement indicating that a dissatisfied party could seek Board review within 30 days of the order. On February 24, 1995, Grover mailed his request for review of the Referee's order to the Board.

CONCLUSIONS OF LAW AND OPINION

An alleged noncomplying employer may contest the Director's noncomplying employer order by filing a request for hearing with the Director 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).

The Board lacks appellate jurisdiction to review a referee's order addressing the issue of noncompliance in cases where the proceeding was not consolidated with a matter concerning a claim or where the employer contested only the Director's noncompliance order. ORS 656.740(4)(c); Ferland v. McMurtry Video Productions, 116 Or App 405 (1992); Spencer House Moving, 44 Van Natta 2522 (1992), aff'd Miller v. Spencer, 123 Or App 635 (1993). However, when an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review of the Referee's order shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

Here, Grover requested hearings regarding the Director's May 27, 1994 and August 9, 1994 noncomplying employer orders. Finding Grover to have employed one or more subject workers without also providing workers' compensation coverage for these employees, the Director determined that Grover was a noncomplying employer. Other than contesting the Director's orders, Grover did not indicate that his hearing request included any other issue.

In light of such circumstances, we conclude that the hearing which was scheduled before the Referee concerned only the status of Grover as an employer. Thus, the Referee's order dismissing Grover's hearing requests did not involve any "matter concerning a claim." Consequently, the Referee's order constitutes a final order of the Director and, as such, the order must be appealed directly to the Court of Appeals. ORS 656.740(1), (3); ORS 183.480(1), (2); Ferland, supra; Spencer House Moving, supra; Kyoto Restaurant, 46 Van Natta 1009 (1994).

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 appellate jurisdiction is limited, an incorrect statement of appeal rights can neither expand nor contract our statutory authority. See Larry J. Powell, 42 Van Natta 1594 (1990); Gary O. Soderstrom, 35 Van Natta 1710 (1983).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

June 9, 1995

Cite as 47 Van Natta 1007 (1995)

In the Matter of the Compensation of
WONDER WINDOM-HALL, Claimant
WCB Case No. 90-06799
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Davis' order that: (1) found that the self-insured employer did not issue a "back-up" denial; (2) upheld the employer's denial of claimant's occupational disease claims for inner ear conditions, brain condition and psychological condition; and (3) declined to award a penalty and related attorney fee for an allegedly unreasonable denial. On review, the issues are "back-up" denial, 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

"Back-up" Denial

This proceeding concerns the compensability of claimant's vestibular disorders, including hydrops, benign paroxysmal positional nystagm (BPPN), and perilymph fistulas; toxic encephalopathy; and dysthymia. Claimant first asserts that the employer accepted a claim for headache, dizziness and nausea. Claimant further contends that they are symptoms of her vestibular disorders and, therefore, the scope of the employer's acceptance includes the inner ear conditions. See Georgia-Pacific v. Piwovar, 305 Or 494 (1988). Based on this reasoning, claimant argues that the employer's denials of her inner ear conditions constitute "back-up" denials that can be upheld only if the employer proves by clear and convincing evidence that the claim is not compensable. See ORS 656.262(6).

Claimant worked as a seamstress at a department store. In early 1989, the store underwent remodeling. In July 1989, she sought treatment after experiencing a period of vomiting, dizziness, fatigue, and headache. Claimant filed an 801 form stating that the nature of the injury was headache, nausea and dizziness resulting from "prolonged exposure to fumes from roofing." (Ex. 1). The employer indicated that it accepted the claim. (Id.) Subsequently, the employer denied payment for particular medical bills, stating that it had accepted only a claim for "toxic exposure to organic solvents." (Exs. 33, 47, 50, 52).

A determination regarding whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449, 454 (1992). Acceptance of a symptom of an underlying disease includes acceptance of that condition regardless of the cause. Georgia-Pacific v. Piwovar, supra, 305 Or at 501-02.

The court recently applied Piwovar in Ledbetter v. SAIF, 132 Or App 508 (1995). In Ledbetter, the claimant injured his right arm and leg at work; he also had preexisting osteomyelitis. An increased episode of pain was diagnosed as "reactivation of chronic osteomyelitis." The carrier thereafter accepted a "claim for claimant's right thigh condition as an exacerbation of a preexisting injury." After the claimant again injured his right thigh, the carrier denied the compensability of the osteomyelitis condition.

The court rejected the carrier's argument that its acceptance did not encompass the preexisting condition, but was limited to the symptoms brought on by the industrial injury. Instead, relying on Piowar, the court held that, by accepting a "right thigh condition," the carrier accepted the osteomyelitis. Id. at 511.

Here, based on the 801 form, we find that the employer accepted a claim for headache, nausea and dizziness. Although the 801 form and subsequent denial letters indicate that the acceptance of such conditions was limited to those resulting from toxic exposure, we find no qualification of the acceptance by such language. Like the courts in Piowar and Ledbetter, we focus on the condition accepted regardless of the cause of that condition.

Moreover, there was evidence that headache, nausea and dizziness are symptoms of the diagnosed vestibular disorders. (Exs. 66-3, 68-4; Tr. 35). Thus, we consider the employer as having accepted such conditions. Georgia-Pacific v. Piowar, supra. Hence, we treat the employer's denial of such conditions as a "back-up" denial. See ORS 656.262(6). As such, in order for the denial to be upheld, the employer must prove by clear and convincing evidence that the vestibular disorders are not compensable. Id. We proceed to address this issue.

Compensability of Vestibular Disorders

Claimant's vestibular disorders include the diagnoses of bilateral perilymph fistulas, hydrops, and benign paroxysmal positional nystagm (BPPN). Claimant's treating physicians, including Dr. Grimm, neurologist, and Dr. Conrad, internist, indicated that claimant's vestibular disorders were caused by toxic exposure at the work place. (Exs. 55-2, 68-5; Tr. 71-72). Dr. Black, neuro-otologist who also treated claimant and performed surgery for the perilymph fistula, opined that claimant's exposure to noxious odors at work caused a period of intractable vomiting, which in turn caused perilymph fistulas.

We first address the causal relationship between claimant's vestibular disorders and toxic exposure. The employer provided evidence indicating that, if claimant was exposed to any toxins at her job, the level was insufficient to cause her vestibular disorders. First, a work place assessment performed by a state agency measured only toxic substances in Picrin, a spot remover used by alterations employees, (Ex. 20); however, the concentration was insufficient to have any impact on claimant's health. (Exs. 46-2, 49-11, 51-31, 51-32).

Toxicologists Drs. Hine and Burton addressed other possible sources of solvents, including fumes from glue used for laying tiles in the alterations room, paint fumes and asphalt fumes. In the case of the glue, the physicians indicated that any solvents would be volatile and, because the tiles were laid down at night, any intoxicating concentration would not be present in the morning, when claimant arrived for work. (Exs. 51-34, 51-35, 69-8). Claimant's exposure to any solvents from paint and asphalt fumes also was greatly reduced by the remote location of the alterations room from the areas that were repainted and repaved and the dilution of the air in the alterations room. (Exs. 46-1, 69-17). Additionally, Dr. Hine found that claimant's progression of symptoms and normal liver and kidney function tests further showed that claimant's exposure to any toxins at most was brief and of low intensity. (Ex. 46). Based on such reasoning, the physicians found that any exposure to solvents or toxins was of such a low level that it was not capable of causing any of claimant's complaints.

We find that such evidence clearly and convincingly proved that claimant's vestibular disorders were not caused by toxic exposure at work. See Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987) (to be clear and convincing, evidence must show that the truth of the facts asserted is highly probable). Claimant offered no persuasive rebuttal evidence. Dr. Conrad was the only physician who opined that claimant was exposed at work to toxins in the form of hydrocarbons from the asphalt fumes. (Tr. 71-72, 115). However, his opinion relied on inaccurate information about the ventilation system and assumed that toxins were present based only on claimant's detection of noxious odors. (Id. at 146). Drs. Hine and Burton persuasively showed that the presence of odor was not an accurate indicator of toxins. (Exs. 51-32, 69-42). Thus, in view of the flawed basis for his opinion, we give no weight to Dr. Conrad's testimony. Accordingly, we hold that claimant's vestibular disorders are not related to a work-related toxic exposure.

We next determine whether, as found by Dr. Black, episodes of intractable vomiting caused by exposure to asphalt fumes resulted in perilymph fistulas. We note that Dr. Black discussed this theory

in relation to perilymph fistulas and not the remaining vestibular disorders of hydrops and BPPN.¹ Therefore, we also confine our discussion to perilymph fistulas.

According to Drs. Hine and Burton, noxious odors such as asphalt fumes are capable of causing nausea, dizziness and vomiting; they further found that claimant's symptoms were more consistent with exposure to noxious odors rather than toxins. (Exs. 46-2, 51-32, 69-42, 69, 43). However, Dr. Burton characterized Dr. Black's theory as "speculative," (Ex. 69-46), and Dr. Brown, a neurologist who performed a record review and testified at hearing on behalf of the employer, found it "hard to accept" that vomiting would cause perilymph fistulas in view of the common occurrence of vomiting and the rare development of perilymph fistulas, (Tr. 515).

The opinions of Drs. Burton and Brown are conclusory in that they are supported by little or no explanation that vomiting cannot cause perilymph fistulas. Thus, we do not find them sufficiently persuasive to constitute clear and convincing evidence that claimant's perilymph fistulas are not compensable as a result from vomiting after exposure to noxious fumes.

In summary, we conclude that the employer failed to carry its burden of proving that claimant's perilymph fistulas were not compensable. Consequently, we conclude that the employer's "back-up" denial of such condition should be set aside. However, with regard to the conditions of hydrops and paroxysmal positional nystagmus, we conclude that the employer clearly and convincingly proved that no work conditions, including toxic exposure, caused such conditions and, thus, they are not compensable. Therefore, we uphold the employer's "back-up" denials of hydrops and paroxysmal positional nystagmus.

Compensability of Toxic Encephalopathy and Dysthymia

We adopt and affirm the relevant portions of the Referee's orders with the following supplementation.

There is no contention that the employer accepted claimant's remaining conditions of toxic encephalopathy and dysthymia and that, consequently, it "back-up" denied such conditions. Thus, in order to prove compensability, claimant must show the requisite causal relationship between her work and the toxic encephalopathy and dysthymia. According to claimant's treating physicians, the conditions were caused by toxic exposure. Based on the previous discussion, we find a lack of proof that claimant was exposed, if at all, to a sufficient level of toxins to cause her conditions. Therefore, we agree with the Referee that the toxic encephalopathy and dysthymia conditions are not compensable.

Penalties and Attorney Fees

We adopt the relevant portion of the Referee's orders with regard to the penalty issue.

Claimant's attorney is entitled to an assessed fee for services regarding the perilymph fistula condition inasmuch as claimant has finally prevailed over the employer's "back-up" denial of that condition. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services is \$8,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, which includes three hearings and two remands from the Board, and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The Referee's order dated February 13, 1995 is reversed in part and affirmed in part. The employer's "back-up" denial of perilymph fistulas is set aside and the claim is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services at the hearing level and on Board review regarding the perilymph fistula, claimant's attorney is awarded an assessed fee of \$8,000, payable by the employer.

¹ Dr. Black in one instance agreed with claimant's attorney's statement that vomiting caused claimant's "vestibular disorders." (Ex. 66-1). However, Dr. Black's reference to vomiting as causative was otherwise limited to perilymph fistulas. (Exs. 58A-3, 59, 66-3). Therefore, we understand Dr. Black's opinion as being limited to perilymph fistulas and not including the diagnoses of hydrops and BPPN.

In the Matter of the Compensation of
DAN D. CONE, Claimant
WCB Case Nos. 94-01799 & 94-01423
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of those portions of Referee Hazelett's order that: (1) set aside its partial denial of claimant's medical services claim for his current low back condition; and (2) awarded claimant's counsel an assessed fee of \$2,400. Claimant cross-requests review of that portion of the Referee's order that upheld the employer's denial of his occupational disease claim for his low back condition. Claimant also requests that the Referee's assessed attorney fee award be increased should he prevail on his occupational disease claim. On review, the issues are compensability, medical services and attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following exceptions: (1) claimant's attending physician, Dr. Henbest (neurologist), was providing conservative treatment for claimant's low back condition during October 1993; (2) there is no medical evidence that a horse plowing exhibition in October 1993 independently contributed to claimant's low back condition; and (3) we do not adopt the second Ultimate Finding of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts alternative theories of recovery for his low back condition. He contends that his condition is compensable, either as a new occupational disease or, alternatively, as a compensable consequence of his accepted 1985 claim for a low back strain. Therefore, we apply the following analysis. First, we determine whether claimant's back condition is compensably related to the 1985 injury, then we determine whether claimant sustained a new occupational disease. In this regard, although claimant has worked for the same self-insured employer, we apply the "responsibility" principles of ORS 656.308(1) in determining under which claim--the 1985 claim or the new occupational disease claim--claimant's condition will be processed. See David L. Large, 46 Van Natta 96 (1994); Peggy Holmes, 45 Van Natta 278 (1993).

Compensability

We begin with a brief summary of the facts. Claimant has been working for the employer since 1980. Until 1986, claimant performed heavy labor moving 100 pound bags of sugar ("throwing sugar"). After 1986, claimant's work duties became seasonal. He worked as a welder from February to September and the remainder of the year was spent performing light work.

Claimant suffered a compensable low back injury in June 1985. Since then, he has had persistent low back pain with occasional numbness and tingling in his legs. (Ex. 37-1; tr. 70, 90). After the 1985 injury, claimant sought treatment from Dr. Williams, D.C. (Ex. 4). Dr. Williams' notes reveal that he treated claimant for further low back symptoms in September 1989 and September 1991. (Ex. 11).

In 1992, claimant's low back condition was still symptomatic and he began treatment with Dr. Henbest. (Exs. 14, 16). On October 7, 1992, Dr. Henbest diagnosed claimant with herniated L4-5 and L5-S1 discs and prescribed conservative therapy. (Ex. 16). After conservative treatment proved unsuccessful in relieving claimant's low back symptoms, Dr. Henbest performed surgery on January 4, 1994. (Ex. 40). Specifically, he operated on the ruptured L4-5 disc. (Exs. 40, 41, 42, 43).

For the past 30 years, claimant has maintained a small farm, primarily tending draft horses. He keeps his horses in pasture, except during the winter when he must feed them (25 to 30 bales of hay per week). (Tr. 56-57). Sometime in 1991 or 1992, claimant began participating in horse plowing events for recreation. He and the other participants would stage these plowing exhibitions twice a year: once in the spring and once in the fall. (Tr. 61). Claimant testified that he developed an "aching back" after a horse plowing event in October 1993; however, he did not seek medical treatment for those symptoms. (Tr. 123).

The employer argues that claimant's current low back condition is due to chronic, noncompensable degenerative disc disease and "strenuous or injurious off-the-job activities." (Reply Br. at 1). Although the facts demonstrate that claimant has pursued an active lifestyle away from work, there is no extrinsic medical evidence to support the theory that his off-duty activities are responsible for his current low back condition.

Specifically, the employer's argument relies entirely on two separate instances, in 1989 and 1991, where claimant sought treatment from Dr. Williams for increased symptoms due to off-duty farming activities (*i.e.*, digging a trench and lifting bales of hay). (See exs. 4-5, 4-15, 4-16, 11). However, there is no indication from Dr. Williams, or any other physician, that claimant's off-duty farming activities in 1989 and 1991, respectively, were the major contributing cause of his low back condition.

Conversely, claimant asserts that the majority of medical treatment he received between 1989 and 1992 was necessitated by worsened low back symptoms resulting from seasonal increases in his work activities. (Resp. Br. at 4, 8). He points out that there is no evidence that he has a preexisting degenerative disc condition. Moreover, claimant argues that the preponderance of medical evidence demonstrates that his employment conditions, including the 1985 injury, contributed more to the causation of his low back condition than all non-work related exposures combined.

Given the multiple, potential causes for claimant's back condition, we find the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967). We generally afford greater weight to the opinions of the claimant's attending physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, claimant was originally treated by Dr. Williams, then by Dr. Henbest. Both doctors' opinions support compensability.

Dr. Williams opined that the 1985 injury caused "acute disc injury," and that condition, when combined with "repetitive microtrauma of work posture," resulted in claimant's current condition and need for treatment. (Ex. 56). Although Dr. Williams did not use "magic words," we conclude that his opinion supports the finding that the 1985 injury caused a disc injury which subsequently worsened due to strenuous work activities (*e.g.*, "throwing sugar" and welding).¹ See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986) ("magic words" are not necessary so long as the medical opinion supports the requisite finding).

Dr. Henbest opined:

"[Claimant] probably sustained a very significant injury, which is consistent with his history of an accident in 1985, followed by repeated trauma to the lower back. This repeated trauma to the lower back could have come from any number of causes. This resulted in a large disc herniation and compromise of the nerve roots. Therefore, it appears, from the history that I have been given, that the June 1985 work accident was the major contributing cause to his current symptoms and condition requiring surgery. The subsequent insults at work and in recreation were the material contributing cause." (Ex. 53).

The employer argues that Dr. Henbest's opinion does not satisfy the major contributing cause standard because he attributed claimant's current low back condition to work activities and recreation. (App. Br. at 5). We disagree. In our view, Dr. Henbest was making a distinction between the greater causal contribution from the 1985 injury and the lesser, but significant, contributions from "throwing

¹ The employer contends that Dr. Williams' opinion is not persuasive because his May 5, 1994 medical opinion did not mention claimant's participation in biannual horse plowing activities. (App. Br. at 5). This argument is without merit. There is no persuasive evidence that claimant's occasional horse showing contributed in any way to his current low back condition. Inasmuch as claimant's low back condition progressively worsened since 1985, one episode of back soreness in 1993 (unrelated to any specific injury) has almost no probative value; particularly considering that he sought no medical treatment for those symptoms. Moreover, since Dr. Williams knew of claimant's farming and horse raising activities, his failure to specifically mention claimant's involvement in organized plowing exhibitions does not diminish the persuasiveness of his medical opinion. (Ex. 4); see Palmer v. SAIF, 78 Or App 151 (1986) (medical opinion is still persuasive so long as omitted facts have no bearing on the relevant issue).

sugar," welding and recreational activities (e.g., farming, camping, snowmobiling). See ex. 8-1. Like Dr. Williams, Dr. Henbest believed that the 1985 injury was significant. Dr. Henbest also believed that the disc condition was worsened by subsequent activities, although he did not distinguish work activities from recreational activities.

Dr. Burton, examining neurologist, had "difficulty directly relating the June 1985 injury to [claimant's] 1993 low back presentation of a lumbar disc syndrome." (Ex. 51-7). Although Dr. Burton suspected that claimant was suffering degenerative disc disease, he was unable to render an opinion, based on reasonable probability, regarding the actual causation of claimant's low back condition. (Ex. 51-8). He stated, however, that "there may have been a disk component" to claimant's 1985 injury. (Ex. 54-5). Dr. Burton also acknowledged that claimant's low back condition was made symptomatic by hefting 100 pound bags of sugar. (Ex. 51-7). He confirmed that the sort of repetitive flexion, extension and turning involved with "throwing sugar," could elicit pain and produce disk herniation. (Ex. 54-8).

Because Dr. Burton's opinions are phrased in terms of possibility (i.e., "may" and "could"), they are not sufficient to carry claimant's burden of proving a work connection with reasonable certainty. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981). Nevertheless, Dr. Burton indirectly corroborated the opinions of Drs. Williams and Henbest, which are phrased in terms of reasonable certainty, by stating that claimant's 1985 injury could have had a "disk component," and that claimant's work activities could have produced a disk herniation. After reviewing the medical record, we conclude that the opinions of Drs. Williams and Henbest are better-reasoned, complete and, therefore, most persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Hence, we find that the 1985 work accident was the major, if not sole, contributing cause of a disc injury. We also find that the disc injury produced by the 1985 accident was pathologically worsened (resulting in disc herniation) due, in major part, to claimant's subsequent work activities. In this regard, we rely in part on the uncontradicted lay testimony that claimant's work activities (sugar throwing and welding) were more strenuous on his back than his off-work activities caring for his horses and participating in horse shows and horse plowing events. Accordingly, we conclude that claimant has established, by medical evidence supported by objective findings, the compensability of his low back condition as a new occupational disease. See ORS 656.802(1)(c),(2); McGarrah v. SAIF, 296 Or 145, 166 (1983); Weller v. Union Carbide, 288 Or 27, 35 (1979). Accordingly, responsibility for the low back condition "shifts" to the new occupational disease claim. See ORS 656.308(1); Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993).

The Referee concluded that claimant failed to prove the compensability of his back condition because none of the persuasive medical opinions considered that "claimant did not report worsened symptoms nor seek treatment until after the [October 1993] horse show and around the time he would have begun hefting hay bales again. At the same time, claimant's work activities should have shifted to the lighter activities required during the off-season." (Opinion and Order at 6). For the following reasons, we disagree with the Referee's conclusion.

First, claimant was undergoing treatment at the time of the October 1993 horse show. Dr. Henbest diagnosed claimant with herniated L4-5 and L5-S1 discs one year earlier. (Ex. 16). Claimant was undergoing conservative care until Dr. Henbest's decision to proceed with surgery in January 1994. The fact that claimant did not seek treatment following the October 1993 horse show supports claimant's position that no traumatic event occurred on that day and that he was simply suffering the persistent symptoms that he has experienced in varying degrees since the 1985 low back injury. (Resp. Br. at 8). Inasmuch as there is no persuasive medical evidence linking claimant's current low back condition to the October 1993 horse show, we disagree with the Referee's finding that claimant's condition was attributable to his off-work activities.

Secondly, the Referee found that, with the exception of Dr. Burton, none of the physicians who examined claimant had a history of his seasonal work increases, recreational horse shows, or farming. We conclude, however, that Drs. Williams and Henbest had a complete and accurate history of claimant's work and off-work activities. Furthermore, as we stated above, Dr. Burton's opinion is reconcilable with the opinions of Drs. Williams and Henbest.

Accordingly, we reverse the Referee's order and direct the employer to process claimant's claim for his current low back condition as a new occupational disease claim. See ORS 656.308(1); David L. Large, supra; Peggy Holmes, supra.

Attorney Fees

The Referee awarded claimant an assessed attorney fee of \$2,400 pursuant to ORS 656.386(1) for his counsel's efforts at hearing in setting aside the employer's partial denial of claimant's medical services claim. Claimant cross-requested review, asking that we increase the Referee's assessed attorney award if we found his occupational disease claim compensable. Specifically, claimant's counsel's statement of services sought an attorney fee award of \$6,166.75, for services at hearing. The employer contends that the Referee's assessed fee is adequate and should not be increased. We agree with claimant that his counsel is entitled to an increased fee for services at hearing and on Board review concerning the occupational disease claim; but, we arrive at a different amount than claimant requested.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's "new occupational disease" claim for his low back condition is \$4,900. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record, claimant's appellate 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. Claimant is not entitled to an attorney fee for services on review regarding the attorney fee issue. See Saxton v. SAIE, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated June 30, 1994 is affirmed in part, modified in part and reversed in part. The self-insured employer's January 19, 1994 denial of claimant's occupational disease claim for a low back condition is set aside and the claim is remanded to the employer for processing according to law. The employer's January 24, 1994 denial is reinstated and upheld. In lieu of the Referee's \$2,400 attorney fee award, claimant's attorney is awarded an assessed fee of \$4,900, to be paid by the employer, for services at hearing and on review. The remainder of the order is affirmed.

June 6, 1995

Cite as 47 Van Natta 1013 (1995)

In the Matter of the Compensation of
FRANK R. KUCHTA, Claimant
WCB Case No. 94-03708
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Bethlahmy's order which upheld the insurer's denial of his current right hip condition and need for surgery. On review, the issue is compensability.

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

The medical evidence establishes that claimant had preexisting conditions which combined with his compensable August 1991 injury to cause his current condition. (Exs. 29-2, 32-1). Under such circumstances, claimant must establish that the compensable injury is the major contributing cause of his current, resultant condition and need for medical treatment. ORS 656.005(7)(a)(B). Even though a work injury precipitates symptoms in a previously asymptomatic, preexisting condition, the work injury must still be the major contributing cause in order for the resultant condition to be compensable. See Dietz v. Ramuda, 130 Or App 397 (1994); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

After our review of the record, we agree with the Referee's conclusion that claimant failed to carry his burden of proving, by a preponderance of the evidence, that his compensable injury is the major contributing cause of his resultant right hip condition and need for surgery. Accordingly, we find that claimant's resultant condition is not compensable.

ORDER

The Referee's order dated December 5, 1994 is affirmed.

June 12, 1995

Cite as 47 Van Natta 1014 (1995)

In the Matter of the Compensation of
THERESA R. CALLAHAN, Claimant
WCB Case No. 94-05006
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Niedig and Gunn.

The insurer requests review of Referee Brazeau's order that set aside its denial of claimant's current psychological condition and need for treatment. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. In addition, we offer the following summary and supplementation of the procedural history.

In June 1992, claimant filed a workers' compensation claim for a mental disorder. At the time, she was treating with osteopath Takacs for symptoms of stress and with counselor Getz due to marital difficulties. On June 30, 1992, at the insurer's request, claimant was examined by psychiatrist Turco. Takacs, Getz and Turco diagnosed adjustment disorder with mixed emotional features.

On July 28, 1992, on referral from her attorney, claimant was examined by psychiatrist Maletzky. Dr. Maletzky diagnosed adjustment disorder with a mixture of anxiety and depression.

Thereafter, in February 1993, claimant was found to have a compensable preexisting adjustment disorder that was worsened by her employment.

A May 3, 1993 Determination Order closed claimant's claim, finding her medically stationary on April 6, 1993. A June 16, 1993 Order on Reconsideration affirmed the May 1993 Determination Order. Claimant requested a hearing. On March 23, 1994, a hearing was held before Referee Thye. The sole issue litigated was whether claimant's psychological condition claim had been closed prematurely.

While Referee Thye's decision was pending, on April 15, 1994, the insurer issued this denial of claimant's current condition and need for treatment as no longer related to the compensable psychological condition.

By order dated April 28, 1994, Referee Thye set aside the June 1993 Order on Reconsideration. The insurer requested review, and also resubmitted the claim for closure.

A June 24, 1994 Determination Order declared claimant not medically stationary. The insurer requested reconsideration. On July 29, 1994, an Order on Reconsideration affirmed the June 1994 Determination Order. The insurer requested a hearing.

On September 28, 1994, Referee Brazeau set aside the April 1994 current condition denial at issue here. This request for review by the insurer followed.

On December 13, 1994, a hearing was held before Referee Menashe on the July 1994 Order on Reconsideration to determine whether claimant's compensable psychological condition had become medically stationary at any time subsequent to the May 1993 Determination Order. On January 10, 1995, Referee Menashe declared claimant medically stationary as of September 30, 1993. Claimant requested review.

On March 1, 1995, the Board affirmed Referee Thye's April 1994 order. After claimant withdrew her request for review from Referee Menashe's January 1995 order, on April 14, 1995, the Board dismissed the request for review in that matter.¹

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's 1992 compensable psychological condition remains a material contributing cause of her need for treatment, Referee Brazeau set aside the insurer's April 1994 current condition denial. On review, the insurer argues that claimant's need for psychological treatment is no longer compensable. In support of its contention, the insurer relies primarily on the opinion of Dr. Turco.

Claimant, on the other hand, argues that her current psychological condition is compensable. In support of her contention, claimant cites the opinions of Dr. Maletzky and Ms. Getz. We find that claimant no longer requires treatment due even in material part to the compensable psychological condition.²

Dr. Turco reexamined claimant on March 30, 1993. He opined that claimant was medically stationary and no longer required treatment. Dr. Takacs concurred with Dr. Turco's report.

Ms. Getz disagreed. On April 26, 1993, she reported that claimant continued to require treatment for the compensable psychological condition.

On May 3, 1993, Dr. Maletzky reported that claimant was not medically stationary, as she was now suffering from a major depressive disorder requiring further treatment. Maletzky anticipated that claimant would recover within three to six months. Thereafter, Dr. Maletzky saw claimant infrequently, last treating her on October 27, 1993.

Dr. Turco disagreed. On June 11, 1993, he replied that claimant did not have a major depressive disorder and no longer required treatment for the compensable condition.

Ms. Getz last treated claimant on September 30, 1993. Getz reported that when last seen, claimant's symptoms had subsided and she was "psychiatrically stationary."

In January 1994, Dr. Takacs reported that claimant remained medically stationary when last seen on September 16, 1993. Dr. Takacs agreed with Dr. Turco's assessment of claimant's condition, and indicated that the compensable psychological condition associated with work had resolved shortly after claimant terminated employment with the insured.

On April 15, 1994, the insurer issued this denial of claimant's current condition and need for treatment as no longer related to the compensable psychological condition.

Dr. Turco again reviewed claimant's medical file (including Dr. Maletzky's and Ms. Getz' most recent reports). On July 12, 1994, Turco reiterated that claimant no longer required treatment for the compensable condition.

Several medical practitioners have considered whether claimant's current need for treatment is related to the compensable psychological condition. Only Dr. Maletzky appears to conclude that it is. After evaluating the opposing medical opinions, we are most persuaded by that of Dr. Turco. See Somers v. SAIF, 77 Or App 259, 263 (1986).

¹ We may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(2). A Board order or a referee's order is an act of a state agency which is expressly subject to judicial notice under ORS 40.090(2). Accordingly, we take official notice of Referee Menashe's January 10, 1995 Opinion and Order, our March 1, 1995 Order on Review affirming Referee Thye's April 1994 order, and our April 14, 1995 Order of Dismissal dismissing claimant's request for review from Referee Menashe's January 1995 order.

² We therefore need not resolve the question of whether the requisite standard of proof is "material" or "major." See Joseph Parry, 46 Van Natta 2318 (1994). We reach this conclusion because, even if the proper analysis is "material," the record does not satisfy such a requirement.

Dr. Turco persuasively explained that claimant's compensable psychological condition has resolved, such that work exposure is no longer a material contributing cause of her need for treatment. Dr. Turco further noted that at no time has claimant had a major depressive disorder. In this regard, Dr. Turco explained that the diagnosis is not substantiated by clinical examination, historical presentation or psychological testing. Turco pointed out that claimant leads a very involved life, and opined that it would be unusual for claimant to be doing well in college and to be as active as she describes herself if she were suffering from a major depressive disorder. Dr. Turco concluded that the cause of claimant's current need for treatment is the preexisting psychological condition for which claimant received treatment prior to the time the compensable condition arose.

Dr. Maletzky, on the other hand, noted that individuals with a diagnosis of major depressive disorder have trouble focusing attention on one topic and usually develop a poor memory. Maletzky acknowledged, however, that claimant was doing well in school. Further, while opining that it would be important to know how claimant uses her leisure time and whether she can enjoy various endeavors, Dr. Maletzky admitted that he did not know the extent of claimant's activities with her fiancé, the nature of her relationships with her children, her activities on the farm, or whether she was engaged in any hobbies, conceding that "probably we haven't gone over that thoroughly." Finally, Dr. Maletzky has not reviewed the psychological testing, taken an extensive developmental history, explored claimant's preexisting problems, or reviewed her medical records. Because Dr. Maletzky based his opinion on an admittedly incomplete history, we conclude that his opinion is not well-reasoned or reliable.

Therefore, based on Dr. Turco's better-reasoned opinion (as supported by family physician Takacs and long time counselor Getz), we conclude that the preponderance of the medical evidence establishes that claimant's 1992 work exposure no longer is a material contributing cause of her need for treatment. Consequently, we reverse the Referee's order, and reinstate and uphold the insurer's April 1994 current condition denial.

Inasmuch as we have reversed the Referee's decision, we also reverse the assessed attorney fee award for services at the hearing level.

ORDER

The Referee's order dated September 28, 1994 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

June 12, 1995

Cite as 47 Van Natta 1016 (1995)

In the Matter of the Compensation of
IVAN E. DAME, Claimant
WCB Case No. 94-07122
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Menashe's order that affirmed a Director's order finding claimant not eligible for vocational assistance. On review, the issue is vocational assistance.

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

In November 1993, claimant compensably injured his right knee while working for an employer located in central Oregon. In January or February 1994, claimant moved to Portland. In February, claimant's treating physician released claimant to work as a security guard. In March, the employer offered claimant the security guard position at a wage 27 cents less than his job-at-injury. Claimant declined the position.

The Director found claimant ineligible for vocational assistance because he did not have a substantial handicap to employment. The Referee affirmed, reasoning that claimant had failed to prove that he lacked the "necessary physical capacities, knowledge, skills and abilities" to work in "suitable employment," based on the evidence that he could perform the security guard job. We agree with the Referee's reasoning and conclusion and on review address only claimant's argument that the security guard job did not qualify as "suitable employment" because it was not "located where the worker customarily worked[.]"

In order to prove a "substantial handicap to employment" and be eligible for vocational assistance, the worker must show that he or she is incapable of performing "suitable employment." ORS 656.340(6)(a), (b). "Suitable employment" in part means a job that is "located where the worker customarily worked or is within reasonable commuting distance of the worker's residence." ORS 656.340(6)(b)(B)(ii). Claimant asserts that the phrase "customarily worked" should be construed as referring to "the labor market in which he is currently located" in Portland.

We find no justification for claimant's interpretation of the statute. The statute uses the past tense in referring to where the worker "customarily worked," followed by the language "or is within reasonable commuting distance of the worker's residence." (Emphasis added.) In light of such language, we find that the statute is most reasonably construed as indicating that "suitable employment" is that which is in the area where the employer-at-injury is located or within reasonable commuting distance of the worker's present residence.

Thus, because the security guard job was with the employer-at-injury, we conclude that it was "located where the worker customarily worked," in satisfaction of ORS 656.340(6)(b)(B)(ii). Furthermore, because the treating physician released claimant to the position, we find that claimant had the "necessary physical capacity, knowledge, skills and abilities" to perform it. ORS 656.340(6)(b)(B)(i). Finally, there is no contention that the job failed to pay a wage within 80 percent of the wage paid for claimant's regular employment. ORS 656.340(6)(b)(B)(iii). Consequently, we conclude that the security guard job qualified as "suitable employment" and claimant did not have a "substantial handicap to employment." ORS 656.340(6)(b)(A).

In conclusion, based on the record developed by the Referee, we find no grounds under ORS 656.283(2) for modifying the Director's order. Colclasure v. Washington County School Dist. No. 48-I, 317 Or 526 (1993).

ORDER

The Referee's order dated September 29, 1994 is affirmed.

June 12, 1995

Cite as 47 Van Natta 1017 (1995)

In the Matter of the Compensation of
DEAN KILLION, Claimant
WCB Case No. 94-02435
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Referee Mills' order that upheld the SAIF Corporation's denial of claimant's injury claim for angina. On review, the issue is compensability.

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

In the first sentence of the last paragraph of the findings of fact on page 3, claimant's hospital admission occurred in June 1993, not June 1992.

Claimant smoked for 15 years, quitting in 1966.

The Referee concluded that claimant's angina was an ongoing condition of the body and that, therefore, it should be analyzed as an occupational disease rather than an injury claim; and, even if it were treated as an injury, claimant failed to prove that his job stress, which combined with his preexisting CAD, was the major contributing cause of his angina. On review, claimant contends that his unstable angina¹, which arose in May 1993, is compensable as a new injury that had its onset during a discrete period of time. We disagree.

Claimant began working as a business agent for the employer, a woodworker's union, in 1991. In January 1992, claimant experienced a heart attack. He was diagnosed with moderately severe CAD, which had developed prior to the heart attack. His occluded right coronary artery was opened by means of an angioplasty procedure. Claimant was also prescribed nitroglycerin tablets for angina pectoris, or chest pain.

In the spring of 1993, claimant's job became more stressful. In May 1993, claimant sought emergency room treatment for chest pain that was not controllable with nitroglycerin. He was diagnosed with unstable angina. Just prior to discharge, claimant again developed chest pain, which was subsequently diagnosed as an inferior myocardial infarction (heart attack). (Exs. 11 through 19). Claimant continued to work. He experienced another heart attack in June 1993. He also experienced increased frequency of angina. He left work on the advice of Dr. Hill, his attending internist, in August 1993.

Claimant contends that his CAD is a predisposition to, not a cause of, the development of angina. There is no medical evidence in the record that supports that view. Rather, Dr. Hill, Dr. Vawter, claimant's treating cardiologist, and Dr. Toren, cardiologist, who performed a records review for SAIF, each agreed that claimant had preexisting CAD, which combined with claimant's stressful working conditions to cause chest pain. The doctors also agreed that claimant's CAD had progressed from the time of his 1992 heart attack to the onset of the episode of unstable angina in May 1993. (Tr. 40, 41, 42, 51, 105, 106, 142, 143). Consequently, claimant must prove that his work stress, which combined with his preexisting CAD, is the major contributing cause of his disability or need for treatment. ORS 656.005(7)(a)(B).

Dr. Toren explained that claimant's episode of unstable angina, which lasted two days in May 1993, resulted from the abrupt closure of the right coronary artery from plaque rupture and clot formation. He also attributed claimant's increased frequency of angina from May to August 1993 to the closure of the right coronary artery. (Tr. 142, 143, 144, 145). Based on his review of the medical records, including claimant's frank heart attacks just after the unstable angina episode and in June 1993, he opined that the reocclusion, not work stress, was the major contributing cause of claimant's increased angina and need for treatment.

We find Dr. Toren's opinion more persuasive than those of Dr. Hill and Dr. Vawter, who each opined, without explaining their reasoning, that, although claimant's right coronary blockage caused his angina, claimant's job stress was the major contributing cause of claimant's need to leave work. (Tr. 42, 52, 58, 110, 112). Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810, 814 (1983).

We, therefore, conclude that claimant has failed to prove compensability of his unstable angina. Consequently, we affirm the Referee's order, which uphold SAIF's denial.

ORDER

The Referee's order dated September 29, 1994 is affirmed.

¹ SAIF contends that angina, which means pain, is a mere symptom of claimant's coronary artery disease (CAD), and, therefore, it is the underlying CAD condition that must be analyzed, not claimant's chest pain. We disagree. First, claimant is not making a claim for CAD. Second, claimant sought treatment for angina, not for the underlying CAD. Moreover, we have addressed the compensability of "chest pain," where claimant's claim and need for treatment, as here, was due to "chest pain." See, e.g., Cleon K. Sinsel, 45 Van Natta 2064 (1993). Finally, a claimant may prove compensability by showing that his symptoms are attributable to work, even though he is unable to prove a specific diagnosis. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988).

In the Matter of the Compensation of
JOSIE SEARL-HENNINGER, Claimant
WCB Case No. 94-06952
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Myzak's order that affirmed an Order on Reconsideration that awarded 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee). In its brief, the self-insured employer contends that if the Referee's order is affirmed, it is entitled to a \$1,893.78 offset in overpaid permanent disability. On review the issues are scheduled permanent disability and offset.

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

The Referee affirmed the Order on Reconsideration which awarded 11 percent scheduled permanent disability for loss of use or function of her right knee. This award was based on lost ranges of motion in the knee and a chronic condition.

Pursuant to OAR 436-35-003(2), the standards for rating disability in effect on the date of the October 5, 1993 Notice of Closure apply to claimant's claim. (WCD Admin. Orders 6-1992 and 17-1992).

On review, claimant contends that she is entitled to an increased award of scheduled permanent disability pursuant to OAR 436-35-230(13)(b). That rule provides:

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

- (A) Grade IV chondromalacia
- (B) Secondary strength loss
- (C) Chronic effusion; or
- (D) Varus or valgus deformity less than that specified in subsection (4) of this rule."

ORS 656.266 places the burden of proof to establish the nature and extent of any disability arising from a compensable injury or disease on the worker. Here, there is no evidence that claimant has either chondromalacia or arthritis. In addition, although claimant argues that her Grade III chondrosis evidences degenerative joint disease, there is no medical evidence in the record which establishes that "Grade III chondrosis" equates with degenerative joint disease. In the absence of such evidence, we are unable to conclude that claimant has degenerative joint disease.

Moreover, even if claimant has degenerative joint disease, we are not persuaded that she has secondary strength loss, chronic effusion or a valgus deformity due to the compensable injury.

Although Dr. Galt opined that claimant had 4/5 weakness of the quadriceps, he later agreed with a physical capacities evaluation which revealed no loss of strength in the right knee. (Exs. 15-2; 16). In addition, the medical arbiter panel found that claimant had 5/5 strength with no specific muscle or peripheral nerve affected. In light of Dr. Galt's subsequent agreement with the physical capacities evaluation finding no loss of strength, we do not find his earlier opinion persuasive. Based on the preponderance of the evidence, we conclude that claimant has established no secondary strength loss of the right knee.

Claimant has a valgus deformity of 7 degrees in both the right and left leg. However, no medical evidence relates this deformity to the compensable injury. Given that claimant also has a 7 degree valgus deformity in the left knee, we are not persuaded the this finding is "due to" the injury. See ORS 656.214(2).

Claimant argues that her testimony and the medical record establishes that she has chronic effusion. Claimant's testimony alone cannot establish permanent impairment. See OAR 436-35-005(5) (impairment is a decrease in body function measured by a physician). Although the record indicates that claimant had swelling after Cybex strength testing and after the physical capacities evaluation, the record contains no medical opinion which indicates that claimant has chronic effusion due to the injury.

Accordingly, on this record, claimant has not established entitlement to further permanent scheduled disability under OAR 436-35-230(13)(b).

The employer seeks authorization of an offset of overpaid permanent disability in the amount of \$1,893.78. At hearing, the parties stipulated that there was an overpayment of \$1,893.78. (Tr. 2).

ORS 656.268(13) authorizes adjustments in compensation due to overpayment only at the time of closure by Determination Order or Notice of Closure. However, the Board's authority to authorize recovery of overpayments is not confined to the Determination Order/Notice of Closure process of ORS 656.268(13) and, if a request is properly made at hearing, an offset may be authorized, even where there is no outstanding compensation against which an offset could be taken. Judith K. Nix, 45 Van Natta 2242 (1993); Steven F. Sutphin, 44 Van Natta 2126 (1992). Here, both parties have stipulated to a \$1,893.78 overpayment. Accordingly, we conclude that the employer is authorized to offset its overpayment against future permanent disability awards in this claim.

ORDER

The Referee's order dated October 14, 1994 is affirmed in part and modified in part. The self-insured employer is authorized to offset \$1,893.78 against future awards of permanent disability in this claim. The remainder of the Referee's order is affirmed.

June 12, 1995

Cite as 47 Van Natta 1020 (1995)

In the Matter of the Compensation of
MARIA WEAVER, Claimant
 WCB Case No. 94-07212
 ORDER ON REVIEW
 Ernest M. Jenks, Claimant Attorney
 Lane, Powell, et al., Defense Attorneys

Reviewed by Board Members Gunn, Turner-Christian and Haynes.

The insurer requests review of that portion of Referee Hazelett's order that set aside its denial of claimant's neck and left shoulder injury claim. In her brief, claimant objects to that portion of the order that declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm the Referee's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is \$1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for her counsel's services regarding the penalty issue.

ORDER

The Referee's order dated October 14, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the insurer.

Board Member Haynes dissenting.

The majority has adopted and affirmed the Referee's order setting aside the insurer's denial of claimant's neck and left shoulder injury claim. At hearing, claimant asserted that she sustained an injury to her neck and left shoulder when she and a co-worker were manually lifting a heavy patient. In his order, the Referee found that "there was something that happened at work and that caused a shoulder injury which required medical services."

Although the Referee discussed the applicable law for proving an injury claim, he did not explicitly rely on any statute in finding the claim compensable. Even according to claimant's treating physician, Dr. Rabie, claimant had "pre-existing neck and shoulder discomfort suggestive of muscular etiology" and the work incident "caused worsening of that discomfort." (Ex. 74-3). A panel of physicians that examined claimant at the insurer's request similarly found that claimant had a preexisting condition that contributed to the need for treatment. (Ex. 81-5). Based on such evidence, I am convinced that the claim properly is determined under ORS 656.005(7)(a)(B). I also am more persuaded by the medical evidence showing that the preexisting condition was the major contributing cause of claimant's need for treatment (Exs. 81-5, 92); the opposing opinions either do not recognize the existence of the preexisting condition or fail to explain in any way how the injury is a greater factor than the preexisting condition (Exs. 89-1, 90-1).

Perhaps in recognition of the inadequacy of the opinions supporting claimant's case, the Referee apparently was most convinced by testimony of the co-worker that claimant exclaimed in pain during the lifting incident, citing it as proof that claimant sustained a slight sprain. I find both claimant's and the co-worker's testimony to be not credible.

When claimant first sought treatment, she reported that her left neck and shoulder were injured when a heavy patient she and a co-worker were manually lifting began to fall. (Exs. 69, 70-2, 72-10, 74-2). In one instance, claimant reported feeling a "crack" in her left shoulder (Ex. 70-2), and at another time she stated she felt severe pain in her left shoulder (Ex. 72-8). Two months after the alleged injury, claimant for the first time reported that the patient attempted to grab her breast and buttocks while being lifted. (Ex. 81-1). To Dr. Aversano and in testimony at hearing, claimant additionally stated that, after the patient grabbed her breast, she "jerked" backward, then felt a "popping" sensation in her shoulder. (Ex. 91, Tr. 14-15). At hearing, claimant further stated that she slipped back against the bed, and the patient and co-worker ended up on top of her. (Tr. 15).

Claimant's embellishment of her story over time reflects badly on her credibility. Moreover, claimant showed a willingness to obfuscate when she denied her history of previous left neck and shoulder treatment to examining physicians. (Ex. 92). Although not making a credibility finding with regard to claimant, the Referee apparently also found her testimony unreliable in light of his statement that "claimant's story alone would not be enough to establish compensability."

The Referee did, however, find the co-worker to be credible. The co-worker testified that the patient grabbed her "chest" and then stated that he was going to grab claimant's buttocks. (Tr. 54). She further indicated that she heard a "pop" after claimant slipped and the patient fell on claimant, all of them landing on the bed. (Id. at 55). It was at that time that claimant began screaming with pain. (Id.)

In light of the inconsistencies, it is difficult to understand the Referee's reliance on the co-worker's testimony. In my opinion, there is no reliable evidence of an accidental injury. Thus, construing the Referee's order as applying only ORS 656.005(7)(a), I also disagree that compensability was proved on this basis.

For these reasons, I respectfully dissent.

June 13, 1995

Cite as 47 Van Natta 1021 (1995)

In the Matter of the Compensation of
ZANE E. PHILLIPS, Claimant
WCB Case No. 94-10158
ORDER ON REVIEW

Pozzi, Wilson, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Referee Livesley's order which: (1) found that SAIF had improperly recalculated claimant's temporary total disability (TTD) rate; and (2) assessed a penalty pursuant to ORS 656.262(10) for SAIF's allegedly unreasonable recalculation of

claimant's TTD rate. Claimant cross-requests review of that portion of the Referee's order which affirmed the award of 17 percent (54.4 degrees) unscheduled permanent disability granted by a Notice of Closure (and affirmed by a subsequent Order on Reconsideration). On review, the issues are temporary disability, penalties and unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, a roofer, injured his low back on December 2, 1991. The claim was closed by Notice of Closure of May 5, 1993 with an award of temporary disability and 17 percent unscheduled permanent disability. An August 16, 1994 Order on Reconsideration affirmed the Notice of Closure.

Claimant's form 801 indicates that he was scheduled to work five days a week for eight hours a day at the rate of \$11 an hour. (Ex. 3). The record reveals, and claimant testified, that his hours varied according to the weather, that he was paid by the hour, and that he was also paid on a piece-work basis in which he would sometimes earn more by piece-work than on an hourly basis. (Ex. 1, 3; Trs. 9, 10, 16, 17).

SAIF initially paid claimant's temporary disability rate based on an average weekly wage of \$440, using the figures on claimant's form 801. (Ex. A). After an internal audit of the claim file, SAIF recalculated the temporary disability rate based on an average weekly wage of \$396.79, using claimant's average weekly earnings for the 26 weeks prior to his injury. (Ex. A; Trs. 26, 28, 30, 32, 33).

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Rate

Reasoning that claimant was either at work or available for work on days of inclement weather, the Referee found that claimant was "regularly employed" pursuant to ORS 656.210(2)(c).¹ The Referee agreed with claimant that, because he was "regularly employed," the computation of his temporary disability must be according to ORS 656.210, rather than OAR 436-60-025(5)(a).² Thus, the Referee found that claimant's temporary disability rate was properly based on an average weekly wage of \$440, as claimant contended.

Moreover, the Referee determined that SAIF's decision to recalculate claimant's temporary disability rate under the aforementioned administrative rule was unreasonable. The Referee then assessed a 25 percent penalty based on the difference between the recalculated rate and the "proper" temporary disability rate of \$440.

On review, SAIF contends that, even if claimant was regularly employed, his temporary disability rate should be calculated pursuant to OAR 436-60-025(5)(a), using the average weekly earnings for the 26 weeks prior to his injury. SAIF is correct.

Although we agree with the Referee that claimant was "regularly employed" for the purposes of ORS 656.210(2)(c), we do not agree that a worker who is regularly employed must have his or her temporary disability rate calculated pursuant to ORS 656.210. Even if claimant was "regularly employed," as characterized in ORS 656.210(2), if he was paid on a basis other than a daily or weekly wage, benefits shall be calculated under the Director's rules, not under ORS 656.210. ORS 656.210(2)(c); Lowry v. DuLog, Inc., 99 Or App 459 (1989); Catherine A. Barringer, 42 Van Natta 2356 (1990).

¹ ORS 656.210(2)(c) provides:

"As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the worker's weekly wage."

² OAR 436-60-025(5)(a) provides:

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

Because claimant was paid on an hourly basis with varying hours, and because he was also paid on a piece-work basis, he was paid on other than a daily or weekly basis. Therefore, we find that SAIF correctly recalculated claimant's temporary total disability rate based on the weekly wage determined pursuant to OAR 436-60-025(5)(a). Harold D. Underwood, 47 Van Natta 77 (1995); Kenneth W. Metzker, 45 Van Natta 1631 (1993).

Claimant contends, however, that, even if the aforementioned rule applies, the intentions of the parties at the time of hire, as opposed to the average wages earned during the 26 weeks prior to his injury, should control. Claimant asserts that the intent of the parties was for him to work 40 hours per week at \$11 an hour. As authority, he cites Qualified Contractors v. Smith, 126 Or App 131 (1994), and Francis A. Sims III, 46 Van Natta 1594 (1994).

In Smith, we had agreed that the claimant had been regularly employed. We concluded, however, that because of the extended gaps in the claimant's employment, the parties' intentions would control concerning the calculation of the claimant's benefits. Based on information provided by the employer on the Form 801 and on the claimant's testimony about his work schedule, we found that it was the parties' intention that when he was working, the claimant was employed 12 hours a day, seven days a week. We calculated the claimant's weekly wage by multiplying his average daily wage by seven. The court affirmed, finding substantial evidence to support our findings.

We find Smith to be distinguishable because it involved a situation concerning "extended gaps" in the claimant's employment. In this case, there is no contention, and the record does not support a finding, that there are extended gaps in claimant's employment. Accordingly, the intent of the parties does not control in this case. See OAR 436-60-025(5)(a).

Francis A. Sims III, *supra*, does not assist claimant, either. In that case, we agreed with the Referee's conclusion that the claimant's correct weekly wage rate for calculating TTD should be based on the parties' intention at the time of hire as reflected by the wage and hour information reflected on the form 801. We cited Smith as authority.

However, as previously noted, Smith was a case involving "extended gaps." Although it is not clear from our opinion in Sims III whether there were extended gaps in the claimant's employment in that case, our citation to Smith implies that there were. If so, a determination of the intentions of the parties concerning the claimant's work schedule was necessary.³

In summary, we find that SAIF properly recalculated claimant's temporary disability rate. It, therefore, follows that the Referee incorrectly assessed a penalty for allegedly unreasonable claim processing. Accordingly, we also reverse the Referee's decision on the penalty issue.

Unscheduled Permanent Disability

Claimant contends that he is entitled to increased unscheduled permanent disability. We adopt and affirm the Referee's reasoning and decision on this issue.

ORDER

The Referee's order dated December 21, 1994 is reversed in part and affirmed in part. That portion which disapproved SAIF's recalculation of claimant's temporary disability rate and assessed a penalty for unreasonable claim processing is reversed. The remainder of the Referee's order is affirmed.

³ In any event, it would be inappropriate to examine the parties' intentions whenever a claimant works for varying hours, shifts and wages. To do otherwise, would violate the express language of OAR 436-60-025(5)(a), which limits consideration of the parties' intentions to situations where there are "extended gaps" and the worker has been employed less than four weeks.

In the Matter of the Compensation of
MELVIN E. SCHNEIDER, JR., Claimant
WCB Case No. 94-10685
ORDER ON REVIEW
Malagon, Moore, 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 Daughtry's order which: (1) set aside its denial of claimant's current skin condition; and (2) awarded claimant's counsel an assessed attorney fee of \$3,000. On review, the issues are compensability and attorney fees.

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

Pursuant to an earlier referee's May 1991 order, the insurer was directed to accept and process claimant's contact dermatitis condition. Claimant eventually received an award of scheduled and unscheduled permanent disability for this condition. (Ex. 20). On August 26, 1994, the insurer denied claimant's current skin condition on the grounds that it was not related to the original accepted claim. (Ex. 8).

The Referee set aside the insurer's denial, finding that claimant's current skin condition was materially related to the originally accepted condition. On review, the insurer contends that claimant's current skin condition is not compensable. We disagree.

Dr. Storrs, a dermatologist, treated claimant for his skin condition in 1991. She reexamined claimant once again in November 1994 at the request of claimant's counsel. Dr. Storrs opined that the current dermatitis condition is "precisely the same condition" for which she treated him in 1991. (Ex. 24). Dr. Storrs emphasized that claimant's original occupational exposure had "unmasked" an irritant dermatitis that would bother him indefinitely.

Inasmuch as Dr. Storrs examined claimant when his skin condition was ordered accepted in 1991 and again in 1994, after his current condition had been denied, we find that she was in an advantageous position to evaluate claimant's current skin condition. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Thus, based on Dr. Storrs' persuasive medical opinion, we find that claimant's current skin condition is the "same condition" as was ordered accepted in 1991.

The insurer may only deny claimant's current condition if that condition is different from the accepted condition. See Rosie Leal, 46 Van Natta 475, 476 (1994); Eileen A. Edge, 45 Van Natta 2051 (1993). Accordingly, because we find that claimant's current skin condition is the same as his prior accepted condition, we conclude that the insurer's denial of his accepted condition constitutes a "back-up" denial of compensability.

In Anthony G. Ford, 44 Van Natta 240 (1992), we held that an insurer may issue a "back-up" denial of a claim more than two years after claim acceptance, so long as the insurer's denial is supported by a showing of fraud, misrepresentation or other illegal activity. Here, the insurer issued its "back-up" denial in 1994, some three years after the Referee's order setting aside its denial.

However, "acceptance" of a claim via a litigation order does not constitute a proper basis for a subsequent "back-up" denial based on fraud, misrepresentation or other illegal activity. See Knapp v. Weyerhaeuser Co., 93 Or App 670, 673 (1988). In any event, even assuming the insurer could issue a "back-up" denial under these circumstances, the insurer offers no argument, and we find no evidence, that the insurer's denial was supported by a showing of fraud, misrepresentation or other illegal activity. Consequently, we conclude that the insurer's "back-up" denial was improper.

Moreover, even if the insurer's denial was not of the "same condition" that it was ordered to accept in 1991, we would still find claimant's current skin condition to be compensable. The insurer does not contest the Referee's application of a material causation standard in determining the compensability of claimant's current condition. We agree for the reasons cited in the Referee's order that claimant's current condition is materially related to his original accepted claim. Accordingly, we conclude that the Referee properly set aside the insurer's denial.

The insurer also argues that the Referee's attorney fee award was excessive. We disagree.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is \$3,000, payable by the insurer. 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 counsel may go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is \$1,075, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 14, 1994 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,075, payable by the insurer.

June 14, 1995

Cite as 47 Van Natta 1025 (1995)

In the Matter of the Compensation of
DEBRA A. ASHDOWN, Claimant
WCB Case No. 94-06262
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Brown's order that: (1) admitted a "post-reconsideration report" from a medical arbiter; and (2) reduced claimant's permanent disability award for a right shoulder condition from 20 percent (64 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issues are evidence and the extent of unscheduled permanent disability.

We reverse the Referee's evidentiary ruling. However, we otherwise adopt and affirm the order of the Referee with the following supplementation.

The Referee determined that claimant had no impairment as a result of her right trapezius and rhomboid strain. Although the medical arbiter opined that claimant's repetitive pushing with the right upper extremity was limited, the Referee found that a preponderance of the medical evidence established the lack of permanent impairment from the December 6, 1992 work incident. The Referee accepted the assessment of claimant's attending and other examining physicians that she suffered no permanent impairment from that injury. Specifically, the Referee found that Dr. Telew's assessment of claimant's condition provided a reasonable explanation for claimant's current complaints: somatoform pain disorder not caused in major part by her industrial injury.

On review, claimant argues the Referee erred in favoring the medical opinions of claimant's attending and examining physicians over that of the medical arbiter. Claimant also objects to the admissibility of Ex. 68, a follow-up letter of the medical arbiter, Dr. Potter. This supplemental report was solicited by the employer subsequent to the Order on Reconsideration.

On this second point, claimant is correct. Subsequent to the Referee's order, we held in Daniel L. Bourgo, 46 Van Natta 2505 (1994), that a "supplemental" or "clarifying" arbiter report prepared at the request of a party subsequent to the reconsideration order constituted "subsequent medical evidence" of the workers' impairment, and was therefore inadmissible pursuant to ORS 656.268(7).¹ We therefore do not consider Ex. 68 on review. See Jim Vallejo, 46 Van Natta 1242 (1994).

¹ In Bourgo, we noted exceptions to this rule: when the pre-reconsideration order arbiter's report was incomplete (as represented by the arbiter) or when the Department compels a supplemental arbiter examination or report. Neither exception is applicable here, however.

OAR 436-35-007(9) specifically provides that where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment.² This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician agrees. See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). Reports of independent medical examiners are not admissible for the purpose of rating impairment unless those findings are ratified by the claimant's attending physician.³ See OAR 436-35-007(8); Tektronix, Inc. v. Watson, 132 Or App 483 (1995) (attending physician rated claimant's impairment where he incorporated the findings of the consulting physician and noted that claimant had no significant impairment).

We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but rather rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. Kenneth W. Matlack, 46 Van Natta 1631 (1994). Furthermore, absent persuasive reasons to do otherwise, we give greater weight to the conclusions of a claimant's attending physician. Weiland v. SAIF, 64 Or App 810 (1983).

Consequently, in assessing the extent of claimant's permanent disability arising out of the December 6, 1992 incident, the record on review properly includes the reports of claimant's attending physician issued before the medical arbiter's report, the medical arbiter's report (pre-reconsideration order) and any report related to claimant's impairment that is ratified by the attending physician before the medical arbiter's report. See Tektronix, Inc. v. Watson, *supra*, 132 Or App at 486.

As noted by the Referee, claimant's attending physician, Dr. Herscher, determined in October 1993 that claimant had no permanent impairment due to the December 6, 1992 work injury. (Ex. 52). Claimant challenges the opinion as conclusory, as it was solicited by the employer in a "sign if you agree" letter. However, prior to agreeing that the strain caused no permanent impairment, Dr. Herscher examined claimant on several occasions (including two visits in September 1993, where claimant complained of bilateral arm and shoulder pain and lots of headaches⁴) and reviewed the "multiple reports" generated by other examining physicians. (Ex. 50). His report of September 21, 1994, which noted that claimant had been medically stationary and able to return to full duty work as of September 9, 1993, indicated that claimant "continues to have multiple somatic complaints" but did not relate those complaints to the work injury. (*Id.*)

Dr. Potter, the medical arbiter, on the other hand, opined that claimant had limits on the repetitive use of her right upper extremity due to the "chronicity of the trapezius and rhomboid muscle pain." He also noted slightly decreased shoulder motion.

Under these circumstances, we are persuaded by Dr. Herscher's opinion that claimant has no permanent impairment as a result of the December 6, 1992 work incident. We find it pertinent that Dr. Herscher examined claimant on several occasions and that he reviewed the findings of claimant's other examining physicians prior to rendering his opinion. In other words, we find no persuasive reason not to defer to the determination of attending physician Dr. Herscher. See Weiland v. SAIF, *supra*. Although the medical arbiter (Dr. Potter) did find claimant had chronic rhomboid and muscle pain, we are suspect of his assumption that the pain resulted from the December 6, 1992 injury, considering Dr. Herscher's opinion as well as his references to claimant's "multiple somatic complaints."

² The disability standards define preponderance of the evidence as meaning "the more probative and 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).

³ Accordingly, to the extent the Referee relied on the opinion of Dr. Telew (the psychiatrist on the independent medical panel) in assessing the extent of claimant's permanent impairment, such reliance was improper. The record does not establish that claimant's attending physician ratified Dr. Telew's findings.

⁴ Initially, claimant's complaints of pain resulting from the work injury were limited to the right shoulder, back and neck (see Exs. 23, 27-1), as the strain occurred when she was feeding wood strips into a dryer with her right hand and arm.

We therefore affirm the Referee's order which reduced claimant's permanent partial disability award to zero.

ORDER

The Referee's order dated October 6, 1994 is affirmed.

June 14, 1995

Cite as 47 Van Natta 1027 (1995)

In the Matter of the Compensation of
LARRY R. BUTLER, Claimant
WCB Case No. 93-13120
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn, Turner-Christian, and Neidig.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Spangler's order which: (1) found that claimant's claim was not barred as untimely filed; and (2) set aside its denial of claimant's neck injury claim. On review, the issues are timeliness of the claim, and if timely, compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,100, payable 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 ALJ's order dated October 11, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,100 to be paid by the self-insured employer.

Board Member Neidig, dissenting.

I agree with the majority's conclusion that claimant's claim is not time-barred, however, I disagree with their conclusion that claimant's injury occurred within the course and scope of employment.

The majority found that claimant's injury fell within the "dual purpose" exception of the "going and coming" rule. Specifically, they reason that the employer, Mr. Wright, arranged Mr. Callahan's work release from jail and instructed claimant to pick up Callahan for work and return him to jail after work. The majority, therefore, concludes that there was a business purpose to claimant's trip. I would find that the "dual purpose" exception does not apply because there was no business purpose to the trip to work. Therefore, the claim would not be compensable under the general "going and coming" rule.

First, for the "dual purpose" exception¹ to apply, there must be a business-related purpose to the trip. Here, arguably, the only business purpose to the trip was to get to work. However, merely going to work, in itself, is insufficient to create such a purpose. SAIF v. Reel, 303 Or 210 (1987)(injuries sustained while going to or coming from work are generally not deemed to arise out of and in the

¹ Under the dual purpose exception, when a trip to or from work is combined with a business-related purpose, an injury incurred during the trip may be compensable. Marshall v. Cosgrave, Kester, Crowe, Gidley, 112 Or App 384, 387 (1992).

course of employment). Moreover, the employer left it to the employees how they got to and from work. Claimant provided his own transportation for himself and his crew to work. Claimant was not compensated for his travel time or for mileage. Therefore, I would find that no employment relationship was created, impliedly or expressly, during the period of "going to and coming from" the job site during the time claimant picked up Callahan from jail and returned him to jail. See Gwinn v. Liberty Northwest Ins. Co., 105 Or App 171, 176 (1991) (J. DeMuniz dissenting; citing I-L Logging Co. v. Mfgs. & Whlse. Ind. Exc., 202 Or 277 (1954)).²

Second, the arrangement between Mr. Wright and the jail for claimant to transport Mr. Callahan to and from work during his work release did not create an employment relationship during that travel time. Both claimant and Mr. Callahan worked for the employer prior to Callahan's incarceration. Prior to Callahan's incarceration, claimant transported Callahan and other crew workers to the job site. Mr. Callahan testified that the sentencing judge suggested a work release and that the jailer contacted Mr. Wright about a work release. Mr. Wright's consent was, thus, required for the work release. However, the work release did not alter the employment relationship between the employer and claimant.³

Furthermore, the social policy implications of creating an employment relationship, because Mr. Wright's consent was required for the work release, persuades me that there was no business purpose to the trip to work. I do not think that an employer should be faced with the dilemma of choosing between a work release for an employee and potential workers' compensation liability or keeping the employee in jail. If claimant had proceeded to work without Callahan (*i.e.*, because the employer had not consented to the work release) and he had the accident on his way to work, claimant's claim clearly would not have been compensable.

Because there was no business purpose to claimant's trip to or from work, the "dual purpose" exception does not apply. Accordingly, claimant's injury did not arise out of his employment. Additionally, claimant was injured while going to work. Thus, his injury did not occur in the course of employment. Therefore, claimant has failed to establish a sufficient relationship between the injury and his employment to prove compensability.

Based on the foregoing reasons, I respectfully dissent.

² Because claimant was not compensated for travel time or mileage and because commuting was not an integral part of his employment, I would also find that claimant was not a "traveling employee." See Kevin G. Robare, 47 Van Natta 318 (1995) (the claimant was not a "traveling employee" because claimant's "travel" amounted to commuting to the work site, his commuting was not work-related business and he was not compensated for travel time or mileage).

³ It is unclear whether Mr. Wright would have directed someone else to pick-up Mr. Callahan if claimant had been unable to do so or whether Mr. Callahan would have gone to work if claimant was unable to pick him up from the jail. The lack of such evidence further supports the conclusion that there was no business purpose to claimant's trip to work.

June 14, 1995

Cite as 47 Van Natta 1028 (1995)

In the Matter of the Compensation of
MARK E. COOPER, Claimant
 WCB Case No. 94-05070
 ORDER ON REVIEW
 Daniel Snyder, Claimant Attorney
 Cummins, Goodman, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Schultz' order that: (1) declined to find premature a Notice of Closure closing his lumbar sprain injury claim; and (2) upheld the self-insured employer's "de facto" denial of claimant's L3-4 disc condition. On review, the issues are premature closure and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception. We do not adopt the first finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Pursuant to former OAR 436-30-035 (WCD Admin. Order 5-1992), the employer administratively closed claimant's lumbar injury claim by Notice of Closure on August 18, 1993, declaring claimant medically stationary as of August 15, 1993. Former OAR 436-30-035(7) provides that the worker will be presumed to be medically stationary when the worker has not sought medical treatment in excess of 28 days, unless so instructed by the attending physician, provided that the insurer has notified the worker that claim closure would occur due to the worker's failure to seek medical treatment. The Referee concluded that the employer's administrative closure was proper and that the medical evidence supported a conclusion that claimant was medically stationary on August 15, 1993. We note that the dispositive issue is whether claimant was medically stationary at the time of the August 18, 1993 Notice of Closure. We disagree with the Referee's conclusions.

In Paniagua v. Liberty Northwest Insurance Corporation, 122 Or App 288 (1993), the court noted that the initial issue to be addressed in administrative closure cases is whether the notice given claimant by an insurer was adequate for claim closure under former OAR 436-30-035. Because the Board reviewed the medical reports and determined the claimant was medically stationary at the time of claim closure, before deciding whether the insurer's notice was sufficient, the court remanded. Id. On remand, we concluded that in order to be entitled to claim closure based on a presumption that the claimant is medically stationary, the notice given by the insurer must be in strict compliance with former OAR 436-30-035. Bertha Paniagua, 46 Van Natta 55 (1994). In reaching this conclusion, we reasoned that the purpose of this rule is not to penalize the worker for failing to see his or her doctor. Rather, we explained, the rule appropriately allows the claim to be closed based on a presumption that, if the worker needed medical treatment, she would have sought medical treatment. However, "the notice given must clearly and plainly state that the claim will be closed if claimant fails to return to her doctor for treatment." Id.

The notice in Paniagua stated only that the claim would be closed if the claimant or her doctor did not contact the insurer within two weeks. Therefore, we found that the notice did not comply with the rule and was, therefore, inadequate to allow claim closure based on a presumption that claimant was medically stationary. Id.

Here, the notice is even more flawed in that it did not mention the possibility of claim closure, let alone plainly state that closure would occur if claimant failed to return to his doctor for treatment. The notice in the instant case advised claimant "[i]f we do not hear from you we will assume that you have completely recovered and are in need of no further medical treatment." (Ex. 7). Thus, we find that the employer's notice was inadequate to trigger application of the presumption. Bertha Paniagua, supra; Tammy M. Tallmon, 46 Van Natta 742 (1994). Consequently, the employer's administrative closure was not proper.

Alternatively, even if the employer's closure was proper, we find that the medical evidence does not support a conclusion that claimant was medically stationary at claim closure. "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). Claimant's condition and the reasonable expectation of improvement are evaluated as of the date of closure. ORS 656.268(1); Alvarez v. GAB Business Services, 72 Or App 524 (1985). 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).

Prior to closure, the only medical evidence addressing the issue of claimant's medical stationary status stated that claimant was not medically stationary. Specifically, on June 5, 1993, Dr. Gancher, examining neurologist, and Dr. Staver, examining orthopedist, examined claimant and opined that he was not yet medically stationary. (Ex. 6-4). Furthermore, although Dr. Brittain, treating chiropractor, released claimant to regular work on May 24, 1993, he offered no opinion as to claimant's medically stationary status.

Finally, the post-closure medical reports also do not support a finding that claimant was medically stationary at closure. In this regard, only Dr. Chester, an orthopedic surgeon who served as the medical arbiter, gave a post-closure opinion as to claimant's medically stationary status at closure. Dr. Chester opined that claimant was not medically stationary at closure, although he noted that the accepted lumbar strain "has probably healed and has no residual at this time." (Ex. 13-2). See Scheuning v. J.R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987) (medical evidence submitted after closure can be considered in determining whether the claimant's claim was prematurely closed in regard to the condition at the time of closure); Brian A. Bundy, 46 Van Natta 382 (1994) (to be considered in determining whether a claimant's claim was prematurely closed, post-closure medical evidence must relate back to the claimant's condition at closure).

Accordingly, we find that the claimant's claim was prematurely closed and affirm the April 14, 1994 Order on Reconsideration that set aside the employer's August 18, 1993 Notice of Closure as premature.

Compensability

At hearing, an issue arose concerning the compensability of a small disc bulge or herniation at the L3-4 level of claimant's spine. The Referee concluded that claimant had failed to establish the compensability of this L3-4 disc condition. In reaching this conclusion, the Referee found that the causation opinions of Dr. Lewis, attending physician, and Dr. Chester were unconvincing because they were unexplained and did not address the preexisting degenerative changes in claimant's lumbar spine. Instead, the Referee found persuasive the opinion of Dr. Rosenbaum, examining neurosurgeon, who opined that the disc bulge at L3-4 was secondary to the diffuse degenerative changes in claimant's lumbar spine. We adopt the Referee's reasoning and conclusions regarding the compensability issue with the following supplementation.

On review, claimant cites U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), for the proposition that "when the compensable injury rendered a pre-existing degenerative spinal condition to become symptomatic and need treatment, then it is compensable." (Claimant's Brief, page 4).

Burtis applied ORS 656.005(7)(a)(B) which provides that "[i]f a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." In Burtis, the claimant had a cervical strain superimposed on a preexisting degenerative cervical spine disease. While the medical evidence indicated that the claimant's cervical strain had not caused or worsened the degenerative condition itself, it did establish that the cervical strain had rendered the degenerative condition symptomatic, resulting in a need for surgery. The court concluded that this symptomatic worsening is all that is necessary under ORS 656.005(7)(a)(B) to make the claimant's surgery compensable, provided that the compensable injury remains the major contributing cause of the need for medical treatment. 120 Or App at 358.

However, in the present case, there is no medical evidence in the record that supports a finding that the compensable lumbar sprain combined with the preexisting degenerative condition to cause a symptomatic worsening that resulted in a need for treatment. Dr. Rosenbaum opined that claimant's disc condition was consistent with and secondary to the diffuse preexisting degenerative changes in his spine. (Ex. 15-4). Dr. Lewis agreed with Dr. Rosenbaum that claimant had degenerative changes but opined that claimant had a small L3-4 disc herniation, without explaining its cause or the relationship of this herniation to the degenerative changes. (Ex. 16). Dr. Chester did not address the preexisting degenerative changes. (Ex. 13). We, therefore, affirm the Referee's order on this issue.

ORDER

The Referee's order dated October 18, 1994 is reversed in part and affirmed in part. That portion of the Referee's order that reinstated the Notice of Closure is reversed. The April 14, 1994 Order on Reconsideration which set aside the Notice of Closure as premature is reinstated and affirmed. Claimant's lumbar sprain claim is remanded to the employer for further processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800, payable by the self-insured employer directly to claimant's attorney. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
LAWRENCE K. DONAGHY, Claimant
WCB Case No. 94-06934
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Hall, Turner-Christian and Haynes.

Claimant requests review of Referee Black's order that affirmed an Order on Reconsideration that awarded 17 percent (25.5 degrees) scheduled permanent disability for loss of use or function of the right leg. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that, under OAR 436-35-230(10), he is entitled to additional scheduled permanent disability for right quadriceps and hamstring weakness. We agree.

OAR 436-35-230(10) 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." OAR 436-35-230(9) sets forth the method for rating impairment for loss of strength due to peripheral nerve injury.

Here, the medical reports specifically assessing claimant's permanent disability arising from his compensable right knee injury establish that his right quadriceps and hamstring strength is 4/5. (Exs. 6-3, 7). On this record, we find that evidence sufficient to establish that claimant's loss of strength was due to loss of muscle or disruptions of the musculo tendonous units relating to his right quadriceps and hamstring. Under the circumstances, we agree with claimant that he has established his entitlement to additional scheduled permanent¹ disability benefits under the rules.

In reaching this conclusion, we acknowledge our decision in Susan D. Wells, 46 Van Natta 1127 (1994). There, we concluded that the claimant had failed to establish a ratable impairment under former OAR 436-35-230(9) (since renumbered OAR 436-35-230(10)), because the medical evidence did not establish why the claimant's quadriceps strength was less than normal. 46 Van Natta at 1128. Here, we conclude that, because the medical reports on which we rely specifically addressed claimant's permanent disability, if any, relating to his compensable right knee injury, those reports implicitly support the conclusion that his weakness in the right quadriceps and hamstring was due to loss of muscle or disruption of the musculo tendonous unit as a result of his compensable injury.

This conclusion finds support in the Workers' Compensation Division bulletin regarding attending physicians' closing reports and examinations. The bulletin provides that, "[i]f loss of strength is due to loss of muscle or to disruption of the musculotendonous unit, [the rating physician shall] name the affected muscle." WCD Bulletin 239 at A-5 (Rev. July 24, 1992). Here, the medical reports named the affected muscles, namely, claimant's right hamstring and quadriceps. That is sufficient under the standards.

Under the rules, claimant is entitled to 6 percent for 4/5 strength in the right quadriceps and 8 percent for 4/5 strength in the right hamstring. OAR 436-35-230(9), (10). Accordingly, claimant is entitled to an additional 14 percent scheduled permanent disability award for loss of strength in his right leg. Therefore, we modify the Order on Reconsideration to reflect this additional award.

¹ The dissent asserts that claimant has failed to establish the permanency of his right leg weakness. We disagree. Dr. Baker, examining physician, with whom treating physician, Dr. Walton, concurred, determined that claimant is permanently restricted from kneeling and squatting, but that any discomfort claimant might experience with the passage of time will, hopefully, slowly subside. (Ex. 6-3, -4, 7). Because Dr. Baker did not explicitly conclude that claimant's right leg muscle weakness would subside over time, we find the report sufficient to establish that the muscle weakness is permanent.

ORDER

The Referee's order dated November 1, 1994 is modified. In addition to the 17 percent (25.5 degrees) scheduled permanent disability granted by the Order on Reconsideration, claimant is awarded 14 percent (21 degrees) scheduled permanent disability for loss of strength of the right leg, for a total award of 31 percent (46.5 degrees). Claimant's counsel is awarded an out-of-compensation fee equal to 25 percent of the increased compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney.

Board Member Haynes dissenting.

The majority concludes that claimant has proved his entitlement to a scheduled permanent disability award for loss of strength of his right leg. Because that conclusion is supported by neither the law nor the facts in this case, I dissent.

Claimant asserts that, under OAR 436-35-230(10), he is entitled to additional scheduled permanent disability for right quadriceps and hamstring weakness. I disagree.

OAR 436-35-230(10) 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, the medical evidence establishes that claimant's right quadriceps and hamstring strength is 4/5. (Exs. 6-3, 7). There is, however, no evidence regarding the cause of that weakness, much less that the weakness was due to muscle loss or disruption of a musculo tendonous unit. Under the circumstances, I agree with the Referee that claimant has failed to establish his entitlement to additional scheduled permanent disability benefits under the rule. That conclusion is in accord with our decision in Susan D. Wells, 46 Van Natta 1127 (1994), where we held that, under former OAR 436-35-230(9) (since renumbered OAR 436-35-230(10)), the claimant had failed to establish that her quadriceps weakness was not addressed by the disability standards when a medical expert failed to explain why the weakness existed.

The majority attempts to overcome this conclusion by holding that the medical evidence "implicitly" supports the conclusion that claimant's muscle weakness is due to loss of muscle or disruption of a musculo tendonous unit. The majority is wrong. The only reference to hamstring and quadriceps weakness is a single sentence in the report of Dr. Baker, examining physician, stating, "Muscle strength in right quadriceps and hamstrings is 4/5[.]" (Ex. 6-3). Dr. Walton, treating physician, concurred in that statement, without any explanation. (Ex. 7). On this record, I find no evidence, either explicit or implicit, regarding why claimant experienced muscle weakness. Accordingly, I would affirm the Referee's conclusion that claimant has failed to establish a ratable condition under OAR 436-35-230(10). See Susan D. Wells, supra.¹

Last, I disagree with the majority's willingness to overlook the lack of evidence regarding the permanency of claimant's muscle weakness. As I stated earlier, the only evidence concerning that weakness is the one-sentence reference to hamstring and quadriceps weakness in Dr. Baker's report, and Dr. Walton's unexplained concurrence therewith. There is no evidence that either physician believed that the weakness was permanent (or that they even considered that issue). I question the decision to award permanent disability benefits when claimant has not established a permanent disability.² Because the majority's reasoning and conclusions are supported by neither the law nor the record, I dissent.

¹ The majority also purports to distinguish this case from Susan D. Wells, supra, under its "implicit" support argument. The majority's distinction is not well-taken. The majority has "de facto" disavowed Wells and its progeny. If that is the majority's intent, it should expressly disavow those cases, so that members of the public and bar are not left wondering about the state of the law regarding this issue.

² The majority attempts to sidestep the permanency issue by reading Dr. Baker's mention of an anticipated improvement in claimant's ability to use stairs comfortably and Baker's silence regarding the muscle weakness-permanency issue as evidence of the permanency of claimant's quadriceps and hamstrings weakness. Because there is no logical or medical support for that reasoning, I disagree with the majority's conclusion that claimant has established that his muscle weakness is permanent.

In the Matter of the Compensation of
MELVIN GREEN, Claimant
WCB Case No. 94-01755
ORDER ON REVIEW
Benjamin W. Ross, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Michael V. Johnson's order which upheld the insurer's denial of his occupational disease claim for a low back condition. On review, the issue is compensability.

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

Claimant began working for the insured in 1989 as a working supervisor. In May 1992, he sustained an off-the-job injury working on his mother's car. In May 1993, claimant compensably injured his low back when he rapidly jumped up from a curb on which he had been sitting to answer a telephone. The initial diagnosis was acute lumbar strain. Claimant was treated conservatively, with the claim being closed by a September 22, 1993 Notice of Closure, which awarded no permanent disability.

Claimant continued to work long hours and to perform strenuous labor. He also continued to experience low back pain and eventually scheduled an appointment with an internist, Dr. Darby, on December 21, 1993. (Ex. 29). Dr. Darby diagnosed low back pain which he described as a "chronic disorder related to his work."

On December 24, 1993, claimant was lifting sandbags out of his pickup truck at home when he experienced an exacerbation of low back symptoms. This prompted a visit to Dr. Darby on December 28, 1993. At that time, Dr. Darby related the low back symptoms to the off-the-job incident of December 24, 1993. (Ex. 40). Dr. Darby also opined that this episode represented another acute exacerbation of a chronic underlying discomfort previously identified in May 1993 and in May 1982, when claimant suffered a low back injury while working for a different employer.

On February 1, 1994, the insurer issued a denial of claimant's current low back condition on the grounds that claimant had injured his back at home lifting sandbags on December 24, 1993 and that, therefore, his back condition was unrelated to his employment. (Ex. 36).

In the meantime, claimant had been evaluated by a consulting neurosurgeon, Dr. Schmidt, who, based on an MRI scan, diagnosed an L5-S1 disc herniation. However, inasmuch as claimant's symptoms on clinical examination did not correlate with the radicular pattern of such a disc, Dr. Schmidt recommended continued conservative care. (Ex. 32). Dr. Schmidt later confirmed that the major contributing cause of claimant's need for treatment after December 24, 1993 was the off-the-job lifting incident. (Exs. 42-2, 43-2).

Claimant has also been examined by Drs. Snodgrass and Strum. They were unable to determine the major contributing cause of claimant's present low back condition. (Ex. 41-7).

At hearing, claimant's counsel described the claim as one for an occupational disease. (Tr. 9). The Referee noted that the opinions of Drs. Schmidt, Snodgrass and Strum either damaged or did not further claimant's claim for an occupational disease. The Referee then concluded that the medical opinion of the remaining physician, Dr. Darby, was insufficient to satisfy claimant's burden of proving that his ongoing work exposure was the major contributing cause of claimant's condition after the December 1993 sandbag incident. Thus, the Referee upheld the insurer's denial.

On review, claimant contends that he has proven a compensable occupational disease claim because his ongoing employment and the compensable May 1993 low back injury are the major contributing cause of his low back condition. Claimant further asserts that Dr. Darby's medical opinion is sufficient to satisfy his burden of proving medical causation. We disagree.

The insurer denied claimant's current low back condition on the grounds that it is related to the off-the job incident in December 1993. Claimant has asserted that his current condition is compensable as a separate occupational disease. Accordingly, claimant must prove that his work activity subsequent to May 1993 injury is the major contributing cause of his current low back condition. See Stacy v. Corrections Division, 131 Or App 610, 614 (1994) (to establish that current condition was a new occupational disease, the referee properly required the claimant to prove that work activities after acceptance of mental stress claim were major contributing cause of current condition); Floyd D. Maugh, 45 Van Natta 442 (1993) (in order to establish a "new" occupational disease, the claimant required to prove work exposures subsequent to his compensable injuries were the major contributing cause of his current condition).¹ Pursuant to Stacy and Dietz v. Ramuda, 130 Or App 397 (1994), the determination of major contributing cause requires that we consider the effect of all possible causes of claimant's condition, including the May 1993 injury.

Dr. Darby commented as follows regarding the cause of claimant's low back condition:

"I believe that the patient's history of low back strain predates his episode of heavy lifting that resulted in his initial consultation with me regarding low back pain on December 28, 1993. It is clear from the medical history that this patient has had periodic exacerbations of his back pain dating back many years. I believe that it is highly likely that he had inflammation in his low back as a result of his heavy work at [the insured] at the time he lifted the sandbags. In that respect, I think that the back discomfort that he experienced following the December lifting incident was exacerbated by the low back condition related to his work. I think that it is clear from his history that a job requiring heavy lifting is likely to result in further problems with low back strain..." (Ex. 40-2).

In resolving complex medical causation issues, such as those presented here, we rely on 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). In this case, we find persuasive reasons not to rely on the medical opinion of claimant's attending physician, Dr. Darby.

It is clear from Dr. Darby's opinion that claimant's ongoing work activities have affected his current low back condition. Dr. Darby, however, does not confirm that those work activities are the "major contributing cause" of claimant's low back condition, as opposed to the December 1993 off-the-job incident. While a physician is not required to use "magic words," see McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986), we are unable to conclude from Dr. Darby's medical opinion that claimant's work activities subsequent to his compensable May 1993 injury are the major contributing cause of his current low back condition.

Accordingly, like the Referee, we do not consider Dr. Darby's medical opinion sufficient to satisfy claimant's burden of proving medical causation. We, therefore, affirm the Referee's order.

ORDER

The Referee's order dated November 7, 1994 is affirmed.

¹ As was the case in Maugh, we do not find Kepford v. Weverhaeuser Co., 77 Or App 363 (1986) to be controlling. In Kepford, the claimant sought compensation for a degenerative condition which preexisted his compensable injury and his subsequent work exposures. Relying on well-established case law to the effect that aggravation of a preexisting disease may be a separate compensable condition, the court concluded that the claimant could establish compensability by proving that his job exposures, along with the compensable injury, were the major causes of a worsening of his preexisting disc disease. Id. at 365.

Here, as in Maugh, the issue is not the compensability of a condition which preexisted claimant's compensable injury. Inasmuch as the insurer denied claimant's current low back condition, and it is this denial that is at issue, we conclude that claimant is seeking compensation for his current low back condition which has evolved out of his compensable injury and subsequent work and off-work exposures.

In the Matter of the Compensation of
CHRISTOPHER E. LINDON, Claimant
WCB Case No. 94-01250
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian, and Hall.

Claimant requests review of those portions of Administrative Law Judge Lipton's order that: (1) decreased claimant's scheduled permanent disability (PPD) award for loss of use or function of the left leg from 7 percent (10.50 degrees), as awarded by an Order on Reconsideration, to zero; and (2) awarded claimant 9 percent (28.8 degrees) unscheduled permanent disability for a low back condition. The insurer cross-requests review of those portions of the order that: (1) awarded claimant 9 percent (28.8 degrees) unscheduled PPD, whereas an Order on Reconsideration had awarded no permanent unscheduled disability; and (2) awarded claimant's counsel an attorney fee equal to 25 percent of the increased unscheduled PPD created by that order. The insurer argues that the ALJ's order awarding an attorney fee creates an unauthorized overpayment. On review, the issues are extent of scheduled and unscheduled permanent disability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW

Extent of Scheduled and Unscheduled Disability

We adopt the ALJ's reasoning and conclusions as they pertain to these issues.

Attorney Fee

Claimant compensably injured his low back in December 1992. A September 15, 1993 Determination Order awarded claimant temporary disability benefits but no permanent disability benefits. Claimant requested reconsideration. A November 23, 1993 Order on Reconsideration awarded claimant 7 percent scheduled permanent disability for his left leg, and affirmed that portion of the Determination Order that awarded claimant no unscheduled permanent disability. The employer paid claimant the 7 percent scheduled award. Thereafter, both claimant and the insurer requested a hearing.

The ALJ reversed the 7 percent scheduled PPD award, but awarded claimant 9 percent unscheduled PPD for the low back. The ALJ also awarded claimant's counsel an attorney fee equal to 25 percent of the increased unscheduled PPD created by that order, and authorized the insurer to offset the value of the scheduled award (\$3,314.12) against the value of the unscheduled award (\$2,880) payable as a result of that order, "after payment of attorney's fees."

On reconsideration, the insurer requested that the ALJ modify the attorney fee award, asserting that the order created an unauthorized overpayment. Relying on Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), the insurer argued that claimant is responsible for paying his attorney's fee out of his previously overpaid scheduled permanent disability award. The ALJ declined to modify his order, and this appeal followed.

On review, the insurer argues that it would be a violation of Lebanon Plywood v. Seiber, 113 Or App 651 (1992), and Jane A. Volk, supra, to order it to pay an attorney fee where all permanent disability compensation due has already been paid to claimant. Claimant does not dispute that the overpaid scheduled disability award may be offset against the unscheduled disability award. However, reasoning that while he has been previously paid scheduled PPD, he has "not been previously paid unscheduled compensation," claimant contends that Jane A. Volk, supra, does not apply to this dispute.¹ We disagree with claimant's contention.

¹ We do not see any meaningful distinction between this case and Jane A. Volk, supra. We interpret claimant's argument as a request to reconsider and disavow Volk. Since Volk is apparently under consideration at the Court of Appeals, see SAIF v. Rapaich, 130 Or 216, 218 n. 1 (1994), we decline to reconsider our holding in Volk at this time.

In Jane A. Volk, supra, the employer paid the claimant 20 percent permanent disability awarded by a Determination Order. On reconsideration, the award was reduced to 11 percent. The claimant requested a hearing. The parties then entered into a stipulation that reinstated the Determination Order's award of 20 percent permanent disability. The parties, however, litigated the issue of the claimant's attorney's entitlement to an attorney fee.

In Volk, we found that the claimant's counsel had been instrumental in obtaining a "substantive increase" in the claimant's permanent disability and was therefore entitled to an "out-of-compensation" attorney fee. However, relying on Lebanon Plywood v. Seiber, supra, we further found that since the compensation was already in the claimant's possession, an order by the Board to the employer to pay the fee created an improper overpayment. Therefore, we held that counsel must seek payment directly or indirectly from the claimant, and delineated an alternative method for recovery by the claimant's counsel of the attorney fee. 46 Van Natta at 684.

Here, a November 23, 1993 Order on Reconsideration awarded claimant 7 percent scheduled permanent disability, but no unscheduled permanent disability. The ALJ reversed the scheduled permanent disability award. However, through claimant's attorney's efforts, the ALJ increased claimant's unscheduled PPD award to 9 percent. On review, we have affirmed that award. Accordingly, claimant's counsel is entitled to an "out-of-compensation" attorney fee of 25 percent of \$2,880, a total of \$720. See ORS 656.386(2).

As noted, however, the insurer has previously paid the 7 percent scheduled PPD award, for a total of \$3,314.12. While conceding that he has already received the full amount of the compensation award, claimant argues that this case differs from Volk, because his attorney has been instrumental in obtaining "new" money for claimant. As there has been no "actual" increase in the amount of compensation due claimant, we do not agree that the increased unscheduled PPD award constitutes new money.

We applied the Volk rationale in Judith K. Nix, on recon 47 Van Natta 22 (1995), to distinguish between a "substantive" increase and an "actual" increase in compensation due a claimant. Finding that the claimant's attorney had obtained both a substantive increase of a previously overpaid permanent disability award, as well as additional permanent disability compensation (actual increase) for the claimant, we concluded that the claimant's attorney fee award should be divided into two parts. We therefore instructed the employer to pay 25 percent of the amount that represented an actual increase in compensation directly to the claimant's attorney. However, applying Volk, we further directed the claimant's attorney to seek recovery of that portion of his attorney fee that represented a previous overpayment (substantive increase) from the claimant.

Unlike Nix, claimant in this case had only a substantive increase in compensation. Rather, like in Jane A. Volk, supra, the full amount of the compensation award, scheduled and unscheduled combined, is already in claimant's possession. Since claimant has already been paid all of the permanent partial disability compensation that is owed him, claimant's attorney must first seek recovery of the fee directly from claimant. See Jane A. Volk, supra. In the event that the attorney's efforts to recover the fee are unsuccessful, claimant's attorney may seek recovery of the fee in the manner prescribed in Volk, supra.²

Finally, claimant is entitled to an assessed attorney fee for prevailing over the insurer's cross-request for review concerning the unscheduled 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 assessed attorney fee for claimant's counsel's services on review is \$1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

² Relying on SAIF v. O'Neal, 134 Or App 338 (May 17, 1995), the dissent contends that we are authorized to order the insurer to pay an "out-of-compensation" attorney fee even though claimant's compensation award has already been paid. Under the particular circumstances presented in O'Neal, we do not disagree with the dissent's contention. However, as previously explained in Volk, the policy concerns which formed the basis of our holding in O'Neal are absent where, as here, claimant has already fully received all of the compensation to which he is substantially entitled pursuant to the insurer's compliance with a prior order.

ORDER

The ALJ's order dated June 17, 1994, as reconsidered July 15, 1994, is affirmed in part and modified in part. The parties are directed to follow the procedure for recovering the out-of-compensation attorney fee awarded by the ALJ's order as set forth in Volk, supra. The remainder of the order is affirmed. For services on review concerning the unscheduled permanent disability award, claimant's counsel is awarded an assessed fee of \$1,000, to be paid by the insurer.

Board Member Hall concurring in part and dissenting in part.

Although I agree with the majority that we should adopt the ALJ's reasoning and conclusions concerning the extent of scheduled and unscheduled disability, I disagree that the attorney fee award should be modified. In particular, I disagree with the majority's decision not to reconsider our holding in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994) (Board Members Hall and Gunn, dissenting).¹

The problem in this case is determining how claimant's attorney fee should be paid when there is no net dollar increase in compensation. The insurer argues that it would be a violation of Lebanon Plywood v. Seiber, 113 Or App 651 (1992), and Jane A. Volk, supra, to order it to pay an attorney fee where all permanent disability compensation due has already been paid to claimant.

In my view, the majority in Jane A. Volk, supra, misread Lebanon Plywood v. Seiber, supra, when it concluded that "we are without authority to create such overpayments." Volk, supra, 46 Van Natta at 683. In Seiber, the issue was whether the employer was required to pay temporary disability to the claimant to which he was not substantively entitled. The court held that the Board had no authority to "impose" an overpayment of benefits by directing a carrier to pay temporary disability beyond the date the claimant became medically stationary. 113 Or App at 654. The Seiber case had nothing to do with adjustments in permanent disability awards or attorney fees. The holding in Seiber should have been narrowly interpreted and the majority in Jane A. Volk, supra, erred by applying Seiber to the payment of attorney fees.

The court recently distinguished Lebanon Plywood v. Seiber, supra, in SAIF v. O'Neal, 134 Or App 338 (1995). The O'Neal court held that ORS 656.386(2) did not preclude the Board from ordering the carrier to pay attorney fees directly to the attorney when the employer's unnecessary and unilateral action made the additional award necessary. Compare Lathrop v. Fairview Training Center, 134 Or App 346 (1995) (the carrier was not obligated to make a direct payment to the claimant's attorney because the retainer agreement between the claimant and his attorney did not satisfy the requirements of OAR 438-15-085(1)).

In SAIF v. O'Neal, supra, the court rejected the carrier's argument that the Board's decision was inconsistent with Lebanon Plywood v. Seiber, supra. The O'Neal court noted that in Seiber there was no need for an overpayment; rather, the claimant was attempting to obtain extra benefits that he would have received had the claim been correctly processed. In SAIF v. O'Neal, however, there was a need for an overpayment because the claimant's attorney was not paid out of the claimant's award of compensation as he should have been. The O'Neal court held that, because the necessity for the overpayment was created by the carrier's unilateral and unnecessary action, the Board had the authority to remedy the situation by ordering the overpayment.

Here, there has been no "unilateral action" by the insurer. Nevertheless, I submit that the Board has the authority to order the insurer to pay an attorney fee when claimant's permanent disability award is adjusted. Even if Lebanon Plywood v. Seiber, supra, applies and the Board has no authority to "impose an overpayment," it still has authority to order an offset. The majority in Jane A. Volk, supra, confused "creating" an overpayment with the Board's authority to order an offset. OAR 436-60-170(1) provides that "[i]nsurers may recover an overpayment of benefits paid to a worker only as specified by ORS 656.268(13), unless authority is granted by a referee or the Workers' Compensation Board." Therefore, the issue in this case is the recovery of an overpayment, not the creation of an overpayment.

¹ For a discussion of the real and theoretical problems associated with collecting the fee from claimant, Member Hall directs the parties to the dissenting opinion in Volk.

The holding in Jane A. Volk, supra, also contravenes OAR 438-15-085(2).² The application of OAR 438-15-085(2) does not "create an overpayment." The overpayment already exists. Rather, the rule limits the amount of increased compensation from which an already existing overpayment can be recovered. The purpose of the rule is to provide an incentive for claimant's attorneys to pursue this type of claim.

This case is analogous to Weyerhaeuser Co. v. Sheldon, 86 Or App 46 (1987). In Sheldon, the court analyzed the predecessor to OAR 438-15-085(2) (former OAR 438-47-085(2)).³ The employer had overpaid the claimant's temporary total disability benefits. A determination order awarded the claimant permanent partial disability (PPD) and also provided that the employer could not offset the prior overpayment against the award. At hearing, the referee increased the PPD award and awarded a fee equal to 25 percent of the increased award. The referee allowed the employer to offset the previous overpayment against the increased award of compensation. Because the overpayment was greater than the amount of the increased award, claimant did not actually receive an additional payment. In a second proceeding, the referee ordered employer to pay the attorney fee pursuant to former OAR 438-47-085(2).

The Sheldon court held that, since the full amount of the claimant's additional award was not as great as the overpayment, former OAR 438-47-085(2) required the employer to pay the amount necessary to cover the claimant's approved attorney fee, because there was no offset as to that amount. Under the rule, even though there has been an overpayment for which an employer may otherwise be entitled to an offset in some amount from the increased award of compensation, the allowable offset is reduced by the amount necessary to cover an approved attorney fee payable out of the increased award. 86 Or App at 49. The court noted that the Board had authority to make "necessary adjustments in compensation" under ORS 656.268(4),⁴ and to authorize offsets, citing Forney v. Western States Plywood, 66 Or App 155 (1983), aff'd 297 Or 628 (1984).

Application of OAR 438-15-085(2) limits the amount of increased compensation from which an already existing overpayment can be recovered. Here, that would mean that the insurer may only offset \$2,160 instead of \$2,880. Based on ORS 656.268(13) and OAR 436-60-170(1) and Sheldon, the Board has the authority to make "necessary adjustments in compensation" and to correct overpayments. Under OAR 438-15-085(2), the Board's authority includes limiting the amount of compensation from which an already existing overpayment can be recovered.

For the foregoing reasons, I respectfully dissent from that portion of the majority's order that modifies the attorney fee award. I would conclude that the ALJ properly authorized the insurer to offset the value of the scheduled award against the value of the unscheduled award after payment of attorney fees.

² 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."

³ Although the rule in Sheldon has been changed, there is no meaningful distinction between former OAR 438-47-085(2) and OAR 438-15-085(2). Former OAR 438-47-085(2) provided:

"An attorney fee which has been approved in accordance with 47-025 or 47-030 to be paid from increased compensation awarded by a referee, the Board or the Court of Appeals shall not be subject to any set-off based on prior overpayment of compensation to claimant by the employer or its insurance carrier. The employer or carrier shall pay the approved attorney fee to the claimant's attorney."

⁴ At the time Sheldon was decided, ORS 656.268(4) provided, in part: "Any determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid." Sheldon, 86 Or App at 49 n.2. That portion of ORS 656.268 has been renumbered to ORS 656.268(13), with minor changes. ORS 656.268(13) provides: "Any determination or notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid."

In the Matter of the Compensation of
RONALD W. MYERS, Claimant
WCB Case No. 94-11302
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
John E. Snarskis, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Podnar's order that awarded claimant 63 percent (94.5 degrees) scheduled permanent disability for each of claimant's hands, whereas an Order on Reconsideration had awarded 5 percent (7.5 degrees) scheduled permanent disability for each of claimant's hands. On review, the issue is extent of scheduled disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer contests the Referee's conclusion that, under OAR 36-35-110(6)(d), claimant has established a Class 4 vascular dysfunction of his hands due to compensable bilateral Raynaud's vasospastic syndrome (Raynaud's phenomenon) and, therefore, that he is entitled to a 63 percent impairment value for each of his hands. We agree with the insurer's contention and reverse the Referee's order.

OAR 436-35-110(6)(d) provides for a 63 percent impairment value for Raynaud's phenomenon that "occurs on exposure to temperatures below 15 [degrees] Centigrade and is only partially controlled by medication." (Emphasis added). Here, the evidence establishes that claimant's bilateral Raynaud's phenomenon occurs on exposures to temperatures below 15 degrees Centigrade. (Ex. 5-2; see Ex. 19-2). There is, however, insufficient evidence that the condition is "only partially controlled by medication."

We addressed this issue in Ryan F. Johnson, 46 Van Natta 844 (1994). There, the carrier argued that the claimant had not established that his Raynaud's phenomenon was only partially controlled by Procardia. One physician testified that Procardia is an effective medication to prevent Raynaud's phenomenon, and another reported that claimant had told him that he did not feel that Procardia made much of a difference in his symptoms. On the basis of the claimant's testimony and his recurrent symptoms, we found that his Raynaud's phenomenon was only partially controlled by medication. 46 Van Natta at 846.

Here, the only evidence regarding the medication control issue consists of claimant's testimony that, approximately a month before hearing, he underwent a course of Nifedipine that did not help. (Tr. 12, 13).¹ There is no medical evidence regarding the efficacy of Nifedipine in controlling Raynaud's phenomenon or substantiating claimant's assertion that the medication was ineffective. Under the circumstances, he has failed to meet his burden under OAR 436-35-110(6). See Ryan F. Johnson, supra. Accordingly, claimant is not entitled to a 63 percent impairment rating under that rule. Therefore, we reverse the Referee's scheduled permanent disability award.

ORDER

The Referee's order dated December 28, 1994 is reversed. The Order on Reconsideration is reinstated and affirmed in its entirety. The Referee's attorney fee award is reversed.

¹ The record also includes a letter from claimant's counsel stating that claimant's findings are not controlled by medication. (Ex. 17A). We do not consider that letter as evidence regarding the medication control issue. See Cruz v. SAIF, 120 Or App 65, 69 (1993) (attorney's unsupported representations are not evidence).

In the Matter of the Compensation of
DALE A. WECKESSER, Claimant
WCB Case No. 93-10648
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 1, 1995 Order on Remand which: (1) increased claimant's scheduled permanent disability award for the loss of use or function of the left ankle from 3 percent (4.05 degrees) to 8 percent (10.8 degrees); and (2) awarded a \$3,000 carrier-paid attorney fee under former ORS 656.388(1) (SB 369, Section 44). Relying on the recently amended version of ORS 656.388(1), SAIF asserts that claimant's attorney fee is limited to 25 percent of the increased compensation granted by our order.

In order to further consider SAIF's motion, we withdraw our June 1, 1995 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 21 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

June 15, 1995

Cite as 47 Van Natta 1040 (1995)

In the Matter of the Compensation of
RONALD DOMENIC, Claimant
WCB Case No. 94-01834
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Hall and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Davis' 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 reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks compensation for his bilateral carpal tunnel syndrome. The ALJ concluded that claimant did not prove that his work was the major contributing cause of his condition. In reaching this conclusion, the ALJ found no persuasive medical evidence establishing causation. Claimant asserts that the opinion from consulting physician Dr. Long is sufficient to prove compensability. We agree.

As noted by the ALJ, the record contains four opinions concerning causation. Dr. Parsons, claimant's treating physician and internal medicine specialist, indicated that claimant's work was the major contributing cause of claimant's carpal tunnel syndrome. (Exs. 8, 11A). Specifically, Dr. Parsons found that frequent lifting and throwing of lumber and the use of a "pickeroon" caused the condition. (Id.)

Dr. Radecki, electrodiagnostic specialist, evaluated claimant at SAIF's request. Relying on statistical information, Dr. Radecki attributed claimant's condition to age, obesity and heredity. (Ex. 13). Dr. Radecki also indicated that a videotape of claimant's work revealed that he did not engage in activity that required repetitive flexion and extension of the wrist. (Id. at 3).

Dr. Podemski, neurologist, also examined claimant at SAIF's request. Dr. Podemski found that claimant's work likely affected his condition by worsening the symptoms, but it was unclear whether it caused a pathological worsening. (Ex. 13A-3). Dr. Podemski found that other factors contributing to the condition included claimant's body structure and, possibly, familial factors. (Id.)

Finally, according to Dr. Long, consulting physiatrist, due to active and repetitive hand use over a 15 year period, claimant "maintained relatively higher pressures in the carpal canals," which in turn produced "progressive and chronic nerve compression." (Ex. 14-5). During a deposition, Dr. Long stated that he had viewed the videotape showing claimant working and indicated that it was the type of activity to cause increased pressure in the carpal canal. (Ex. 16-7). In particular, Dr. Long stated that the "kind of work that was displayed on the videotape if done on a rapid, frequent, highly repetitive basis is the kind of work that would put the individual at substantial risk of developing median compression and symptoms of carpal tunnel syndrome, particularly if it was done over a period of years." (*Id.* at 8). Dr. Long also concluded that the work was the major contributing cause of claimant's condition. (*Id.* at 10).

The ALJ found Dr. Long's opinion unpersuasive because, based on his own viewing of the videotape, the ALJ determined that claimant's job was not performed on a "rapid, frequent, highly repetitive basis." We disagree with the ALJ's reasoning. Although the ALJ perhaps would not describe the work as "rapid, frequent, highly repetitive," Dr. Long found that claimant's work was of such a nature as to be the major contributing cause of his carpal tunnel syndrome. In other words, based on the totality of Dr. Long's opinion, including explanations offered after viewing the video tape, we construe his opinion to be that claimant's job was the major contributing cause of claimant's condition.

Furthermore, inasmuch as Dr. Long provided the most persuasive explanation for claimant's condition, and does so in the role of consulting physician, we find his opinion most reliable. See Somers v. SAIF, 77 Or App 259 (1986). Based on Dr. Long's opinion, we conclude that claimant proved his bilateral carpal tunnel syndrome compensable. ORS 656.802(2).

Claimant's attorney is entitled to an assessed 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 fee for claimant's attorney's services at hearing and on review is \$3,000, payable by SAIF. 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 counsel may go uncompensated.

ORDER

The ALJ's order dated October 6, 1994 is reversed. The SAIF Corporation's denial of claimant's occupational disease claim is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of \$3,000, payable by the SAIF Corporation.

June 15, 1995

Cite as 47 Van Natta 1041 (1995)

In the Matter of the Compensation of
ROBERT K. HEDLUND, Claimant
 WCB Case No. 93-14958
 ORDER ON REVIEW (REMANDING)
 Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) found that the issues raised by claimant's hearing request from the SAIF Corporation's denial of claimant's medical services claim for treatments provided by "non-MCO" physicians had been resolved in claimant's favor as a result of SAIF's "pre-hearing" rescission of its denial; and (2) dismissed claimant's hearing request. On review, the issue is the propriety of the dismissal. We remand.¹

¹ SAIF's positions have been presented in response to claimant's motion for an extension of the briefing schedule and Board staff counsel's solicitation of an opinion regarding a possible remand to the Hearings Division. Thus, a standard briefing schedule has not been implemented. Nonetheless, since the parties have each availed themselves of opportunities to advance their respective written arguments, we consider it to be in the interests of substantial justice to proceed with our review at this time.

FINDINGS OF FACT

In December 1993, claimant requested a hearing from SAIF's denial of certain medical bills from claimant's family physician. Asserting that the physician (Dr. Dorsey) was not a member of a Managed Care Organization (MCO), SAIF contended that it was not responsible for Dr. Dorsey's bills.

Following several reschedulings, a hearing was eventually set for March 1995. In January 1995, claimant sought further postponement of the hearing. Shortly thereafter, SAIF announced that claimant had been inadvertently enrolled in the MCO. Apologizing for any confusion caused by its oversight, SAIF advised claimant that he was not subject to the "MCO" requirement.

In February 1995, in response to inquiries from the ALJ, SAIF declared that claimant could continue treatments with Dr. Dorsey. In addition, SAIF verified that, since all bills from Drs. Dorsey and Cannard had been paid, there were no outstanding bills regarding claimant's claim.

On February 24, 1995, the ALJ issued an "Opinion and Order." In light of the aforementioned responses from SAIF, the ALJ concluded that no hearing was necessary because claimant had prevailed on the issues raised by his hearing request. Consequently, the ALJ dismissed claimant's hearing request.

Claimant timely requested Board review of the ALJ's order. Stating that he had "been paying Dr. Cannard's office myself for the past year or so, and also Dr. Dorsey at times," claimant asked that the ALJ's order "be set aside."

CONCLUSIONS OF LAW AND OPINION

The ALJ's dismissal order was based on the assumption that all outstanding medical bills had been satisfied by SAIF. Since SAIF was also no longer asserting its opposition to Dr. Dorsey's status as claimant's physician, the ALJ determined that claimant had fully prevailed over all the issues raised by his hearing request.

The assumptions drawn by the ALJ were appropriate in light of SAIF's announcements. Nevertheless, based on the representations contained in claimant's request for Board review (that he has personally paid several bills from Drs. Cannard and Dorsey), it is apparent that an issue or issues raised as a result of claimant's hearing may well remain unresolved.

In light of such circumstances, we find that the record has been incompletely and insufficiently developed. ORS 656.295(5). Accordingly, we consider it appropriate to remand this case to the ALJ. In this way, the ALJ can consider claimant's challenge to SAIF's announcement indicating that no disputes between them remained unresolved.

In determining that remand is appropriate, we wish to emphasize that our decision should not be interpreted as a ruling on the substance of the representations contained in claimant's submission. We further recognize SAIF's arguments that: (1) claimant's contentions represent "an attempt to grant new issues onto a case that was initiated almost more than one and one-half years ago;" and (2) since it has not received medical bills for claimant's allegedly unreimbursed personal payments, claimant's reimbursement request is premature. Each of these assertions may well ultimately prove to be valid. Nevertheless, the proper venue to allow the parties to present their respective positions and to develop a record is the Hearings Division.² We consider this to be particularly appropriate where, as here, claimant's hearing request has been dismissed without the convening of a hearing. Following this "remand" proceeding, the ALJ will be able to determine whether a justiciable controversy within the jurisdiction of the Hearings Division continues to exist.

² Should this case solely pertain to the nonpayment of medical bills, we further note that a question would likely arise regarding whether the Hearings Division is the proper forum to resolve such a dispute. See amended ORS 656.245(6); ORS 656.248(13); SB 369, Sections 25 & 26 (June 7, 1995). However, since such a determination can not be made until the issues are clarified, we find that the ALJ is the proper adjudicator to make the decision (both procedurally and substantively). Thus, we decline to address this potential jurisdictional question.

Accordingly, the ALJ's order dated February 24, 1995 is vacated. This matter is remanded to ALJ Bethlahmy to determine whether any issues resulting from claimant's hearing request continue to exist between claimant and SAIF. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the ALJ finds that no justiciable controversy exists within the jurisdiction of the Hearings Division, the ALJ shall proceed with the issuance of a dismissal order. If the ALJ finds that issues between the parties remain unresolved, the ALJ shall reschedule a hearing on the merits at an appropriate time as determined by the ALJ.

IT IS SO ORDERED.

June 15, 1995

Cite as 47 Van Natta 1043 (1995)

In the Matter of the Compensation of
THURMAN M. MITCHELL, Claimant
WCB Case No. 91-14771
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 19, 1995 Order on Remand which: (1) set aside its partial denial of claimant's medical services claim for travel expenses; and (2) awarded a carrier-paid attorney fee under former ORS 656.388(1). Relying on recently amended versions of ORS 656.327(1)(a), 656.704(3), and 656.283(1)(a), SAIF asserts that jurisdiction to review all medical treatment disputes vests solely with the Director of the Department of Consumer and Business Services. SAIF therefore requests that we vacate our Order on Remand and hold that the Hearings Division lacks jurisdiction to consider the claim.

In order to further consider SAIF's motion, we withdraw our May 19, 1995 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 21 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

June 15, 1995

Cite as 47 Van Natta 1043 (1995)

In the Matter of the Compensation of
JOHNNY C. TINKER, Claimant
WCB Case Nos. 92-10036 & 92-03014
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Lundeen, et al., Defense Attorneys

Maryland Casualty (on behalf of Giesy, Greer & Gunn) requests reconsideration of our May 18, 1995 order which found it responsible for claimant's current low back condition. Maryland challenges our decision to the extent that it finds Maryland responsible for claimant's L3-4 and L5-S1 conditions (Maryland acknowledges that the record supports our conclusion that Maryland accepted claimant's L4-5 condition). Specifically, Maryland contends that the medical evidence does not establish that: (1) claimant's L3-4 and L5-S1 conditions are causally related to his August 1982 compensable injury; and (2) Maryland's acceptance was limited to claimant's L4-5 condition. Further, Maryland argues that amended ORS 656.262(6) is now applicable to this matter.

In order to further consider Maryland's motion, we withdraw our May 18, 1995 order. The other parties are granted an opportunity to respond. To be considered, those responses must be filed within 21 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
JERRY CARROLL, Claimant
WCB Case No. 94-00301
ORDER ON RECONSIDERATION
Ernest M. Jenks, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

On May 19, 1995, we affirmed an Administrative Law Judge's (ALJ) order that set aside the self-insured employer's denial of claimant's aggravation claim for a low back condition. It has come to our attention that our order neglected to clarify whether the attorney fee awards granted by the ALJ's and our orders were awarded to claimant's current or former attorney. Inasmuch as claimant's attorney has not challenged claimant's former attorney's representation that all services at the hearings and Board level in this case were performed by claimant's former attorney, we conclude that the attorney fees granted by the ALJ's and our orders were awarded to claimant's former attorney.

Accordingly, as supplemented herein, we adhere to our May 19, 1995 order. The parties' 30-day rights of appeal shall continue to run from the date of our May 19, 1995 order.

IT IS SO ORDERED.

June 16, 1995

Cite as 47 Van Natta 1044 (1995)

In the Matter of the Compensation of
DENNIS E. FEDDERSEN, Claimant
WCB Case No. 93-14709
ORDER ON REVIEW
Ackerman, et al, Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that declined to award temporary disability compensation in addition to that awarded by an Order on Reconsideration, for periods from November 4, 1991 through January 9, 1992 and from March 31, 1992 through May 22, 1992. On review, the issue is temporary disability. We modify.

FINDINGS OF FACT

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

Claimant is entitled to \$197.47 additional temporary disability compensation.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to establish entitlement to additional temporary disability compensation, based on a conclusion that the record does not substantiate either the amount due or the amount paid. We disagree.

We note at the outset that the self-insured employer's sole argument on review is that claimant is not substantively entitled to additional temporary disability. However, because the issue of claimant's substantive entitlement to temporary disability was not raised at hearing,¹ we decline to address it on review. See Robert L. Bedwell, 43 Van Natta 2497, on recon 43 Van Natta 2702 (1991), aff'd mem., 116 Or App 248 (1992); Donald A. Hacker, 37 Van Natta 706 (1985) (Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy).

¹ The issues at hearing were extent of unscheduled permanent disability, amount of temporary disability, and penalties and attorney fees for failure to timely pay \$277.71 in time loss compensation. (Tr. 1-2).

Claimant argues entitlement to temporary disability compensation (total and partial) totaling \$5,072.24 and contends that he has been paid only \$4,695.77.² Specifically, claimant contends that he should have received temporary partial disability in the following amounts, for the following time periods: \$35.27 (November 18, 1991-December 1, 1991); \$282.18 (December 16, 1991-December 29, 1991); and 98.76 (March 31, 1992-May 22, 1992), for a total of \$414.21. (See Ex. 37). The employer does not dispute these calculations. However, the employer asserts that claimant was paid: \$39.12; \$284.58; and \$170.75, for these time periods (respectively), for a total of \$494.45. (See Ex. 28). Claimant does not challenge the employer's records concerning these payments.

Because neither claimant's specific calculations nor the employer's specific payments are disputed and the amounts of both are substantiated in the record, we rely on them.

Accordingly, on this evidence, we conclude that claimant was paid \$80.24 more temporary partial disability compensation for the above-mentioned periods than he now claims is due.³ Thus, the current claim for a \$277.71 underpayment (see note 2, *supra*) must be reduced by \$80.24 (the amount the employer's payment records reveal that claimant's temporary partial disability compensation was overpaid for the periods in question), so that the maximum possible amount due is \$197.47.

The employer does not dispute the amount of claimant's temporary total disability benefits. (Brief p. 2). Accordingly, because claimant's temporary partial disability was overpaid (by \$80.24, see n.3, *supra*), but the amount of temporary total disability claimed is not contested and the total temporary disability requested is \$277.71, we conclude that claimant has shown that he was underpaid in the amount of \$197.47.⁴

Finally, because the employer has offered no reason for failing to timely and correctly calculate and pay claimant's temporary disability compensation, we conclude that the processing of this claim was unreasonable and a penalty is warranted. See *Lester v. Weyerhaeuser*, 70 Or App 307, 311-312, rev den 298 Or 427 (1984) (Unexplained delay in paying compensation is unreasonable); *Ernest J. Meyers*, 44 Van Natta 1054, 1055-56 (1992) (Insurer's conduct delayed claimant's compensation and is unreasonable as it is unexplained).

ORDER

The ALJ's order dated August 15, 1994 is modified in part and affirmed in part. The self-insured employer is directed to pay \$197.47 additional temporary disability compensation to claimant and a penalty of 25 percent of that amount, one-half of that penalty to be paid to claimant and one-half to claimant's attorney. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an approved attorney fee of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total "out-of-compensation" attorney fee award granted by the ALJ's order and this order shall not exceed \$3,800.

² Based on these figures, claimant would be owed \$376.47. However, because claimant requested only \$277.71 additional compensation at hearing, he may not successfully seek more than that on review. Thus, the question is whether claimant has established entitlement to \$277.71 additional temporary disability (at most).

³ The employer paid \$494.45. Claimant argues entitlement to only \$414.21. The difference is \$80.24.

⁴ \$277.71 (temporary partial and total disability claimed) minus \$80.24 (temporary partial disability overpaid) = \$197.47 due.

In the Matter of the Compensation of
MARK HOYT, Claimant
WCB Case No. 94-05746
ORDER ON REVIEW
Jolles, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn, Turner-Christian and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Schultz's order that set aside its denial of claimant's left hand injury claim. On review, the issue is whether claimant's injury arose out of and occurred in the course of his employment. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The employer is a wood products company, whose plant is located in an industrial area. Claimant, who worked a 6 p.m. to 2:30 a.m. shift, went on a mandatory unpaid half-hour lunch break at approximate 10 p.m. in the employer's lunchroom. Claimant was not required to use the employer's lunchroom; however, given the employer's location and the time of night, the lunchroom was the most practical place to take a break.

After eating his meal, claimant laid his head down on his folded arms to rest. Mr. Garner, a co-worker, and other employees, were also on a mandatory break. Garner had a pocket knife, which he had sharpened earlier. Garner showed other employees how sharp the knife was by cutting newspaper. Garner began pestering claimant, poking him with his left hand, while holding the open knife in his right hand. Without lifting his head, claimant reached back with his left arm to swat Garner's hand away. In the process, claimant accidentally impaled his hand on Garner's knife, causing a serious wound.

Claimant, Garner and other employees routinely carry pocket knives at work, for use in cutting bindings and other packaging on the wood products they handle. The employer does not require employees to carry knives, but acquiesced in that practice.¹ The employer has a written policy that forbids horseplay at work.

The employer denied claimant's left hand injury claim on the ground that it occurred outside the course and scope of his employment. Applying the seven-factor work-connection test set forth in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985), the ALJ concluded that claimant's injury arose out of and occurred in the course of his employment.

The insurer asserts that the ALJ misapplied the Mellis factors. We agree with the ALJ that claimant's injury arose out of and occurred in the course of his employment. However, we offer the following analysis.

The Mellis test inquires whether the activity that resulted in a worker's injury (1) was for the benefit of the employer; (2) was contemplated by the employer and employee, either at the time of hiring or later; (3) was an ordinary risk of and incidental to the employment; (4) was paid activity; (5) was on the employer's premises; (6) was directed by or acquiesced in by the employer; and (7) occurred while the employee was on a personal mission. 74 Or App at 574.

¹ The insurer concedes that the employer acquiesced in its workers' carrying and using knives at work. (Employer's Reply Brief at 3).

In Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the Supreme Court re-examined ORS 656.005(7)(a)'s work-connection standard and clarified the proper analytical framework. The Court reiterated that, to establish the compensability of an injury, the claimant must show that the injury: (1) occurred in "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. Id. at 366. As the Court explained, neither element is dispositive; rather, one must consider "all the circumstances" to determine if the claimant has satisfied the work-connection test. Id. at 366, 369.

In First Interstate Bank of Oregon v. Clark, 133 Or App 712 (1995), the Court of Appeals addressed Norpac Foods' impact on the Mellis analysis. The court concluded:

"The analytical framework set out in Norpac Foods does not significantly change the nature of our inquiry under ORS 656.005(7)(a); it essentially incorporates the tests for work-connection that have been established through case law. However, we believe that reliance on the Mellis test, as the test of work-connection, is inconsistent with the Norpac Foods framework, because the Mellis test does not necessarily allow a meaningful consideration of each of the two elements of the inquiry. Strict adherence to the seven-factor test also does not allow consideration of the totality of the circumstances, as required by Norpac Foods. Accordingly, we conclude that the factors identified in Mellis should no longer be used as an independent and dispositive test of work-connection. Nonetheless, depending on the circumstances, some or all of those factors will remain helpful inquiries under the Norpac Foods two-prong analysis." 133 Or App at 717 (emphasis in original).

In view of Clark, we apply the two-prong analytical framework set forth in Norpac Foods, and consider any helpful Mellis factors.

Our first inquiry is whether claimant's injury occurred "in the course of" his employment. There is no dispute that claimant's injury occurred while claimant was on a mandatory lunch break in the employer's lunchroom, the only practical location for such a break. We find that evidence sufficient to establish the "in the course of employment" element of the work-connection test.

Next, we consider whether claimant's injury "arose out of" his employment. In doing so, we determine whether the conditions of claimant's employment put him in a position to be injured. Henderson v. S.D. Deacon Corp., 127 Or App 333, 338-39 (1994). Considering all the circumstances, we conclude that they did.

Claimant injured his left hand in an attempt to stop Garner from pestering him during a mandatory lunch break, which resulted in claimant impaling his hand on Garner's open knife; Garner had been using the knife to cut newspapers to display the knife's sharpness. Claimant was injured while Garner displayed a knife for a purpose not directly related to their employment. Nevertheless, in view of the facts that claimant and Garner were on a mandatory lunch break in the employer's lunchroom, the only practical choice for such a break, that workers generally carried and used knives to assist them in completing their work duties, and that the employer had acquiesced in this practice, we find that claimant's conditions of employment put him in a position to be injured. Accordingly, claimant has satisfied the "arising out of employment" element of the work-connection test.

The insurer argues that, under Jennifer Kammerer, 46 Van Natta 1147 (1994) and Jennifer J. Kahn, 43 Van Natta 2760 (1991), being the target of a co-worker's horseplay is not considered to be an ordinary risk of, or incidental to, employment. Therefore, the argument goes, because claimant was injured by virtue of Garner's horseplay, claimant's injury was not an ordinary risk of, or incidental to, his employment. We disagree.

Based on our review of the record, we find that Garner's "pestering" of claimant constituted horseplay, but that his use of the knife to cut the newspaper did not. See Webster's II New Riverside University Dictionary 593 (1984) ("horseplay" defined as "[r]owdy or unruly behavior."); see also Stark v. State Industrial Acc. Com., 103 Or 80 (1922) (shooting an air-hose at co-worker constituted horseplay). Although Garner's horseplay (pestering claimant) may have been the catalyst that set in motion the

chain of events that resulted in claimant's injury, the presence of the knife (for reasons unrelated to the horseplay) was the proximate cause of claimant's injury. Because Kammerer and Kahn involved situations where horseplay directly resulted in the claimants' injuries, we find those cases distinguishable.

In sum, we find that claimant's left hand injury arose out of and occurred in the course of his employment. Therefore, we affirm the ALJ's decision setting aside the insurer's denial of claimant's claim.

Claimant is entitled to an attorney fee for his counsel's 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 Board review is \$1,000, to be paid by 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 ALJ's order dated August 26, 1994 is affirmed. For services on Board review, claimant's counsel is awarded \$1,000, to be paid by the insurer.

Board Member Haynes dissenting.

Although I agree with the majority's discussion of the relevant law, I do not concur with its application. In particular, I find little support for the majority's conclusion that claimant's injury arose out of his employment. Accordingly, I dissent.

In determining that claimant satisfied this element, the majority relies on "the facts that claimant and Garner were on a mandatory lunch break in the employer's lunchroom, the only practical choice for such a break, that workers generally carried and used knives to assist them in completing their work duties, and that the employer acquiesced in this practice[.]" According to the majority, such facts show that the conditions of claimant's employment put him in a position to be injured, thereby proving a causal relationship between work and the injury.

I first note that the fact of claimant and Garner taking a lunch break in the employer's lunchroom also was relied upon in finding that claimant's injury arose in the course of his employment. Although I do not necessarily think that the same factors cannot establish that an injury arose out of and was in the course of employment, in this case I see no basis for finding that claimant's and Garner's voluntary use of the lunchroom constitutes a condition of employment. In other words, the chance placement of Garner and claimant in the same room at the same time has no relevance to whether the injury arose out of claimant's employment.

More importantly, the majority does not refer to the fact that Garner's "pestering" of claimant was a "condition" that resulted in the injury. Conveniently, the majority disposes of this factor in a subsequent discussion by stating that, although such activity "may have been a catalyst that set in motion the chain of events that resulted in claimant's injury," the presence of the knife was the proximate cause. The majority thus does not appear to be bothered by the inconsistency of ignoring Garner's "pestering" while relying on "facts" much further removed down the causal chain.

The only logical explanation for the majority's treatment of Garner's "pestering" activity is the majority's desire to play down the strength of such evidence against finding a causal relationship. The record shows that the employer had a policy against horseplay and that claimant and other supervisory personnel had warned Garner several times against engaging in such activity. (Tr. 19, 26; Ex. A). Even according to the majority, Garner's actions constituted horseplay. As such, there is no basis for finding it to be a condition of employment. Furthermore, the horseplay was just as much a "proximate cause," if not more so, than the presence of the open knife, since claimant reached out his hand in direct reaction to Garner's pokes and taps. Such activity certainly was more proximate than the previously discussed "facts" cited by the majority.

The majority also provides little discussion concerning the other "condition" that resulted in claimant's injury, the presence of the open knife, apparently finding it sufficiently resolved by deciding that displaying an open knife does not constitute horseplay. Determining whether such a factor is a condition of employment is a closer question because the employer did not have a policy addressing the use of knives at work. However, the record does show that the knives were used to perform work, such as cutting banding and shrinkwrap. (Tr. 20, 32). There was no evidence that an open knife was used in the lunchroom during a break, much less when engaging in horseplay. Under such circumstances, I cannot conclude that Garner's use of an open knife was a condition of employment.

Because I would find that neither Garner's "pestering" of claimant nor his use of an open knife were conditions of work, I would conclude that claimant's injury did not arise out of his employment. The majority's treatment of this issue is better suited to a civil action for negligence, where a plaintiff may establish causation on the theory of foreseeability. As the Gilmore court stated, an injury is not compensable under workers' compensation without showing "some causal connection." 318 Or 363, 369 (1994). In my opinion, such a test demands more than foreseeability. Here, as demonstrated by the majority, there simply is not evidence that work conditions directly resulted in claimant's injury.

June 16, 1995

Cite as 47 Van Natta 1049 (1995)

In the Matter of the Compensation of
HOWARD S. JOHNSON, Claimant
WCB Case No. C501338
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, Brunn, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On May 16, 1995, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The agreement provides that the consideration is a lump sum payment of \$6,000 and the "insurer's waiver of all but \$1,000.00 of its third party lien[.]" The CDA does not indicate whether claimant achieved a third party settlement, the amount of such settlement, or the amount of the insurer's third party lien.

A carrier can agree to partially or totally reduce its lien against a claimant's third party settlement as "consideration" for a CDA. However, we have disapproved a proposed CDA in which consideration for the agreement consisted of the carrier's reduction of its lien, but the CDA contained no provision indicating that a third party settlement or judgment had been achieved. E.g., Kenneth Hoag, 43 Van Natta 991 (1991). We found that, in the absence of such information, we were unable to determine the "amount to be paid the claimant" as required by OAR 436-60-145(3)(j). Id. Furthermore, we reasoned that, because allocations of a third party recovery to the claimant's attorney and the claimant precede any distribution to the carrier, the "value" of any consideration flowing to claimant as a result of the CDA where no third party recovery was achieved was "presently not ascertainable."

Although the CDA in this case also does not state whether a third party settlement was achieved, we find it distinguishable from Hoag. In Hoag, the entire amount of consideration consisted of the carrier's reduction of its lien. Here, because the CDA provides for a payment of \$6,000, the agreement contains an "amount to be paid claimant" that is "presently ascertainable." In other words, at a minimum, the consideration is at least \$6,000. As such, we conclude that, whether or not claimant achieves an increased portion of any third party settlement proceeds because the carrier agreed to reduce its lien, the proposed disposition is not unreasonable as a matter of law. See ORS 656.236(1)(a).

In conclusion, we hold that the CDA is in accordance with the terms and conditions prescribed by the Director. ORS 656.236(1). Therefore, the parties' CDA is approved. Claimant's attorney fee of \$1,500 also is approved.

IT IS SO ORDERED.

June 16, 1995

Cite as 47 Van Natta 1050 (1995)

In the Matter of the Compensation of
WILFRED E. ODDSON, Claimant
WCB Case Nos. 94-00341 & 93-11155
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) set aside the employer's partial denials of claimant's bladder, bowel, and impotence dysfunctions and psychological disorder; (2) awarded claimant's counsel a \$22,000 attorney fee for prevailing on the compensability issue. Claimant cross-requests review of the ALJ's attorney fee award of \$2,200 for successfully defending the August 25, 1993 Order on Reconsideration and the \$22,000 attorney fee award for the compensability issue, contending that each is inadequate. On review, the issues are compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We supplement as follows.

At hearing, the employer withdrew its request for hearing on the Order on Reconsideration. (Tr. 4).

Claimant submitted a Statement of Services in the amount of \$44,000.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that claimant's urinary, bowel, impotence and psychological conditions are compensable components of his May 1990 compensable injury. The employer contends that the denied conditions are unrelated to the injury.

We adopt and affirm that portion of the ALJ's order addressing the compensability of the denied conditions, beginning with the first paragraph on page 8. Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (a condition that arises directly, even if belatedly, from the original injury is subject to a material contributing cause standard, not a major contributing cause standard).

Because claimant has proven the compensability of the denied conditions, it is unnecessary for us to address the employer's argument regarding the "back-up" denial issue.

Attorney Fees - Order on Reconsideration

The ALJ awarded claimant's attorney an assessed fee of \$2,200 for successfully defending the August 25, 1993 Order on Reconsideration. Claimant contends that this fee is inadequate. The employer did not respond to claimant's contention. Nevertheless, on de novo review, we are authorized to reverse, modify, or make such disposition of the case as we deem appropriate. ORS 656.295(6); Destael v. Nicolai Co., 80 Or App 596 (1986). After conducting our review, we conclude that no attorney fee under ORS 656.382(2) is appropriate on the premature closure issue.

In order to support an attorney fee under ORS 656.382(2), claimant must prove that the employer initiated a request for a hearing to obtain a disallowance or reduction in the claimant's award of compensation, that claimant's attorney performed legal services in defending the compensation award, and that the ALJ found on the merits that the claimant's award of compensation should not be disallowed or reduced. See Strazi v. SAIF, 109 Or App 105 (1991).

Here, the employer withdrew the medically stationary issue raised by the Order on Reconsideration, at the beginning of the hearing. Since the medically stationary issue was no longer before the ALJ, she was forestalled from making a finding on the merits that claimant's award of compensation was not disallowed or reduced and was without authority to award attorney fees under ORS 656.382(2). Strazi v. SAIF, *supra*; Terlouw v. Jesuit Seminary, 101 Or App 493 (1990); Agripac v. Kitchel, 73 Or App 132 (1985); Kenneth J. Short, 45 Van Natta 342 (1993). Accordingly, we reverse the ALJ's \$2,200 attorney fee award under ORS 656.382(2).

Attorney Fees - Compensability

The ALJ awarded claimant's attorney an assessed fee of \$22,000 for prevailing at hearing against the employer's denials. On review, the employer contends that this fee is excessive; claimant contends that it is inadequate. We agree with the ALJ that this is a reasonable fee for claimant's attorney's services in this matter.

In determining an appropriate fee for claimant's attorney's services at hearing, we consider the factors set forth in OAR 438-15-010(4). Those factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The file consists of 132 exhibits. Claimant's counsel generated 34 exhibits, including treatment plans, chart notes, laboratory reports, medical records, and opinion letters from Drs. Rich, Radecki, Kaempf, Galen, Friedman, Phipps, Denekas, specialists who had treated claimant, as well as the articles from professional medical journals relied upon by claimant's expert witnesses. (See Supplemental Exhibit Lists dated November 8 and 19, 1993; February 7, 11 and 25, 1994; March 21 and 29, 1994, and April 4, 1994).

The hearing was conducted over two days separated by six weeks' time. The transcript of the first day involved four witnesses, including two expert witnesses, and 94 pages. The second day was convened to present closing arguments, in which claimant's attorney demonstrated a lucid comprehension of the medical complexities in this case, clarified the medical evidence and analyzed the medical opinions. Claimant's attorney devoted approximately 100 hours of attorney time and 22 hours of staff time to the compensability issue at hearing.

We draw the following conclusions from the foregoing findings. The value of the compensability issue is high, in that claimant will be receiving compensation for partially denied bladder, bowel and impotence conditions, which, to date, includes medical diagnosis and treatment, medications, catheterization, incontinence supplies, and potential penile implant surgery.

The issue in dispute involved highly complex factual and medical matters, considerably more complex than those compensability disputes that are generally presented for Hearing and Board resolution. The events which transpired at hearing level (preparation for two hearings, the first postponed in response to a late medical examination on the part of the employer, a 94 page transcript and closing arguments) were greater than those which normally arise when the Board confronts a compensability dispute of average complexity. The parties' respective counsels, both highly experienced, presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for our resolution. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering the above factors and applying them to this case, we find that the fee awarded by the ALJ on the compensability issue was reasonable.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$4,000, payable 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. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated June 13, 1994 is affirmed in part and reversed in part. That portion of the order that awarded claimant's counsel a \$2,200 assessed fee for successfully defending the Order on Reconsideration is reversed. For services on review concerning the compensability issue, claimant's counsel is awarded a reasonable assessed fee of \$4,000, payable by the self-insured employer. The remainder of the ALJ's order is affirmed.

June 16, 1995

Cite as 47 Van Natta 1052 (1995)

In the Matter of the Compensation of
JORDICE C. SAVAGE, Claimant
 WCB Case No. 93-14180
 ORDER ON REVIEW
 Michael B. Dye, Claimant Attorney
 Bostwick, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation (compensability). We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, including the "Ultimate Facts," with the following correction and supplementation.

The first sentence of the seventh paragraph on page two is corrected to reflect that Drs. Strum and Brooks examined claimant on October 21, 1993.

The "Ultimate Facts" are supplemented as follows: Claimant's current low back condition, a right-sided herniated disc at L5-S1, is directly and materially related to her compensable May 1992 back injury.

CONCLUSIONS OF LAW AND OPINION

The ALJ held that claimant carried her burden of proving that her current right sided L5-S1 herniated disc constitutes a compensable aggravation of her accepted low back strain injury claim.¹ We reach the same result, based on the medical evidence.

¹ The ALJ reasoned that the insurer's April 23, 1993 Notice of Closure (which awarded 14 percent unscheduled permanent disability for claimant's low back and 9 percent disability for loss of the left leg, based in part on claimant's October 29, 1992t scheduled permanent surgery for a left-sided L5-S1 herniated disc. (See Ex. 28A-2)) lacks preclusive effect, because it is not a "final judgment" or a "final order of an administrative agency." Nevertheless, the ALJ decided that the insurer is precluded from denying that claimant's left L5-S1 herniated disc (which was discovered before the insurer issued its acceptance of claimant's "acute lumbosacral strain") is part of her accepted claim, because the Notice of Closure evidences an acceptance of that condition. Compare Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) (Where a carrier failed to challenge Determination Orders on the grounds that they included awards for a noncompensable condition, the carrier was later precluded from denying that that condition was part of the accepted claim); but see amended ORS 656.262(10), SB 369, 68th Leg., Reg. Sess., Section 28, (June 7, 1995). Therefore, the ALJ reasoned that the insurer is equitably estopped from arguing that the left-sided disc is not part of the accepted claim and, further, foreclosed from issuing a "back-up" denial of the left-sided disc condition by the requirements of ORS 656.262(6).

Because we conclude that the current aggravation claim for a right-sided L5-S1 herniated disc is compensable on the merits, we need not determine whether principles of claim preclusion or equitable estoppel apply or whether the Notice of Closure award constitutes an acceptance of the left L5-S1 disc condition.

On review, the insurer contends that the compensable condition is limited to a low back strain and, even if it is deemed to have accepted claimant's left L5-S1 disc condition, the right L5-S1 disc condition currently at issue is not compensably related to the industrial injury. We disagree.

On September 15, 1992, Dr. Buza, treating surgeon, opined that claimant's left L5-S1 disc herniation was related to her work activities for the insured. (Ex. 14). On October 29, 1992, Dr. Buza performed a partial hemilaminectomy, facetectomy, foramotomy and discectomy at L5-S1. (Ex. 18). After surgery, claimant returned to her regular physically demanding work delivering parcels. She continued to suffer low back pain and treated conservatively. (Tr. 6-7). Her symptoms worsened gradually. On August 8, 1993, following a physical examination for the insurer, claimant was very sore and experienced pain radiating into her right leg for the first time. Her treating chiropractor took her off work completely. (Tr. 8, Ex. 33).

Drs. Strum and White examined claimant on October 21, 1993. They could not say whether claimant's condition had worsened since claim closure, but recommended that Dr. Buza obtain films to assess whether there had been progressive disc deterioration since the surgery, "a well known sequelae." (Ex. 34-6-7). Drs. Strum and White stated, "If there has been settling of the disc space with early degenerative change, that would be objective evidence of pathological worsening of her condition which basically would be a continuation of the process related back to her original injury." (Ex. 34-7). On December 3, 1993, an MRI scan revealed claimant's current ruptured disc at L5-S1 on the right. (Exs. 37, 38). Dr. Buza diagnosed a "recurrent" disc at L5-S1. (Ex. 39).

On February 2, 1994, Drs. Tesar, Wilson, and Davies examined claimant and opined that claimant's original left-sided herniated disc resulted from preexisting degenerative disc disease, because she had no "injury," and a normal disc would not herniate without injury. They further opined that claimant's current right-sided herniated disc is a worsening of her degenerative condition, unrelated to her May 1992 work injury. (Ex. 41-7-8). We do not find this opinion persuasive because claimant did have an injury and did not have preexisting spinal degeneration. See Somers v. SAIF, 77 Or App 259 (1986).

On May 5, 1994, Dr. Buza checked a box indicating concurrence with the February 2, 1994 report by Drs. Tesar, Wilson, and Davies. (Ex. 45-49). However, Dr. Buza later explained his opinion on May 25, 1994. (Ex. 45). He stated that he agreed with the examining physicians to the extent that "everybody has degenerative disease." (Ex. 45-29-30). On the other hand, he expressly did not agree that claimant had no significant back injury. (Ex. 45-37).

As we read Dr. Buza's opinion, claimant's current right-sided ruptured disc does not necessarily result from degenerative disease,² just because no specific injurious event preceded her most recent (right-sided) herniation. Instead, based on claimant's history, Dr. Buza opined that the initial left-sided herniation (whether it occurred in May or July of 1992) and the recurrent right-sided herniation of the same disc (whenever it occurred) were directly related to the May 1992 injurious event. (See Exs. 45-18-20, 45-26, 45-38-39, 45-42-43).

Dr. Buza's opinion regarding causation is entirely consistent with claimant's medical history. There is no indication that claimant had a degenerative condition at the time of her May 1992 compensable injury. (See Ex. 2). She suffered only one injury (in May 1992) and her back problems continued and worsened gradually thereafter (Tr. 8), without an additional injurious event.³ Dr. Buza further explained that, although the rate of "recurring" discs is only 4 percent, that is what happened in

² Dr. Buza acknowledged that, if a trivial event precipitated a herniated disc, the major cause of the rupture would probably be preexisting degeneration. (Ex. 45-43-45). However, Dr. Buza did not view claimant's May 1992 strain injury as a trivial event and he noted repeatedly that it marked the beginning of claimant's back problems.

³ If claimant had suffered an intervening injurious event, Dr. Buza's opinion might have related the current herniated disc to that event, rather than to the accepted May 1992 strain injury. (See Ex. 45-22-26). However, claimant suffered no such intervening injury prior to the right sided herniation.

claimant's case. (Ex.45-20). Recurrence happens because of "injury" to the disc space.⁴ (Ex. 45-22). The injury to claimant's L5-S1 disc space happened at work in May 1992. As we understand Dr. Buza's opinion⁵, claimant's May 1992 injury was the major cause of the injury to her L5-1 disc space. (See Ex. 45-42-43).

Considering Dr. Buza's advantageous position as claimant's treating surgeon, his accurate history, and his well-reasoned opinion, we find his conclusions persuasive. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988); Somers v. SAIF, *supra*. Accordingly, based on Dr. Buza's opinion, we conclude that claimant's current right-sided disc herniation is directly and materially related to her May 1992 accepted back strain injury. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 1992). Finally, we note that the worsening element of this aggravation claim is not disputed and we find that claimant has established a worsening of her compensable condition greater than any waxing and waning of symptoms contemplated by the last arrangement of compensation. Consequently, the claim is compensable under ORS 656.273.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,500, 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 issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 17, 1994 is affirmed. For services on review, claimant's counsel is awarded a \$1,500 attorney fee, payable by the insurer.

⁴ We note that Dr. Buza once acknowledged that a recurrent herniation (due to injury to the disc space) could result from a tear in the annulus or from degenerative disease. (Ex. 45-26). However, upon considering claimant's particular circumstances (especially her significant work injury), Dr. Buza concluded that claimant's current disc herniation is directly related to her May 1992 work injury. (See note 5, *ante*). Because this reasoning is entirely consistent with the medical record, we see no reason to discount it.

⁵ In our view, Dr. Buza considered and ruled out preexisting degeneration as a contributing factor. Under these circumstances, claimant would not be subject to the major contributing cause standard imposed by ORS 656.005(7)(a)(B). However, even if claimant was subject to such a standard, we would interpret Dr. Buza's opinion as satisfying it. Therefore, it is unnecessary for us to determine whether or not ORS 656.005(7)(a)(B) is applicable.

In the Matter of the Compensation of
GERALD J. DAHL, Claimant
WCB Case Nos. 95-01057, 94-06642, 95-01056 & 94-04446
ORDER OF DISMISSAL
Coons, et al., Claimant Attorneys
Safeco Legal Department, Defense Attorney
Employers Defense Counsel, Defense Attorneys

Safeco Insurance Company (Safeco) requested review of that portion of Administrative Law Judge Marshall's order that set aside its denial of claimant's bilateral wrist condition. Liberty Northwest Insurance Corporation (Liberty) moves to dismiss the request for review on the ground that, before it filed its request for review, Safeco formally accepted claimant's claim. In its response to Liberty's motion, Safeco requests that we remand this matter to the ALJ for an arbitrator's decision pursuant to ORS 656.307. We grant Liberty's motion to dismiss.

FINDINGS OF FACT

On February 13, 1995, the ALJ issued an Opinion and Order setting aside Safeco's responsibility denial of claimant's bilateral wrist condition. On March 3, 1995, Safeco accepted the claim by a Notice of Acceptance. The notice informed claimant that Safeco was accepting a disabling occupational disease "[p]er opinion & order of 2-13-95 bilateral carpal tunnel syndrome and bilateral lesion of the ulnar nerve." On March 13, 1995, Safeco requested Board review of the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Liberty asserts that, in view of Safeco's unqualified acceptance of claimant's bilateral wrist condition, Safeco is barred from appealing the ALJ decision. We agree.

In SAIF v. Mize, 129 Or App 636 (1994), before it petitioned for judicial review of a Board order, the carrier accepted the claimant's claim by a clear and unqualified Notice of Acceptance. The court held that the carrier's acceptance rendered moot any controversy over the compensability of the claimant's claim, and dismissed the carrier's petition for judicial review. Id. at 640. In so concluding, the court emphasized that, once a carrier officially notifies a claimant that it has accepted a claim, it may not subsequently deny compensability without complying with ORS 656.262(6). Id.

In Scott C. Clark, 47 Van Natta 133 (1995) and Timothy L. Williams, 46 Van Natta 2274 (1994), we applied the Mize reasoning. In Clark, the carrier sent the claimant two letters indicating that it had accepted his claim; in Williams, the carrier accepted the claimant's claim by a Notice of Acceptance. In each case, we concluded that the carrier's clear and unqualified acceptance rendered moot any controversy regarding the compensability of the claimant's claim. Clark, supra, 47 Van Natta at 134; Williams, supra, 46 Van Natta at 2276. Therefore, we granted the claimants' motions to dismiss the carriers' requests for Board review.

This case is analogous to Mize, Clark and Williams. In reaching that conclusion, we acknowledge that those cases involved compensability disputes, whereas this case involves a responsibility dispute. However, we discern no justifiable basis for distinguishing those cases on that ground. The determinative event is the carrier's clear and unqualified acceptance of the claim. Accordingly, we hold that, when a carrier clearly and unqualifiedly accepts a claim after an ALJ sets aside its responsibility denial, any issue regarding compensability or responsibility is thereby rendered moot.

Here, Safeco issued a Notice of Acceptance, indicating that it was accepting claimant's CTS and ulnar nerve conditions. Although the notice states that it issued "[p]er opinion & order of 2-13-95," there is no indication that the acceptance was contingent on Safeco's appeal of that order or that the acceptance was otherwise qualified. See Donna J. Calhoun, 47 Van Natta 454 (1995) (Mize distinguished on ground that "1502" form and Notice of Closure indicated that the employer's "acceptance" was contingent on its appeal of referee's order); see also Vernon E. Faulkner, 47 Van Natta 707 (1995) ("1502" form was only indication of carrier's "acceptance;" because that form does not constitute an acceptance, the Board denied the claimant's "Mize" motion to dismiss). Indeed, Safeco did not appeal the matter until 10 days after it issued the Notice of Acceptance. Under the circumstances, we find that Safeco issued a clear and unqualified acceptance that rendered moot any controversy between the parties regarding the compensability of or responsibility for the claim.

Safeco argues that its claims adjuster issued the written acceptance to inform claimant of a change in the designated paying agent, not to waive the right to appeal the ALJ's order. We disagree.

First, the ALJ set aside Safeco's denial and found it responsible for processing the claim according to law. Such claim processing does not include the obligation to accept the claim while the compensability issue is litigated on appeal. Mize, supra, 129 Or App at 639.

Second, in Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993), the court held that a claims examiner's testimony regarding the intended effect of a denial was irrelevant; rather, the express language of the denial controlled. In Mize, the court applied the same reasoning to acceptances. 129 Or App at 639. Therefore, the claims adjuster's testimony regarding the intended effect of the acceptance in this case is irrelevant; rather, the clear and unqualified language of the acceptance controls.

Last, Safeco argues that its Notice of Acceptance was issued by "mistake." Even assuming that there is sufficient evidence to support that argument, under Mize, Safeco still must comply with ORS 656.262(6) to revoke its initial unequivocal acceptance. 129 Or App at 640. Because there is no evidence that Safeco attempted to comply with that statute, we reject its mistake argument. See Timothy L. Williams, supra, 46 Van Natta at 2275 (Board rejected carrier's mistake argument, because carrier had not complied with ORS 656.262(6)). Consequently, we reject Safeco's mistake argument.

Finally, arguing that a "307" order issued after the hearing, but before the ALJ issued his order, Safeco requests remand for the issuance of an arbitrator's decision. When such circumstances exist, we are authorized to treat an ALJ's order as an arbitrator's decision without the need for remand. See Michael J. Joseph, 46 Van Natta 1257, 1258 (1994) (when no one objected to admission into record of a "307" order that had issued after hearing, the proceeding was properly characterized as an arbitration under ORS 656.307). That reasoning is, however, dependent on our retaining jurisdiction over a viable appeal. Because, as described above, Safeco's appeal has been rendered moot by its unequivocal acceptance of the claim, there no longer exists a viable appeal over which we may retain jurisdiction. Therefore, we reject Safeco's remand argument.

For these reasons, we dismiss Safeco's request for Board review.

IT IS SO ORDERED.

June 19, 1995

Cite as 47 Van Natta 1056 (1995)

In the Matter of the Compensation of
LOREY L. KELLEY, Claimant
WCB Case No. 94-09451
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. Claimant also renews her objection to the ALJ's decision to exclude Exhibit 0. On review, the issues are evidence and compensability.

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

Exhibit 0 is 73 pages long and consists of two Opinion and Orders (involving different claimants), a partial deposition of Dr. Radecki (involving a different claimant), and a survey of numerous physicians which asked if they agreed with Dr. Radecki's opinion as set forth in the partial deposition. Inasmuch as none of the documents contained in Exhibit 0 pertain to this claimant or the specific claim that is the subject of this proceeding, we agree with the ALJ that Exhibit 0 is not relevant. Consequently, the ALJ did not abuse his discretion in declining to admit Exhibit 0. See Davey L. Odle, 44 Van Natta 2464 (1992)(ALJ did not abuse discretion in excluding transcript of prior hearing involving the claimant for purposed of attacking the claimant's credibility).

ORDER

The ALJ's order dated November 23, 1994 is affirmed.

June 19, 1995

Cite as 47 Van Natta 1057 (1995)

In the Matter of the Compensation
PENNY S. ORCUTT, Claimant
WCB Case No. 94-04996
ORDER ON REVIEW (REMANDING)
Bischoff & Strooband, Claimant Attorneys
Roberts, et al, Claimant Attorneys

Reviewed by Board Members Niedig and Gunn.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) denied its "pre-hearing" motion to compel claimant to supply her "pre-claim" medical records; (2) denied its motion to continue the hearing for further discovery regarding claimant's prior carpal tunnel syndrome; (3) prohibited cross-examination of claimant regarding her prior bilateral carpal tunnel syndrome; and (4) set aside its denial of claimant's occupational disease claim for a bilateral hand condition. In its brief, the insurer requests that the matter be remanded for the submission of further discovery regarding claimant's bilateral carpal tunnel syndrome. On review, the issues are evidence, remand, and compensability. We vacate and remand.

FINDINGS OF FACT

Claimant began working for the employer in August 1993 as a maintenance person. In late October 1993, she began experiencing pain and swelling in her hands. In February 1994, she sought treatment for her bilateral hand symptoms from Dr. Gilmour, M.D., who diagnosed degenerative joint disease with arthritic swelling. In his chartnotes, Dr. Gilmour indicated that claimant had previously suffered from bilateral carpal tunnel syndrome which had resulted in release surgeries bilaterally. In March 1994, Dr. Gilmour indicated that claimant was also suffering from secondary carpal tunnel syndrome.

On March 11, 1994, claimant filed an 801 form alleging that she had sustained soft tissue injuries to both hands as a result of her work activities. Claimant also indicated that she had not suffered any prior injuries to her hands. However, claimant informed a supervisor that she had previously had bilateral carpal tunnel syndrome. In a March 21, 1994 statement to the insurer's investigator, claimant indicated that she had had carpal tunnel syndrome surgery four years previously in Washington. When asked the identity of the physician who performed the surgery, claimant stated that she could not remember. On March 23, 1994, the insurer denied claimant's claim.

On April 21, 1994, claimant retained counsel and requested a hearing concerning the insurer's denial. In a May 31, 1994 letter to claimant's attorney, counsel for the insurer enclosed claimant's statement to the investigator and demanded information relating to claimant's carpal tunnel syndrome including the physicians and/or facilities from whom claimant sought treatment. On June 5, 1994, claimant's counsel replied indicating that he had no documentation concerning the carpal tunnel syndrome and would not supply any information other than documents. Thereafter, the insurer's counsel moved for an order compelling discovery. By letter dated June 27, 1994, the ALJ denied the insurer's pre-hearing motion.

At hearing, the insurer moved for a continuance of the hearing in order to obtain discovery regarding claimant's prior carpal tunnel surgery. The ALJ denied the motion based on his June 27, 1994 decision denying the insurer's motion to compel discovery. In addition, the ALJ indicated that he would sustain claimant's counsel's objection to any question the insurer asked claimant concerning the prior carpal tunnel syndrome. The ALJ then allowed the insurer's counsel to ask questions as an offer of proof. In response to the questioning, claimant testified that she had symptoms of numbness and tingling in her hands while working at a prior Washington employer. She further testified that she did not file a workers' compensation claim for this condition. She indicated that her treating physician was a Dr. Gustafson, but that she could not remember the name of the surgeon. Finally, she testified that the surgery took place at Skaggit Valley Hospital in Mt. Vernon, Washington.

In addition, the ALJ sustained claimant's objection to questions asked of Lorena Miller, the employer's personnel manager, regarding statements claimant had made concerning her prior carpal tunnel syndrome condition. Under an offer of proof, Ms. Miller testified that claimant had told her in 1994 that she had had similar hand symptoms in the past.

CONCLUSIONS OF LAW AND OPINION

The ALJ declined to continue this matter based on his prior ruling which did not compel claimant to provide discovery concerning her prior bilateral carpal tunnel syndrome. In addition, the ALJ ruled that the insurer could not cross-examine claimant with regard to her prior condition. The insurer contends that the matter should be remanded to allow it an opportunity to obtain further evidence regarding claimant's prior bilateral hand condition. We agree with the insurer in part.

ALJ's 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 ALJ's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

With regard to the ALJ's pre-hearing ruling which declined to compel claimant to provide medical documentation of her prior carpal tunnel syndrome, we find no abuse of discretion. Under OAR 438-07-015(3), a carrier is entitled to documents from claimant which pertain to the claim. However, in his June 5, 1994 letter, claimant's counsel indicated that he did not have any such documents. That representation is not disputed. Since claimant was not in possession of the requested documents, it follows that she had no duty to provide the documents to the insurer. We now turn to the ALJ's rulings at hearing.

The ALJ's "pre-hearing discovery" decision provides no basis for preventing the insurer to cross-examine claimant and Ms. Miller regarding a prior condition that may have affected the same body parts which claimant presently claims are work-related. Moreover, such questions could be highly relevant to the issue of causation. While an ALJ is not bound by the rules of evidence, restricting the insurer's right to cross-examine claimant under these circumstances does not achieve substantial justice. ORS 656.283(7). Consequently, we conclude that the ALJ abused his discretion by preventing the insurer's counsel from questioning claimant with regard to claimant's prior carpal tunnel syndrome symptoms and treatment.

Inasmuch as the ALJ did allow the insurer to cross-examine claimant under an "offer of proof," we now examine that portion of the record. In responding to the insurer's question, claimant, for the first time, gave the name of a physician who treated her previously as well as the name of the medical facility where her prior surgery was performed. Notwithstanding this newly uncovered information, the insurer was not allowed to continue the hearing by virtue of the ALJ's prior evidentiary ruling. In light of claimant's responses, we conclude that it was an abuse of discretion for the ALJ to have effectively denied the insurer's request to continue the hearing to allow for further discovery with regard to claimant's prior carpal tunnel syndrome condition. In reaching this conclusion, we find that the insurer exercised due diligence in trying to obtain this information prior to hearing, but was unable to do so until claimant, (for the first time), provided that information in her testimony. OAR 438-06-091(4); 438-06-081(4).

Finally, the ALJ abused his discretion by not allowing Ms. Miller's testimony with regard to statements made to her by claimant concerning her prior carpal tunnel surgery and the similarity of those symptoms to her current symptoms. However, since Ms. Miller's testimony is in the record as an "offer of proof," it is not necessary to elicit further testimony from Ms. Miller on remand. Rather, on remand, the ALJ should consider Ms. Miller's testimony in its entirety.

Accordingly, the ALJ's order dated December 15, 1994 is vacated. This matter is remanded to ALJ Mongrain for further proceedings consistent with this order. In other words, the ALJ shall schedule another proceeding at which time the insurer will be permitted to present additional evidence regarding claimant's prior carpal tunnel condition and surgery. In addition, claimant will be allowed to present rebuttal evidence, if any, regarding her prior carpal tunnel condition and surgery. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VELMA L. VETTERNACK, Deceased, Claimant
WCB Case No. 93-06051
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant, through her statutory beneficiary (Dixie Miller, claimant's sister and dependent), requests review of Administrative Law Judge (ALJ) Galton's order that declined to award unscheduled permanent partial disability for her psychological condition. The self-insured employer argues that we erred in remanding this matter to the ALJ for the limited purpose of admitting additional evidence regarding whether a statutory beneficiary exists to continue claimant's claim. On review, the issues are scope of review and extent of unscheduled permanent disability.

We adopt and affirm the ALJ order, with the following comments.

Our initial order remanded the case to the ALJ for the limited purpose of admitting additional evidence regarding whether a statutory beneficiary exists to continue claimant's claim. On remand, the ALJ admitted Exhibit 7, an affidavit from claimant's sister, wherein she describes herself as claimant's dependent. On this evidence, the ALJ determined that claimant's sister was claimant's dependent under ORS 656.005(10) and a statutory beneficiary, who is therefore entitled to continue the deceased claimant's claim. See ORS 656.005(2). We agree and adopt the ALJ opinion in this regard, noting that the employer does not contest it on review.

Instead, the employer contends that we exceeded our authority in remanding the case to the ALJ, because no party requested remand. We disagree.

If no person was a statutory beneficiary entitled to continue claimant's claim after claimant's death, a putative beneficiary would not have standing to request a hearing. See *Trice v. Tektronix, Inc.*, 104 Or App 461 (1990). Under such circumstances, a request for hearing (by a person without standing) is properly dismissed. Id.; see also *Rogue Rodriguez-Fernandez, Dec'd*, 46 Van Natta 2369 (1994); *Arturo Barron*, 46 Van Natta 2362 (1994).

As we stated before remand, the record in this case did not initially reveal whether a statutory beneficiary existed. Accordingly, because we were unable to discern a basis for granting the request for hearing (i.e. that the requesting party had standing to invoke the ALJ's jurisdiction), we remanded the case and the potential defect was cured. Under these circumstances, remand was within our authority and appropriate. See 656.295(6) ("The board may . . . make such disposition of the case as it determines to be appropriate.").

Finally, we agree with the ALJ's findings that claimant was not psychologically stationary when she died and that permanent psychological impairment findings would be speculative. See OAR 436-35-007(17). Consequently, we adopt the ALJ's opinion and conclusion on the merits.

ORDER

The ALJ's order dated August 20, 1993, as supplemented October 20, 1994, is affirmed.

In the Matter of the Complying Status of
ROY WESLER, Noncomplying Employer
WCB Case No. 91-14814
and, In the Matter of the Compensation of
GEORGE G. SEELY, Claimant
WCB Case No. 94-01138
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Curtis & Strickland, Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) found that the noncomplying employer's request for hearing, concerning the compensability of claimant's injury claim, was timely; and (2) set aside the SAIF Corporation's acceptance, on behalf of the noncomplying employer, of claimant's injury claim. On review, the issues are jurisdiction and compensability. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Timeliness/Jurisdiction

We adopt the conclusions and reasoning as set forth in the ALJ's order with the following supplementation.

Relying on Blain v. Owen, 106 Or App 285 (1991), the ALJ concluded that the noncomplying employer's request for hearing, concerning the compensability of claimant's claim, was timely. In so concluding, the ALJ found that OAR 436-80-060(2)(c), which imposed a 60-day time limit on a request for hearing by a noncomplying employer, was not valid. Claimant contends that the ALJ did not have the authority to invalidate the administrative rule, and under that rule, the noncomplying employer's request was not timely.

While claimant is technically correct that neither the Hearings Division nor the Board has the authority to invalidate a Director's rule, the Board may give an administrative rule no effect where the rule is inconsistent with or seeks to limit a statutory provision. See SAIF v. St. Clair, 134 Or App 316 (1995); Alan G. Herron, 43 Van Natta 267, 270, recon, 43 Van Natta 1097 (1991). Here, as the ALJ noted, OAR 436-80-060(2)(c) set a 60-day time limit which is inconsistent with the unambiguous language of ORS 656.283(1), which as interpreted by the Blain court, allowed a noncomplying employer to request a hearing "at any time." Consequently, while the rule may not be invalid, we agree that it should not be given any effect. Therefore, the noncomplying employer's request for hearing was timely.

Finally, claimant contends that the amended version of ORS 656.054(1) (effective September 29, 1991), should retroactively apply to the noncomplying employer's request for hearing. That provision limits the time period in which a noncomplying employer may request a hearing to within the time the claim may be accepted or denied as provided in ORS 656.262. See Elizabeth D. Miller, 46 Van Natta 721 (1994).

Inasmuch as claimant did not raise this issue at hearing, we are not inclined to address it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). In any event, claimant's contention assumes that the statutory time period has begun running. However, there is no evidence that the employer was ever notified of the Director's referral of the claim to SAIF or of his right to object to the claim. Elizabeth D. Miller, supra. Moreover, it is likely that a retroactive application of amended ORS 656.054(1), which would essentially deprive the noncomplying employer of its right to challenge the compensability of claimant's claim, would be considered an unjust result. See Ida M. Walker, 43 Van Natta 1402 (1991).

Compensability

We adopt the conclusions and reasoning as set forth in the ALJ's order with the following supplementation.

Subsequent to the ALJ's order, the court issued its opinion in First Interstate Bank of Oregon v. Clark, 133 Or App 712 (1995). In Clark, the court reiterated that the legal framework for determining whether an injury "arose out of" and "in the course of" employment included two prongs: (1) whether the injury occurred in the course of employment (considering time, place and circumstance); and (2) whether a causal connection existed between the injury and the employment. The court further reasoned that, although the seven factors set forth in Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, rev den 300 Or 249 (1985), were helpful inquiries under the two-prong test, those factors should not be used as an independent and dispositive test of work-connection.

Here, the ALJ considered the "Mellis" factors in determining whether claimant's injury arose out of and was in the course of his employment, but ultimately concluded that claimant's injury was not sufficiently work-related to be compensable. Inasmuch as claimant was injured while performing a duty that was not part of his job duties and occurred at a time when claimant was not actually working for the employer, we agree with the ALJ that claimant has not established that his injury arose out of and in the course of his employment. In reaching this conclusion, we have not used the "Mellis" factors as an independent and dispositive test for determining work-connection, but rather as a tool in resolving the course and scope question.

ORDER

The ALJ's order dated October 11, 1994 is affirmed.

June 19, 1995

Cite as 47 Van Natta 1061 (1995)

In the Matter of the Compensation
TERESA C. WOODS, Claimant
WCB Case Nos. 94-08676 & 93-09768
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Brown's order that: (1) upheld the insurer's denial of claimant's November 1992 low back injury claim; and (2) upheld the insurer's denial of claimant's May 1993 low back injury claim. On review, the issue is compensability.

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

Claimant asserts that the ALJ's erred in finding that claimant was an unreliable witness and hence, that she had failed to establish the compensability of either of her low back injury claims. We disagree.

We first consider claimant's November 1992 low back injury claim. The record is inconsistent regarding when this supposed work injury occurred. Claimant testified that a work incident in late October or early November 1992 caused her initial low back injury. (Tr. 3, 13, 16). However, some of the documentary evidence indicates a date of injury of October 1, 1992 (Exs. 12, 22-2); other written evidence suggests a date of injury in mid-October 1992. (See Ex. 4-1; see also Ex. 10A).

The record is also inconsistent regarding the cause of the first injury. A November 20, 1994 medical report states that there was no history of known trauma that resulted in claimant's initial low back complaints. (Ex. 1). In a February 11, 1993 report, Dr. Klump, treating neurosurgeon, reported that claimant "actually began having back trouble about a year and a half ago when she picked up her 15 month old son. This was mildly troublesome. However, about three months ago she began having pain in her left buttock and posterior thigh and calf." (Ex. 4-1).

Thereafter, in an August 24, 1993 office note, Klump reported that he and claimant had discussed the possibility that her low back problems were work related. (Ex. 24A-2). He stated, "As far as she can tell there was no specific incident, either initially or this second time after returning to work, that caused the symptoms." (*Id.*)

Meanwhile, in a July 16, 1993 "801" report, claimant for the first time reported that she was injured while lifting and carrying crates of till bags out of a vault at work. (Ex. 13). She reported a similar history to the examining physician panel. (Exs. 22, 22A; *see* Ex. 24). Only thereafter did Dr. Klump become aware of claimant's work lifting activities. (Exs. 23, 25, 26-7, -8, -9).

On this record, we find that there are significant historical inconsistencies regarding when and how claimant injured her low back in 1992. Because claimant is the source of the histories on which the medical causation opinions are based, and because she has supplied inconsistent histories, we agree with the ALJ that claimant is an unreliable witness and, therefore, that she has failed to satisfy her burden of proof. *See Maria T. Galicia*, 46 Van Natta 542, 543 (1994) (Board found that medical opinions based on unreliable histories lacked persuasive force).

We reach the same conclusion regarding claimant's second low back injury claim. On June 12, 1993, claimant initially reported that she had "shooting pain from mid back down to left hip" after wrapping packages at work approximately four days earlier. (Ex. 8). Thereafter, she reported to Dr. Klump a history of onset of low back pain approximately June 8, 1993 as a result of standing and wrapping heavy packages. (Exs. 11-1, 12).

In a September 10, 1993 "801" form, however, claimant reported a May 31, 1993 date of onset of low back pain. (Ex. 19). The examining physician also reported a May 31 history of onset of low back pain. (Ex. 22-2).

At hearing, claimant attributed her second low back injury to a specific incident on May 31, 1993, in which she had to carry a heavy package at work without assistance. (Tr. 7-8). She testified that, as she pushed the package to the entrance, she felt her back "pop" and then felt immediate pain down her left leg. (Tr. 8).

We find the discrepancies between claimant's reports regarding the onset of low back pain in May or June 1993, and her reference for the first time at hearing to a specific work lifting/pushing incident sufficient to create a doubt about her reliability with respect to her second low back injury claim. This conclusion is supported by the fact that claimant did not mention a back "pop" until hearing.

In sum, for these additional reasons, we agree with the ALJ that claimant is an unreliable witness and, therefore, that the medical opinions on which she relies lack persuasive force. *See Maria T. Galicia*, *supra*, 46 Van Natta at 543. Accordingly, we affirm the ALJ's decision upholding the insurer's denials of claimant's two low back injury claims.

ORDER

The ALJ's order dated July 15, 1994 is affirmed.

June 20, 1995

Cite as 47 Van Natta 1062 (1995)

In the Matter of the Compensation of
JEANNE P. MORGAN, Claimant
 WCB Case No. C5-01592
 ORDER APPROVING CLAIM DISPOSITION AGREEMENT
 Starr & Vinson, Claimant Attorneys
 Employers Defense Counsel, Defense Attorneys

Reviewed by the Board en banc.

On June 13, 1995, 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 her compensable injury. We approve the proposed disposition.

Along with the agreement, the parties submitted an "addendum" whereby the parties waived the 30-day waiting period. The addendum also provides that the insurer will pay the sums due to claimant and her attorney upon approval of the CDA by the Board. The addendum was signed by claimant, claimant's attorney, and the insurer's attorney.

Before the enactment of recent legislation, the worker could disapprove the CDA within 30 days of submitting the disposition for approval to the Board. Former ORS 656.236(1)(c). In light of that provision, we previously held that approval of a CDA must await the expiration of the 30-day period. Louis R. Anaya, 42 Van Natta 1843 (1990). Effective June 7, 1995, ORS 656.236 was amended so that "a disposition may provide for waiver of the [30-day period] if the worker was represented by an attorney at the time the worker signed the disposition." SB 369, 68th Leg., Reg. Sess., § 24(1)(b), § 66 (June 7, 1995).

Inasmuch as the addendum provides for the waiver of the 30-day period, claimant was represented by an attorney at the time she signed the CDA, and the addendum is signed by claimant, her attorney, and the insurer's attorney, we conclude that it conforms with the new law. Furthermore, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. SB 369, § 24(1)(a); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of \$3,875, payable to claimant's counsel, also is approved.

IT IS SO ORDERED.

June 21, 1995

Cite as 47 Van Natta 1063 (1995)

In the Matter of the Compensation of
PATRICIA E. HERRON-BURBANK, Claimant
WCB Case No. 94-08578
ORDER DENYING RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our May 25, 1995 order that awarded claimant an insurer-paid attorney fee under ORS 656.382(2) for claimant's counsel's services on Board review. Contending that the \$1,000 award was excessive and disproportionate to the interests involved, the insurer seeks reduction of claimant's attorney fee.

After considering the insurer's contentions, we have nothing to add to our prior decision. Accordingly, the insurer's request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our May 25, 1995 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELMER F. KNAUSS, Claimant
WCB Case No. 94-02325
ORDER ON RECONSIDERATION
Emmons, Kropp, et al, Claimant Attorneys
Michael Fetrow (Saif), Defense Attorney

On May 30, 1995, we issued an Order on Reconsideration, which republished and supplemented our May 3, 1995 Order on Review that affirmed an Administrative Law Judge's order awarding claimant a total of 49 percent (156.8 degrees) unscheduled permanent disability for a cardiovascular condition. Noting that it had filed a petition for judicial review of our May 3, 1995 order prior to the issuance of our May 30, 1995 reconsideration order, the SAIF Corporation requests that we withdraw our May 30, 1995 order as "void."

We decline SAIF's invitation. Inasmuch as we withdrew our May 3, 1995 order for the purpose of reconsideration within the 30-day appeal period of ORS 656.295(8), our May 30, 1995 order is valid. SAIF v. Fisher, 100 Or App 288 (1990). The filing of SAIF's petition for judicial review prior to issuance of our May 30, 1995 order does not affect our reconsideration authority. Id.

Accordingly, SAIF's request for withdrawal of our May 30, 1995 order is denied. The parties' rights of appeal shall continue to run from the date of our May 30, 1995 order.

IT IS SO ORDERED.

June 21, 1995

Cite as 47 Van Natta 1064 (1995)

In the Matter of the Compensation of
BETTY S. TEE, Claimant
WCB Case No. 88-11538
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

The self-insured employer requests reconsideration of our May 25, 1995 Order on Review which affirmed Administrative Law Judge Hoguet's order granting claimant permanent total disability benefits. Noting that Senate Bill 369, Section 14, creates a new definition of "gainful employment" different from the standard we applied in this case, and contending that the new definition applies retroactively, the employer seeks reversal of claimant's permanent total disability award.

In order to allow us sufficient time to consider the employer's motion, we withdraw our May 25, 1995 order. Claimant is allowed 21 days from the date of this order to submit a response to the motion. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELINDA K. WILSON, Claimant
WCB Case No. 93-12536
ORDER ON REVIEW (REMANDING)
Gatti, Gatti, et al, Claimant Attorneys
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) denied its motion to reopen the record; (2) set aside the employer's "de facto" denial of claimant's dorsal (thoracic) strain condition; and (3) assessed a penalty for the employer's allegedly unreasonable claims processing. On review, the issues are the propriety of the ALJ's procedural ruling, remand and, alternatively, compensability and penalties. We vacate and remand.

FINDINGS OF FACT

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

In October 1993, claimant requested a hearing regarding the employer's "de facto" denial of her cervical and dorsal (thoracic) strains. She supplemented the request in November 1993 and January 1994. A hearing was held before former ALJ Emerson in January 1994. Emerson closed the evidentiary record and heard closing arguments.

Prior to issuing an order in this matter, ALJ Emerson resigned from his position. In a July 7, 1994 letter, Presiding ALJ (formerly Referee)¹ Tenenbaum advised the parties of Emerson's resignation and sought to determine how the parties wished to proceed. She proposed the following options: one, to assign the file to another ALJ, who would prepare an order based on the exhibits and transcript, and any recorded closing argument; in the absence of recorded closing argument, or at any parties' choice, the parties could re-argue the case before a new ALJ; or two, the parties could "start from scratch and re-try the case before a new ALJ."

On July 18, 1994, claimant requested that another ALJ prepare an order. The next day, the employer advised Presiding ALJ Tenenbaum of its desire to re-litigate the case before a new ALJ.

On August 2, 1994, the parties' attorneys held a teleconference with Presiding ALJ Tenenbaum. Tenenbaum's notes of the teleconference reveal the following: The basis for the employer's request concerned claimant's credibility. The employer argued that, even if credibility had not been an "overt issue," a new ALJ "might have subtle demeanor impressions that could be relevant." Based on her review of the former ALJ's notes, Tenenbaum concluded that credibility was not at issue and, seeing no reason for a new hearing, denied the employer's request.

Thereafter, Presiding ALJ Tenenbaum assigned the matter to ALJ Lipton, who reopened the record for written closing arguments. Thereafter, the employer renewed its request for another hearing. ALJ Lipton denied the request and decided the matter based on the record, as supplemented by the written closing arguments, that had been presented before former ALJ Emerson. ALJ Lipton upheld the employer's denial of claimant's cervical condition, set aside its denial of the dorsal (thoracic) condition, and assessed a penalty. The employer requested Board review.

CONCLUSIONS OF LAW AND OPINION

Propriety of ALJ's Procedural Ruling/Remand

The employer has requested that we remand this matter for another hearing. For the following reasons, we grant the employer's request.

¹ "Referee" has been changed to "Administrative Law Judge." SB 369, 68th Leg., Reg. Sess., § 51 (June 7, 1995).

We may remand this matter to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed or heard. ORS 656.295(5). Remand is appropriate on a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

The employer argues that, because Presiding ALJ Tenenbaum gave it the choice of "starting from scratch," ALJ Lipton erred in declining to grant its request for a new hearing. We agree.

OAR 438-06-050 authorizes the presiding ALJ or his or her delegate to rule on all preliminary matters concerning hearings.² Accordingly, Presiding ALJ Tenenbaum and ALJ Lipton had the authority to rule on the employer's requests for another hearing. Further, we conclude that Presiding ALJ Tenenbaum had, and exercised, the authority to offer the parties alternative methods of proceeding after ALJ Emerson's departure.

In essence, by voicing its desire to re-litigate the case before a new ALJ, the employer was seeking to reopen the record for a continuance of the hearing. As such, we review the ALJs' rulings for an abuse of discretion. E.g., Ellen F. Slayton, 46 Van Natta 2373 (1994).

Because Tenenbaum gave the parties the option of "starting from scratch," the Hearings Division was bound to follow through with that option when the employer sought to exercise it. Further, because Presiding ALJ Tenenbaum's offer to "start from scratch" was unqualified, the employer's request for another hearing before an ALJ who would issue the opinion and order was, by itself, sufficient to trigger the Hearings Division's obligation to schedule another hearing in this matter.³

Finally, because "[c]redibility is always potentially an issue in a compensability case," Jeffrey M. Fisher, 46 Van Natta 729, 730 (1994), we conclude that substantial justice requires that the ALJ who issues the opinion and order in this particular matter have the opportunity to observe claimant's demeanor. See ORS 656.283(7).

In reaching this conclusion, we have considered evidence that claimant's thoracic symptoms did not become acute until days after the March 9, 1993 injury, and discrepancies in claimant's testimony and the histories on which the medical experts relied. (Cf. Exs. 2, 3, 6, and 8 with Tr. 9, 16-19). Claimant maintains that she informed her physician shortly after the work incident that she had experienced upper back pain and that she had told the physician about her onset of back symptoms after standing at home; the early medical records do not corroborate that testimony. (Id.) Because we find that evidence sufficient to create a potential, if not an actual, issue regarding claimant's credibility, we conclude that the employer is entitled to another hearing.

In sum, we conclude that, under these particular circumstances, it was an abuse of discretion for the employer's request for another hearing to have been denied. Because we find this a compelling reason for remand, and to assure that the parties will be afforded substantial justice, see ORS 656.283(7), we remand this matter to ALJ Lipton for another hearing.

We distinguish this case from Roderick A. Mespelt, 42 Van Natta 531 (1990), and Norma L. Bemrose, 42 Van Natta 2787 (1990). Those cases held that due process does not require that an administrative decision maker have the opportunity to hear and see witnesses at hearing. Because this case does not involve a due process challenge, Mespelt and Bemrose are inapposite. Moreover, in

² OAR 438-06-095 concerns disqualification of ALJ's. No one relies on that rule here.

³ The dissent views Presiding ALJ Tenenbaum's letter to counsel as requiring an agreement by the parties to one of the options posed therein. We disagree. The letter plainly states that one of the options was "to start from scratch and retry the case before a new [ALJ]." Because it is unqualified, we believe that a more reasoned reading of that language is that the option could have been exercised at the behest of either party.

Mespelt, the claimant, through his counsel, had consented to a decision by a referee who had not presided at hearing. For this additional reason, we distinguish Mespelt from the instant case.⁴

Accordingly, we vacate ALJ Lipton's November 18, 1994 order. The matter is remanded to ALJ Lipton for further proceedings consistent with this order. The proceedings shall be conducted in any manner that will achieve substantial justice. Thereafter, the ALJ will issue a final, appealable order.

IT IS SO ORDERED.

⁴ We note that, in Bemrose, the Board rejected the claimant's argument that she was denied procedural due process because the ALJ who issued the order, but did not conduct the hearing, did not have the benefit of making a credibility finding based on demeanor. That conclusion was based on the holding that due process does not require that an ALJ writing an order have conducted the hearing and, more important, the lack of medical evidence establishing a causation. Here, in contrast, no due process argument has been asserted; and, as demonstrated by ALJ Lipton's findings, there are medical opinions supporting the compensability of the claim.

Board Member Gunn dissenting.

ALJ Emerson heard this case, then resigned after closing the record, but before issuing a written order. The majority concludes that it was an abuse of discretion for two other ALJ's -- ALJ Lipton, who authored the written order in this case, and Presiding ALJ Tenenbaum -- to have denied the employer's requests for another hearing. I disagree.

First, the alleged basis for the employer's requests for a new hearing is credibility. There is no evidence that credibility was ever an issue; indeed, credibility was not even mentioned until the teleconference between the Presiding ALJ and the parties regarding the employer's initial written request to re-litigate the matter. On that ground alone, I would hold that the denial of the employer's requests was not an abuse of discretion.

In reaching this decision, I recognize that we have held that "[c]redibility is always potentially an issue in a compensability case." Jeffrey M. Fisher, 46 Van Natta 729, 730 (1994) (emphasis added). However, because granting a party the opportunity to re-litigate a case is such a serious step, under these circumstances, I would require at least some evidence that credibility was actually at issue. Here, there is no such evidence.

The majority attempts to create an actual credibility issue by pointing out some minor discrepancies between claimant's testimony and some of the medical records. I find the attempt unpersuasive. See Keith A. Goodridge, 44 Van Natta 1676, 1677 (1992) (minor discrepancies in testimony are not sufficient to find a claimant not credible). Moreover, nothing in this record indicates that ALJ Lipton could not independently evaluate claimant's credibility based on the substance of her testimony before ALJ Emerson. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Second, following ALJ Emerson's resignation, Presiding ALJ Tenenbaum gave the parties the choice of consenting to the submission of the record to another ALJ for a written order or "start[ing] from scratch." In my view, Tenenbaum's "offer" contemplated that the parties would agree to one of those options. Here, the parties disagreed regarding how to proceed. Therefore, in my estimation, the factual predicate for the "acceptance" of Tenenbaum's "offer" is missing. Accordingly, I believe that the Hearings Division was not obligated to schedule another hearing in this matter when only the employer sought to "start from scratch."

In sum, because there is no evidence of any issue that actually warrants re-litigation of this matter, and because the parties did not agree to re-try this case before a new ALJ, I would hold that it was not an abuse of discretion to deny the employer's requests for another hearing. Consequently, instead of remanding this matter to the Hearings Division for further proceedings, I would address the merits of the employer's appeal. To do so now, rather than later, would give heed to one of the fundamental policies underlying Oregon's Workers' Compensation Act; namely, the reduction of litigation and elimination of the adversarial nature of compensation proceedings. ORS 656.012(2)(b). Because the majority's decision to give the employer a "second bite at the apple" flies in the face of that policy, I dissent.

In the Matter of the Compensation of
GEANA K. CANNON, Claimant
WCB Case No. 94-08747
ORDER OF ABATEMENT
Malagon, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

The insurer requests abatement and reconsideration of our May 26, 1995 Order on Review that affirmed that portion of the Administrative Law Judge's (ALJ) order that set aside the insurer's "de facto" denial of claimant's cervical strain condition and reversed that portion of the order that set aside the insurer's "de facto" denial of a bilateral upper extremity overuse condition. The insurer asserts that, under Senate Bill 369, enacted after the issuance of our order, the ALJ was without jurisdiction to address the cervical and bilateral upper extremity overuse conditions because claimant did not satisfy amended ORS 656.262(6)(d).

In order to consider this matter, we withdraw our May 26, 1995 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 21 days from the date of this order.

IT IS SO ORDERED.

June 22, 1995

Cite as 47 Van Natta 1068 (1995)

In the Matter of the Compensation of
JANET A. CARTER, Claimant
WCB Case No. C5-01627
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Harrell & Nester, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

On May 22, 1995, we acknowledged receipt of the parties' claim disposition agreement (CDA). Pursuant to that agreement, in consideration of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The initial CDA received by the Board provided that the accepted conditions were "right hand/wrist arthritis and bilateral feet arthritis[.]" In exchange for the release of her rights, excluding medical services, the insurer agreed to pay \$54,000. Our letter acknowledging receipt of the CDA noted a WCB Case Number of C5-01394.

We subsequently received an addendum; the accompanying letter from claimant's attorney stated that the document was intended to "clarify that the bilateral feet arthritic condition, which was noted as an accepted condition on the original CDA agreement, has a separate claim number." Claimant also requested that the submission of the addendum "not alter or enlarge the 30 day waiting period assigned to the original CDA designated under case number C5-01394." New summary sheets also were enclosed; for the claim concerning the right hand/wrist arthritis, the amount of disposition is \$53,000, and for the claim concerning the bilateral feet arthritic condition, the amount of disposition is \$1,000.

Parties to a claim, "by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable[.]" ORS 656.236(1)(a) (emphasis added). In view of the statute's reference to a singular "claim" (as opposed to "claims"), we find that a separate CDA is necessary for parties to resolve each claim. See also OAR 436-60-145(1), 438-09-020(1).

Here, based on the information contained in the addendum and accompanying letter, we understand claimant to have two claims: one for the right hand/wrist arthritis and another for the bilateral feet arthritis. Because the initial CDA resolved both claims in the same document, it did not conform with ORS 656.236(1)(a). However, we consider the addendum as remedying this defect by providing the amount of disposition in each claim. Thus, we have assigned WCB Case Number C5-01627 to this CDA which concerns claimant's bilateral feet arthritis claim.

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

Claimant filed her hearing request more than 60 days after the employer denied her current CTS condition as a new occupational disease and indicated that her closed CTS claim would be reopened. (Exs. 19, 20). Claimant asserts that she was "confused" by the employer's actions and, therefore, she did not take any action until the employer closed the reopened claim several months later.

A hearing request must be filed no later than the 60th day after a claimant is notified of a denial. Former ORS 656.319(1)(a) (amended by Senate Bill 369, 68th Leg., Reg. Sess., § 39 (June 7, 1995)). A hearing request that is filed after 60 days, but within 180 days, of a denial confers jurisdiction if the claimant has good cause for the late filing. Former ORS 656.319(1)(b). Mistake, inadvertence, surprise or excusable neglect constitute good cause. E.g., Hempel v. SAIF, 100 Or App 68, 70 (1990). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234 (1984). Moreover, confusion regarding the contents of a denial does not, without reasonable diligence, constitute good cause. See Mary M. Schultz, 45 Van Natta 571 (1993) (confusion regarding status of claim caused by receipt of interim compensation insufficient to prove good cause; further, lack of diligence in clearing up confusion also prevented finding of good cause); see also Tuan A. Ho, 45 Van Natta 2413 (1993) (claimant's inability to read English did not establish good cause in the absence of reasonable diligence). Claimant has the burden of proving good cause. Cogswell v. SAIF, supra, 71 Or App at 237.

Here, claimant professed to be "confused" by the employer's denial of her current CTS condition as a new occupational disease and its reopening of her accepted CTS claim. There is no evidence, however, that claimant exercised any diligence in attempting to resolve her confusion until after the employer closed the reopened claim several months after the denial issued. Under the circumstances, claimant's failure to act in the face of her confusion prevents her from successfully demonstrating that she had good cause for failing to request a hearing within 60 days of the employer's denial. See Mary M. Schultz, supra; Tuan A. Ho, supra. Accordingly, we affirm the ALJ's decision dismissing claimant's hearing request.

ORDER

The ALJ's order dated August 25, 1994 is affirmed.

Board Member Hall dissenting.

In Joan C. Gillander, 47 Van Natta 391, 393, on recon 47 Van Natta 789 (1995) (Board Member Hall, dissenting), I criticized this Board's overly narrow interpretation of former ORS 656.319(1)(b)'s "good cause" exception to the requirement that a claimant file a hearing request within 60 days of a claim denial. Particularly, I noted the incongruity between our obligation to construe workers' compensation statutes liberally in favor of injured workers, and the Board's elevation of the "good cause" standard to a level that only rarely can be satisfied. See id.

This case is yet another example of that incongruity. Here, claimant became understandably confused when the employer simultaneously denied her current carpal tunnel syndrome (CTS) condition as a new occupational disease and indicated that her closed CTS claim would be reopened. Claimant did not take any action until the employer closed the reopened claim several months later (but within 180 days).

Relying on factually similar cases narrowly construing the "good cause" exception, the majority has concluded that claimant's confusion was not a legitimate basis for her delay in filing a hearing request on the employer's denial. I question the majority's reliance on those cases, because they offer no policy reasons why justifiable confusion regarding complicated claims processing activities is not the paradigm "good cause" basis for failure to act within 60 days of a denial.

I would hold that "good cause" for failure to file a hearing request within 60 days can be established by showing actual and reasonable confusion regarding particular claims processing activities. That holding comports with appellate case law regarding the "good cause" requirement. "Good cause" in the delayed hearing request context means "mistake, inadvertence, surprise or excusable neglect," as those terms are used in ORCP 71B(1). E.g., Brown v. EBI Companies, 289 Or 455 (1980); Hempel v. SAIF, 100 OR App 68, 70 (1990). Those terms are to be liberally construed "to the end that every

litigant shall have his day in court and his rights and duties determined only after a trial upon the merits of the controversy." King v. Mitchell, 188 Or 434, 443 (1950) (construing section 1-1007, O. C. L. A., precursor of former ORS 18.160 (repealed by Or Laws 1981, ch 898, § 53), precursor of ORCP 71); see Wagar v. Prudential Ins. Co., 276 Or 827, 832 (1976) (Supreme Court has uniformly held that former ORS 18.160 should be liberally construed).

Claimant has established actual and reasonable confusion regarding the employer's simultaneous denial of her current CTS condition as a new occupational disease and reopening of her earlier accepted CTS claim. Accordingly, I would hold that claimant has established "good cause" for filing an untimely hearing request regarding the denial. For these reasons, I respectfully dissent.

June 22, 1995

Cite as 47 Van Natta 1074 (1995)

In the Matter of the Compensation
DELORES HANNER, Claimant
 WCB Case No. C5-01395
 ORDER APPROVING CLAIM DISPOSITION AGREEMENT
 Malagon, et al, Claimant Attorneys
 Lundeen, et al, Defense Attorneys

On May 22, 1995, the Board acknowledged receipt of the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration 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.

Following receipt of the CDA, the parties submitted an "addendum" amending the CDA. That document in part provides that the CDA terms do not include attorney fees or penalties associated with any act, or failure to act, occurring only after the day the Board receives this agreement.

Effective June 7, 1995, ORS 656.236 was amended to provide that, "[u]nless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement." SB 369, 68th Leg., Reg. Sess., §§ 24, 66 (June 7, 1995).

Inasmuch as the addendum "otherwise specifies" that the CDA does not resolve issues pertaining to "attorney fees or penalties associated with any act, or failure to act, occurring only after the day the Board receives this agreement," we find that the CDA does not dispose of such matters. Furthermore, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. Amended ORS 656.236(1)(a); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of \$1,250, payable to claimant's counsel, also is approved.

IT IS SO ORDERED.

June 22, 1995

Cite as 47 Van Natta 1074 (1995)

In the Matter of the Compensation of
RONALD J. HENRIKSON, Claimant
 WCB Case No. 94-11499
 ORDER ON REVIEW
 Emmons, et al, Claimant Attorneys
 Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order that awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist) and 2 percent (3 degrees) scheduled disability for loss of use or function of the left forearm (wrist), whereas an Order on Reconsideration awarded no permanent disability. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation. In order to establish entitlement to a chronic condition award, the medical evidence must establish, at least, a partial loss of ability to repetitively use the body part. OAR 436-35-010(6); Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995); Donald E. Lowry, 45 Van Natta 1452 (1993). Here, as the ALJ found, the only medical evidence that might satisfy claimant's burden is the November 1, 1994 report from Dr. Melgard, claimant's treating physician. (Ex. 32). However, we agree with the ALJ that this report is not persuasive because it represents an unexplained change of opinion. (Exs. 24, 26, 27).

No hearing was held in this matter; instead, the matter was presented to the ALJ through the written record and the parties' stipulations and closing arguments. The parties stipulated as to what claimant's testimony would have been if he had testified. Claimant does not contend that the ALJ incorrectly reported the parties' stipulation in this matter. However, claimant argues that the ALJ misinterpreted that stipulation by finding that claimant did not assert an inability to perform certain activities due to his symptoms. We need not address this argument because lay testimony alone is insufficient to establish "impairment" under the standards. OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991).

ORDER

The Administrative Law Judge's January 19, 1995 order is affirmed.

June 22, 1995

Cite as 47 Van Natta 1075 (1995)

In the Matter of the Compensation of
DANIEL R. LOYNES, Claimant
WCB Case No. 94-05290
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Daughtry's order that awarded claimant temporary total disability (TTD) benefits from July 5, 1993 through July 30, 1993. Claimant cross-requests review of those portions of the ALJ's order that: (1) found that claimant was not entitled to TTD benefits after January 5, 1994; and (2) declined to assess a penalty for SAIF's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

In their February 17, 1994 stipulation, the parties agreed to settle "all issue(s) raised or raisable at this time * * *." (Ex. 6A-1). Pursuant to the stipulation, SAIF agreed to accept a flexion injury at L4 and L5 and to pay claimant's attorney a \$1,000 fee, and claimant's hearing request was dismissed with prejudice. (Id. at 2).

CONCLUSIONS OF LAW AND OPINION

TTD From July 5, 1993 to July 30, 1993

The ALJ concluded that the parties' February 1994 stipulation did not implicate the doctrine of issue preclusion and, therefore, that claimant was not precluded from litigating his entitlement to temporary disability. The ALJ then concluded that, on the merits, claimant had established his entitlement to TTD from July 5 through July 30, 1993. SAIF asserts that claim preclusion bars claimant from asserting any entitlement to TTD benefits during that time. We agree that claimant is barred from asserting such an entitlement, but for the following reasons.

Claimant compensably injured his ribs, right shoulder and low back during a May 1993 work injury while employed for SAIF's insured. SAIF accepted the rib and shoulder conditions; it neither accepted nor denied the low back condition.

On June 7, 1993, Dr. Klass, claimant's then-attending physician, released claimant to modified work as of June 8, 1993. (Ex. 1A). The employer sent claimant a written offer of modified employment. (Ex. 1AA). On June 29, 1993, Dr. Klass withdrew the first modified work release and released claimant to modified work as of July 5, 1993. (Exs. 1CCC, 1D). The employer did not issue another written offer of modified employment following the second release. Claimant worked two days thereafter. (Tr. 3). SAIF paid claimant temporary partial disability (TPD) from July 5 through July 29, 1993. (Exs. 1DD, 1DDD, 13).¹

On November 22, 1993, claimant filed a hearing request, raising issues including a "de facto" denial of the low back condition, penalties and attorney fees. (See Ex. 6A). On February 17, 1994, the parties signed and an ALJ approved a stipulation resolving claimant's request for hearing. The stipulation provided that the parties "agree[d] to settle all issue(s) raised or raisable at this time * * *." Pursuant to the stipulation, SAIF accepted claimant's low back condition, agreed to pay an attorney fee and claimant's hearing request was dismissed with prejudice. Claimant subsequently filed the hearing request in this case, asserting an entitlement to TTD for the period, *inter alia*, between July 5 and July 30, 1993.

If a stipulation contains language settling "all issues that were raised or raisable" at the time of settlement, the claimant is barred from litigating a matter that was at issue, or of which the claimant had notice, at the time of settlement. *Safeway Stores, Inc. v. Seney*, 124 Or App 450, 454 (1993); see *Good Samaritan Hospital v. Stoddard*, 126 Or App 69 (1994). The correct inquiry is whether the matter could have been negotiated before approval of the settlement agreement. *Stoddard*, *supra*, 126 Or App at 73. This analysis is based on contract law, not the principles of claim or issue preclusion. See *id.* at 72.²

On this record, we conclude that claimant's entitlement to TTD in July 1993 could have been negotiated before the parties' stipulation was approved in February 1994. The stipulation manifests the parties' intent to settle "all issues raised or raisable" at the time of settlement. Claimant maintains that he is entitled to TTD from July 5, 1993 through July 30, 1993, because SAIF did not issue another written offer of modified employment following Dr. Klass's second work release. Well before the settlement agreement was approved, however, claimant was aware that SAIF had not issued a second written offer of modified employment and had only paid TPD in July 1993. Under those circumstances, we find that claimant was on notice that there was a potential dispute concerning his entitlement to TTD benefits in July 1993. As such, the July 1993 TTD matter was an issue that could have been raised before February 1994; therefore, litigation of that issue is barred by the parties' stipulation.

Claimant asserts that the July 1993 TTD issue was not resolved by the stipulation because, pursuant to the stipulation, SAIF accepted his low back condition, and that claim is in open status. We disagree. The stipulation purported to settle all issues then "raised or raisable"; there is no exception for issues concerning the status of the claim. Accordingly, we conclude that, regardless of the status of the claim, the stipulation bars litigation of the July 1993 TTD issue.

For these reasons, we reverse the ALJ's decision awarding claimant TTD benefits from July 5, 1993 through July 30, 1993.

TTD from January 6, 1994 to April 25, 1994

We adopt and affirm the ALJ's analysis regarding this issue.

¹ On July 29, 1993, Dr. McGill authorized TTD benefits. (Ex. 1DDDD). Those benefits are not at issue in this case.

² Claimant refers us to *Cravens v. SAIF*, 121 Or App 443 (1993), in support of his argument that neither claim nor issue preclusion bars the litigation of the July 1993 TTD matter. *Cravens* is inapposite. That case involved a stipulation that did not include the "raised or raisable" language present in the present stipulation. Moreover, the issue in this case concerns the legal effect of a contract (the stipulation); neither claim nor issue preclusion is implicated here.

TTD From April 25, 1994 Forward

We adopt and affirm the ALJ's analysis regarding this issue, with the following supplementation.

Claimant asserts that he is entitled to TTD from April 25, 1994 forward, because Dr. Buza verified his temporary total disability that day. We disagree.

On February 16, 1994, Dr. Buza stated that he did not feel that claimant could return to his regular job as a tree pruner. (Ex. 5). A chart note of the same date states, "He has been doing early return to work program called AGC for his employer. He is not able to go to work he states because if he does climb at all, the next day or so he has severe pain for several days. * * * I believe he is capable of doing light duty." (Ex. 6).

In an April 25, 1994 chart note, Dr. Buza noted that claimant "cannot work in the trees." (Ex. 9). After summarizing claimant's subjective complaints, Buza noted, "[Claimant] has been kept off work. He had normal strength and sensation and reflexes. Good motions of the lumbar spine. Will keep him off work and have him receive a PCE." (Id.; emphasis added)

Subsequently, in a June 2, 1994 letter to SAIF, Dr. Buza stated, "[Claimant] was released to light duty January 3, 1994, and I feel he is physically able to do that job." (Ex. 12). Finally, in concurrence letters drafted by SAIF's and claimant's counsels, Dr. Buza indicated that he had not altered claimant's modified work release on April 25, 1994, but had continued the prior modified work authorization. (Exs. 14-2, 15).

We agree with the ALJ that Dr. Buza's April 25, 1994 chart note effectively continued claimant's release to modified employment. The earlier chart notes reflected Buza's belief that claimant was not able to return to his regular work. The April 25 note itself referred to claimant's inability to "work in the trees" -- his regular employment. Accordingly, we conclude that April 25 Buza's plan to keep claimant "off work" manifested his intent to restrict claimant from his regular work only. That conclusion finds ample support in the post-April 25 evidence, in which Dr. Buza clarifies that the April 25 chart note was intended to continue claimant's release to modified employment. For these additional reasons, we affirm the ALJ's decision not to award claimant TTD from April 25, 1994 forward.

Penalties

Because we have concluded that claimant is entitled to none of the compensation he seeks, SAIF could not have unreasonably resisted the payment of compensation. Accordingly, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated September 26, 1994 is affirmed in part and reversed in part. The ALJ's award of TTD benefits from July 5, 1993 through July 30, 1993 is reversed. The ALJ's "out-of-compensation" attorney fee award is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
TIMOTHY MARES, Deceased, Claimant
WCB Case No. TP-95003
THIRD PARTY DISTRIBUTION ORDER
Bennett & Hartman, Claimant Attorneys
Lundeen, et al, Defense Attorneys

The personal representative of the deceased worker's estate ("claimant") has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action and the "just and proper" distribution of proceeds from that third party settlement. See ORS 656.587 and 656.593(3). Specifically, the dispute involves objections from Liberty Northwest Insurance Corporation (Liberty), as paying agent, to the proposed allocation of the \$84,500 settlement: \$15,000 to the decedent's widow and \$69,500 to the decedent's parents. Claimant also seeks an award of attorney fees pursuant to ORS 656.382(1) for Liberty's allegedly unreasonable refusal to the payment of compensation.

We conclude that the proposed \$84,000 settlement is reasonable and that the proposed distribution between the widow and decedent's parents is just and proper. We further conclude that claimant is not entitled to an assessed attorney fee under ORS 656.382(1).

FINDINGS OF FACT

The deceased worker, age 29, was electrocuted October 23, 1990 while working for Conflo, Inc./Western Concrete Pumping, Inc. as a concrete pumper truck operator. After pouring a concrete load from the truck he was assigned, the decedent drove the truck to a nearby parking lot to clean it. During the cleaning, the boom of the truck rose and came into contact with a high powered electrical line, thereby energizing the truck. Decedent died when his head came into contact with the concrete chute.

The day before the accident, the decedent had noticed a problem with a boom control lever on his assigned truck. Decedent and a co-worker, Pastor, determined that the "C" slip had worn and was not strong enough to hold the return spring. Instead of reporting the lever problem to management (and risk losing the truck and valuable work time) decedent and Pastor fashioned an external spring out of wire and "jerry-rigged" the control lever. The defective vertical boom control lever apparently caused the boom to raise up into the power lines the following day.

At the time of his death, decedent and his wife of two years had been separated for approximately two weeks. Although she had moved out, decedent's wife was waiting at the work site on the day of the accident. They had planned to go to dinner together and, according to decedent's wife, discuss reconciliation.

Three days prior to his death, decedent completed a life insurance policy designation of beneficiary form and identified his father, rather than his estranged wife, as the beneficiary.¹ Decedent stated on the form that he intended to divorce his wife.

Decedent smoked marijuana on occasion. Co-worker Pastor indicated he had observed decedent smoking marijuana on many occasions off work and that decedent admitted to smoking marijuana on the job.

Several months after decedent's death, his wife moved back to her home town to rejoin her two daughters from a previous marriage, who were living with their father. Decedent's wife resumed a relationship with her ex-husband.

Decedent's wife, as personal representative of the decedent's estate, filed a wrongful death action in October 1993. Certain defendants were dismissed on statute of repose and limitations grounds, and all other defendants filed dispositive motions prior to the scheduled January 1995 trial. One defendant, the general contractor, was granted summary judgment. Other defendants argued, among other things, that the Workers' Compensation laws provided the exclusive remedy (because the truck was allegedly owned by Conflo and Conflo and Western constituted one employer) and also that the decedent's contributory negligence (the jerry-rigging of the lever and/or marijuana use) caused the accident.

¹ The life insurance benefits ultimately went to decedent's wife, with the consent of decedent's father.

On the eve of trial, the personal representative and defendants agreed to settle the action in its entirety for the total amount of \$84,500. The personal representative then petitioned for and received approval of the settlement and the proposed distribution (allocating \$15,000 to the wife and the remainder to the decedent's parents) from the Probate Court.

Pursuant to ORS 656.593, the personal representative sought from Liberty, as the paying agency, approval of the settlement and the proposed distribution of the settlement proceeds. Liberty refused to approve the settlement or the distribution. The personal representative then petitioned the Board to approve the settlement and its distribution pursuant to ORS 656.587 and 656.593(3).

As of April 27, 1995, Liberty had paid out \$67,811.34 in widow's benefits to decedent's wife, and had set aside \$291,875 as reasonable claim reserves for anticipated future payments of widow's benefits.

CONCLUSIONS OF LAW AND OPINION

Reasonableness of the Proposed Settlement

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Everett L. Weems, 44 Van Natta 1192 (1992), aff'd, Weems v. American International Adjustment Co., 123 Or App 83 (1993), aff'd, 319 Or 140 (1994); Natasha D. Lenhart, 38 Van Natta 1496 (1986).

A paying agency's failure to recover full reimbursement for its entire lien is not determinative as to whether a third party settlement is reasonable. Jill R. Atchley, 43 Van Natta 1282, 1283 (1991). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Weems, supra; Jill R. Atchley, supra.

In this case, Liberty does not challenge the amount of the proposed settlement (\$84,000) but the proposed allocation of that settlement. In exercising our independent judgment, we agree that the proposed settlement is reasonable given the liability issues in the wrongful death case. For example, if the jury determined that Conflo owned the concrete pumper truck, the action against Western would fail as matter of law, since the two entities were one employer for purposes of the Workers' Compensation laws. If the jury determined that decedent's death was caused by decedent's and Pastor's jerry-rigging of the boom control lever, the action would fail under the fellow servant rule. If the jury determined that decedent's marijuana use contributed to his death, that fact could also limit or prevent the defendants' liability.

Accordingly, after reviewing the record (particularly Liberty's concession that the proposed settlement amount is appropriate), we do not find the settlement amount of \$84,500 to be "grossly unreasonable." In fact, we conclude that the proposed settlement is reasonable. We, therefore, approve the settlement. ORS 656.587.

Distribution Of Settlement Proceeds

Having approved the settlement, we proceed to a determination of a "just and proper" distribution of the settlement proceeds under ORS 656.593(3). We are to judge each case on its own merits when determining whether the proposed distribution is "just and proper." Urness v. Liberty Northwest Ins. Corp., 130 Or App 454 (1994).

Here, Liberty concedes that whatever right to the settlement proceeds it may have attaches only to that portion of the proceeds allocated to decedent's wife, because decedent's parents are not "beneficiaries" under the workers' compensation statutes. See Scarino v. SAIF, 91 Or App 350, rev den, 306 Or 660 (1988). Consequently, Liberty argues that the proposed allocation of the settlement proceeds (\$15,000 to decedent's wife and the remaining \$69,500 to decedent's parents) is unjust and improper because it shields most of the money from Liberty's lien.²

² Liberty outlines the result of the proposed allocation as follows: Decedent's parents will receive \$38,772.70 after fees and costs, the attorney will receive \$28,166.67 in fees and the widow will receive \$8368 after attorney fees. If Liberty's distribution from that sum follows the formula set out in ORS 656.593, it will recover a maximum of \$5579 against a claim that has the potential payout of \$359,686 (the \$67,811 already paid plus the \$291,875 reserve for anticipated future widow's benefits).

As a preliminary matter, we find that because Liberty is the party with an interest in establishing that the proposed allocation is unjust and improper, it has the burden of proof on this issue. See Robertson v. Davcol, Inc., 99 Or App 542, 546 (1989); Neil C. Duclos, 43 Van Natta 28 (1991).

The allocation of damages among beneficiaries of a wrongful death action under ORS 30.030 is not the same as determining a just and proper distribution of settlement proceeds under ORS 656.593(3).³ Liberty Northwest Ins. Corp. v. Golden, 116 Or App 64, 67 (1994). Thus, we are not necessarily bound by the findings of the probate court. See Robbie W. Worthen, 46 Van Natta 987 (1994). We have previously recognized, however, that the probate court's approval of a wrongful death settlement distribution is instructive on the issues of fairness, justness and propriety.⁴ See Duclos, *supra*; Theresa J. Lester, 47 Van Natta 57 (1995).

For example, in Duclos, we upheld as "just and proper" a proposed equal distribution of a \$155,100 wrongful death settlement between the decedent's surviving spouse and his adult daughter, which had previously received contingent approval of the probate court. We rejected the paying agency's unsubstantiated contention that the settlement disbursement was designed to avoid its lien, since the adult daughter's share of the proceeds would not be subject to the lien. Rather, we relied on sworn affidavits of the decedent's daughter and widow that the equal distribution represented a just, fair and reasonable compensation for their respective financial and emotional losses resulting from the decedent's death.

More recently, in Theresa J. Lester (on remand from the Court of Appeals) we found a probate court order to represent a "just and proper" distribution where half of the wrongful death settlement proceeds were allocated to each of the decedent's two minor children, with the estranged husband receiving nothing. There, the record established that the decedent and her husband had an extensive history of marital discord and were separated at the time of her death. We considered it "just and proper" for the paying agency to recover its actual and future claim costs from the two children's shares and not to receive any reimbursement for its surviving spouse claim costs since the settlement proceeds were designed to compensate the profound losses sustained by the decedent's minor children.

Here, claimant argues that the proposed allocation of settlement proceeds is appropriate under the circumstances: Decedent and his wife had separated. Decedent indicated on an insurance form that he intended to obtain a divorce and designated his father as the life insurance beneficiary just days before his death. Decedent was from a large, tight-knit family and enjoyed a close relationship with his parents up until his death. In support of this contention, claimant's representative submitted an affidavit from the attorney who represented certain defendants in the wrongful death case. The attorney indicated there was strong evidence that the decedent's marriage was over and stated that, in his view, decedent's parents suffered a significantly greater loss than the wife.

Liberty argues, on the other hand, that the record does not justify the parents receiving nearly five times more than the widow, given the relative losses of the parents and widow. In support of this contention, Liberty submitted an affidavit from a pro tem Probate Judge who indicated that the proposed settlement is not within the normal range of wrongful death apportionment agreements because the apportionment does not account for pecuniary loss accruing to the decedent's estate and leaves the widow with virtually no recovery. Liberty points to the fact that the widow suffered both a pecuniary loss and loss of society, whereas the decedent's parents suffered loss of society only.

³ The issue for the probate court under ORS 30.030 is the amount that each beneficiary in the action is to receive, according to that beneficiary's loss. The issue for the Board under ORS 656.593(3) is determining what amount is just and proper for the paying agency to receive on its lien.

⁴ Compare James W. Swanson, 40 Van Natta 780 (1988), where we dismissed the paying agency's petition concerning the just and proper distribution of proceeds from a third party settlement because the probate court had already ruled on the identical "paying agency lien" issue. Here, as in Duclos and Lester, the probate court only approved the settlement and the proposed allocation of proceeds, it did not make any rulings regarding the nature or the amount of the paying agency's "lien" and its application to the proceeds.

Based on Oak v. Pattle, 86 Or App 299, rev den, 304 Or 149 (1987), we reject Liberty's argument that the allocation is improper because it does not provide for pecuniary loss to the estate. In Oak, the court affirmed a probate court's apportionment under ORS 30.040 of an entire wrongful death settlement to the decedent's mother, leaving nothing for the decedent's estate or her estranged father. The court rejected the estranged father's contention that some of the settlement proceeds should be distributed to him as reflecting pecuniary loss to the estate and his loss of society. Instead, the court held that since the evidence showed that the decedent had maintained a close and loving relationship with her mother and had little or no relationship with her father, it was appropriate that the entire settlement go to the mother to compensate her for the loss of society and companionship. This case therefore stands for the proposition that an entire wrongful death settlement may be apportioned to compensate for loss of society under ORS 30.020(2)(d), and need not account for pecuniary loss accruing to the estate under ORS 30.020(2)(c).

We similarly reject Liberty's argument that because decedent's wife (unlike decedent's parents) suffered a pecuniary loss as well as loss of society as a result of decedent's death, her portion of the settlement proceeds should be greater. Neither the wrongful death statutes nor the workers' compensation laws require that we measure a beneficiary's loss or determine a just and proper distribution based primarily upon that person's pecuniary loss. Indeed, by specifically allowing recovery for loss of society, companionship and services of the decedent, ORS 30.020(2)(d) clearly recognizes that the decedent's immediate family will likely suffer more from his or her untimely death than merely pecuniary loss. See Norwest v. Presbyterian Intercommunity Hospital, 293 Or 543, 565 (1982).

On this record, we conclude that the proposed allocation of the settlement proceeds is just and proper. The evidence establishes that decedent maintained a close and loving relationship with his parents, that he and his wife were separated at the time of his death, and that he was contemplating a divorce. Under these circumstances, we find no grounds to disturb the proposed allocation of settlement proceeds that has been given approval by the Probate Court. Further, there is nothing in the record to suggest that in allocating most of the settlement proceeds to decedent's parents, the parties engaged in "gamesmanship" to shield proceeds from Liberty's lien. See Scarino v. SAIF, supra.

Attorney Fee

Finally, claimant seeks the award of an attorney fee due to Liberty's allegedly unreasonable refusal to approve the third party settlement or the proposed apportionment of the settlement proceeds. However, we have previously held that the third party statutes do not provide authorization for an attorney fee award other than that disbursed from the third party recovery. See Catherine Washburn, 46 Van Natta 182 (1994); Robbie W. Worthen, 46 Van Natta 226 (1994); Theresa J. Lester, 43 Van Natta 338 (1991). Consequently, we lack authority to grant claimant's request.

In conclusion, we find the proposed \$84,000 settlement for the wrongful death action is reasonable. ORS 656.587. We further find that the proposed allocation of that settlement, \$15,000 to the decedent's wife and \$69,500 to the decedent's parents, results in a distribution to Liberty as the paying agent that is just and proper under ORS 656.593(3). The decedent's widow is directed to distribute to Liberty its statutory share of the proceeds from her portion of the settlement in accordance with ORS 656.593(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY J. McKENZIE, Claimant
WCB Case Nos. 93-11096 & 93-10078
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Thye's order which: (1) found that claimant's psychological claim had been prematurely closed; and (2) directed it to pay temporary disability. On review, the issues are premature claim closure and temporary disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

With the following supplementation, we adopt and affirm the ALJ's analysis and conclusion regarding the premature claim closure issue.

The ALJ relied, in part, on the MCMI to conclude that claimant's psychological condition was not medically stationary. The MCMI report states that it cannot be judged definitive, but should be viewed as only one facet of a psychological assessment and used in conjunction with additional clinical data. (Ex. 76-8). In addition, the report provides that it should only be evaluated by a trained clinician. Based on the MCMI report's own disclaimer, we disagree with the ALJ's reliance upon the report in the absence of a medical expert opinion interpreting the MCMI results in a manner supportive of claimant's claim. See Edward Johnson, 46 Van Natta 471 (1994) (ALJ is not permitted to substitute his own opinion for the medical evidence in the record).

Notwithstanding the above, we agree with the ALJ's ultimate finding that Dr. Fleming's opinion establishes that further psychological treatment was reasonably expected to improve claimant's psychological condition.¹ We, therefore, conclude that claimant's claim was prematurely closed and that the May 7, 1993 Determination Order and the September 17, 1993 Order on Reconsideration must be set aside.

Having determined that claimant's claim was prematurely closed, the extent of permanent disability issue is moot. However, we proceed to address the "procedural" temporary disability issue.

Temporary Disability

Claimant's 1985 lumbar and cervical injury claim was reopened, in February 1989, for an authorized training program (ATP), but the ATP was terminated on March 26, 1990 due to claimant's failure to participate. A July 26, 1990 Determination Order (DO) closed the claim, awarding temporary disability from February 21, 1989 to February 28, 1989 and from April 11, 1989 to May 16, 1990 (medically stationary date).

The employer stopped paying temporary disability benefits on March 26, 1990 when the vocational training was terminated. Following the July 1990 DO, the employer paid temporary disability through May 16, 1990.

¹ As a result of prior litigation, claimant's psychological condition has been found compensable. Mary J. McKenzie, 44 Van Natta 2302 (1992), aff'd mem Tri-Met, Inc. v. McKenzie, 121 Or App 686 (1993). Thus, to the extent that the opinions of Drs. Parvaresh and Glass suggest that claimant does not suffer from a compensable psychological condition, their opinions are inconsistent with the law of the case. We discount their opinions accordingly. See Kuhn v. SAIE, 73 Or App 768 (1985).

In our November 17, 1992 Order on Review, we found claimant's psychological condition compensably related to her November 7, 1985 injury claim. We also set aside the July 26, 1990 Determination Order as premature on the basis that the psychological condition was not medically stationary. Mary J. McKenzie, supra. The Court of Appeals affirmed our order on July 14, 1993. Tri-Met, Inc. v. McKenzie, supra.

Pending appeal of our November 1992 order, the employer paid no temporary disability after May 16, 1990. Claimant requested a hearing seeking enforcement of the Board's 1992 order. The parties agreed that any temporary disability owing from May 16, 1990 to November 17, 1992 was stayed under former ORS 656.313 (amended by SB 369, 68th Leg., Reg. Sess., § 38 (June 7, 1995)). On May 4, 1993, ALJ Menashe directed the employer to pay temporary disability from November 17, 1992 (the issuance date of our order finding the psychological claim compensable and setting aside the closure order) until such benefits could be lawfully terminated. The employer appealed.

On February 2, 1994, we affirmed ALJ Menashe's order. Since the claim had been closed on May 7, 1993, we further determined that the employer was obligated to pay temporary disability from November 17, 1992 until the claim closure date. Mary J. McKenzie, 46 Van Natta 187 (1994). The employer appealed and again did not pay temporary disability pending appeal of our order. On December 14, 1994, the court affirmed our February 1994 order. Tri-Met, Inc. v. McKenzie, 131 Or App 759 (1994).

The May 7, 1993 Determination Order awarded temporary disability from February 21, 1989 through February 28, 1989 and from April 11, 1989 through August 7, 1990. A September 17, 1993 Order on Reconsideration affirmed the March 30, 1993 medically stationary date; awarded temporary disability from February 21, 1989 through February 28, 1989, April 11, 1989 through May 17, 1990 and November 17, 1992 through March 30, 1993; and awarded permanent disability. Both the employer and claimant requested a hearing challenging the September 17, 1993 Order on Reconsideration. Those requests resulted in this proceeding.

ALJ Thye determined that the July 14, 1993 "compensability" decision of the Court of Appeals, which affirmed our November 1992 order finding claimant's psychological condition compensable, removed any stay of compensation under former ORS 656.313. The ALJ further found that, since claimant's psychological condition remained nonmedically stationary and that none of the requirements of former ORS 656.268(3) for termination of temporary disability had been satisfied, claimant was entitled to temporary disability commencing May 17, 1990 until claim closure.

The employer raises a number of arguments to support its position that claimant is not entitled to temporary disability. Most of these arguments have been previously rejected in our February 2, 1994 order. Mary J. McKenzie, supra. However, we address the issue of whether claimant is entitled to temporary disability benefits under former ORS 656.313.

Former and current ORS 656.313(1)(a) authorize the employer to stay the payment of temporary disability benefits which accrued prior to our November 17, 1992 order which found the claim prematurely closed (May 16, 1990 through November 16, 1992), pending the employer's appeal of our November 1992 compensability decision. See Felipe A. Rocha, 45 Van Natta (1993) (where the insurer requested Board review of the earlier ALJ's holding that the claim was compensable and because the temporary disability award was not for a period accruing from the date of that ALJ's order, the insurer was entitled to stay the payment of that award pending its appeal).

However, the ".313 stay" did not apply to temporary disability benefits that accrued from the date of our November 17, 1992 order until claim closure. This stay also did not apply to the employer's subsequent appeals of the May 1993 ALJ Menashe's "enforcement" order and of our February 1994 order affirming the enforcement order.² Were we to conclude otherwise, the compensation to which the employer seeks to apply the ".313" stay is the very compensation which under ORS 656.313(1)(a)(A) cannot be stayed.

² The compensation awarded by the May 1993 Determination Order and the September 1993 Order on Reconsideration was stayed pending the employer's appeal of our November 1992 compensability decision. Diamond Fruit Growers v. Goss, 120 Or App 390 (1993).

As we stated in Rocha, supra and in John R. Heath, 45 Van Natta 840 (1993) aff'd Anodizing, Inc. v. Heath, 129 Or App 352 (1994), ORS 656.313(1)(a)(A) creates a statutory obligation to continue payment of temporary disability benefits awarded by an order until claim closure or the order is reversed, regardless of the outcome of the appeal. Here, the statutory obligation to pay such benefits commenced with our November 17, 1992 order.

The stay of temporary disability benefits that had accrued from May 17, 1990 to November 11, 1992 ended when the July 14, 1993 court decision, finding the psychological claim compensable, became final. See Lucille K. Johnson, 45 Van Natta 1678 (1993) (insurer's stay authorization under former ORS 656.313 ended when it did not appeal Board order affirming the prior ALJ's decision that the claim was compensable). At the time the stay ended, the claim had been closed by a May 7, 1993 Determination Order, which awarded temporary disability from April 11, 1989 to August 7, 1990 and which found claimant's conditions medically stationary on March 30, 1993. However, as found above, we have set aside the May 7, 1993 Determination Order as premature.

Therefore, we conclude that the employer is obligated to pay temporary disability benefits from May 17, 1990 to August 7, 1990 and from November 17, 1992 until such benefits can be lawfully terminated.³ See John R. Heath, supra; ORS 656.313(1). The ALJ's temporary disability award shall be modified accordingly.

Claimant's attorney is entitled to an assessed fee for services on review concerning the premature claim closure issue. ORS 656.382(2). After considering claimant's attorney fee petition and the employer's objection to the petition and 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 \$1,000 payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney fee petition, the employer's objection and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Finally, we note that claimant is not entitled to a fee for services on Board review regarding her counsel's unsuccessful defense of the ALJ's temporary disability award.

ORDER

The ALJ's order dated September 7, 1994 is modified in part and affirmed in part. In lieu of the ALJ's award of temporary disability, claimant is awarded temporary disability from May 17, 1990 to August 7, 1990 and from November 17, 1992 until termination as authorized by law. The ALJ's "out-of-compensation" attorney fee award is modified accordingly. The remainder of the ALJ's order is affirmed. For services on Board review regarding the premature closure issue, claimant's attorney is awarded a \$1,000 assessed attorney fee, to be paid by the self-insured employer.

³ Assuming for the sake of argument that the employer could terminate temporary disability benefits under former ORS 656.268(3) prior to claim closure, the employer has not shown any circumstances under that statute in which it would have been entitled to do so. See Deborah Walden, 46 Van Natta 785 (1994) (claimant not entitled to temporary disability benefits under former ORS 656.313(1)(a)(A) when no longer entitled to such benefits pursuant to former ORS 656.268(3)(b)).

In the Matter of the Compensation of
GREG V. TOMLINSON, Claimant
WCB Case No. 94-11703 & 94-06920
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

This is a consolidated review of WCB Case Nos. 94-06920 and 94-11703. Inasmuch as we have found the issues in these cases to be inextricably intertwined, we have found it to be in the interests of substantial justice to conduct our review in consolidation. In WCB Case No. 94-06920, claimant requests review of Administrative Law Judge (ALJ) Menashe's order which set aside an Order on Reconsideration as invalid. In WCB Case No. 94-11703, the insurer requests review of that portion of ALJ Neal's order which declined to vacate a Determination Order and subsequent Orders on Reconsideration. On review, the issues are whether claimant prematurely requested reconsideration of a Determination Order and jurisdiction. We reverse ALJ Menashe's order in WCB Case No. 94-06920 and affirm ALJ Neal's order in WCB Case No. 94-11703.

FINDINGS OF FACT

Claimant compensably injured his left knee on June 3, 1993, a claim the insurer accepted as a nondisabling left knee derangement and chondral flap tear. On July 23, 1993, the insurer denied left knee replacement surgery on the ground that it was due to preexisting degenerative changes. Claimant nevertheless underwent the surgery on July 29, 1993. Claimant requested a hearing from the denial.

On November 10, 1993, claimant's counsel requested that the Evaluation Section classify the claim as disabling. By Determination Order of November 18, 1993, the claim was classified as disabling as claimant had requested. The insurer was directed to process the claim as disabling. The evaluator's worksheet for the Determination Order noted that claimant's surgery had been denied.

On February 2, 1994, a prior ALJ set aside the insurer's denial of claimant's surgery request. The next day, on February 3, 1994, claimant's counsel wrote the Department's Appellate Unit, advising that the letter should be considered as a request for reconsideration of "any Determination Orders including the one issued on November 18, 1993." (Ex. 8). Noting that there had been a denial of surgery, claimant's counsel enclosed a copy of the prior ALJ's order setting aside the insurer's denial of surgery. Among the issues raised in the request for reconsideration was premature closure. (Ex. 9).

The Appellate Unit acknowledged claimant's reconsideration request on February 7, 1994, listing the date of the disputed Determination Order as November 18, 1993. (Ex. 10). The very next day (February 8, 1994), the Department issued a Determination Order closing the claim with an award of 5 percent scheduled permanent disability for claimant's left knee and awarding temporary disability from the date of injury to July 28, 1993, the day before the knee replacement surgery. (Ex. 12). Claimant's medically stationary date was also listed as July 28, 1993 (the day before the "denied" surgery). The evaluator's worksheet noted that the surgery had been denied. (Ex. 11).

The Appellate Unit issued several reconsideration orders on February 28, March 1 and March 3, 1994. The February 28th reconsideration order affirmed the February 8, 1994 Determination Order, but the March 1st reconsideration order subsequently rescinded the February 8, 1994 Determination Order, finding the Determination Order to have been prematurely issued in the absence of medical evidence that claimant was medically stationary from the total knee replacement surgery. (Ex. 15). The March 3rd order affirmed the November 18, 1993 Determination Order, which had reclassified the claim to disabling.

At no time during or immediately following the reconsideration proceeding did the insurer object to the Department's authority to reconsider the February 8, 1994 Determination Order. Instead, on June 10, 1994, the insurer requested a hearing (WCB Case No. 94-06920). The first time the insurer challenged the Order on Reconsideration based on its procedural validity was at the September 9, 1994 hearing before ALJ Menashe in WCB Case No. 94-06920.

Claimant's attending physician declared claimant medically stationary from his knee surgery on April 19, 1994. The insurer then requested claim closure on April 25, 1994. (Ex. 16A). This resulted in the issuance of a May 5, 1994 Determination Order that awarded 35 percent scheduled permanent disability for claimant's left leg. Claimant requested reconsideration. A September 16, 1994 Order on Reconsideration increased claimant's scheduled permanent disability to 38 percent.

On September 26, 1994, ALJ Menashe in WCB Case No. 94-06920 set aside the March 1, 1994 Order on Reconsideration (in effect reinstating the February 8, 1994 Determination Order). Thereafter, the insurer asked the Department to find the May 5, 1994 Determination Order and September 16, 1994 reconsideration order void.

An October 3, 1994 Order on Reconsideration amended the award of temporary disability in the September 16, 1994 reconsideration order, but did not declare the May 5, 1994 Determination Order and September 16, 1994 reconsideration order invalid. On October 6, 1994, the Appellate Unit reiterated its position that the May 5, 1994 closure was a valid closure addressing the permanent disability due to claimant's compensable knee replacement surgery. (Ex. 26).

The insurer requested a hearing, seeking an order vacating the May 5, 1994 Determination Order and the September 16, 1994 and October 3, 1994 reconsideration orders (WCB Case No. 94-11703). This hearing was conducted by ALJ Neal.

CONCLUSIONS OF LAW AND OPINION

WCB Case No. 94-06920

At the hearing before ALJ Menashe (WCB Case No. 94-06920), the insurer contested the March 1, 1994 Order on Reconsideration, asserting that it had been prematurely issued because claimant's February 3, 1994 reconsideration request (received on February 7, 1994) preceded the February 8, 1994 Determination Order and was, therefore, itself premature. Citing Syphers v. K-W Logging, Inc., 51 Or App 769 (1981) and Barr v. EBI Companies, 88 Or App 132 (1987), ALJ Menashe found that claimant's request for reconsideration was premature with respect to the February 8, 1994 Determination Order. Reasoning that there was no valid request for reconsideration from the February 8, 1994 Determination Order, ALJ Menashe further concluded that the Appellate Unit did not have the authority to issue the March 1, 1994 reconsideration order. The effect of ALJ Menashe's order is that the February 8, 1994 Determination Order (which closed the claim without consideration of the compensable knee replacement surgery) was reinstated.

Although ALJ Menashe found that claimant's reconsideration request was premature, we find that, under the particular circumstances of this claim, it was not. We reach this conclusion for the following reasons.

Claimant's request for reconsideration was received one day prior to issuance of the February 8, 1994 Determination Order. However, the reconsideration request expressly advised the Department of the unusual procedural posture surrounding this particular claim. Specifically, claimant's request noted that the insurer's denial of surgery had recently been set aside. Moreover, the reconsideration request referred not only to the November 18, 1993 Determination Order, but also to "any Determination Orders." According to the evaluator's worksheet, the February 8, 1994 Determination Order did not consider claimant's surgery, which a prior ALJ had just a few days previously determined to be compensable, in evaluating the claim for temporary and permanent disability. In other words, claimant's temporary disability was terminated the day before the surgery which the insurer had denied and claimant's permanent disability resulting from that surgery had not been evaluated.

Based on the specific information contained in claimant's request for reconsideration (particularly his reference to "any Determination Orders" in conjunction with his express notification regarding the compensability of his previously denied knee replacement surgery), we find that the reconsideration request expressly described and pertained to the February 8, 1994 Determination Order. Since it is uncontested that the request was in the Department's possession following issuance of the February 8, 1994 Determination Order, we conclude that the Department was authorized to conduct its

reconsideration.¹ Based on the lack of medical evidence that claimant was medically stationary from his knee surgery, the Appellate Unit properly set aside the February 8, 1994 Determination Order as premature.

We recognize that the court in Syphers and Barr held that a request for hearing on whether a claim should be accepted is premature if it precedes a denial or expiration of the statutory period in which to accept or deny a claim. However, those cases concerned premature requests for hearing concerning claims which had neither been accepted nor denied. Since it was unclear whether the claimants would be entitled to any relief by virtue of their claims, the requests were considered invalid.

Here, in contrast, claimant was expressly seeking reconsideration of a prior Determination Order (which had specifically not considered a denied surgery) and any other Determination Orders. In doing so, claimant also submitted a copy of the recent ALJ's order setting the surgery denial aside. In light of such circumstances, we conclude that claimant's intentions were clear. He was objecting to any Determination Orders that did not consider his knee replacement surgery as part of his compensable condition. Because the February 8, 1994 Determination Order specifically fit that description, claimant's reconsideration request was effective. Thus, we do not find Barr and Syphers to be controlling.²

In conclusion, we find that the March 1, 1994 Order on Reconsideration was properly issued. Accordingly, we reverse ALJ Menashe's order in WCB Case No. 94-06920 and reinstate the reconsideration order. The insurer does not challenge claimant's contention that his claim was prematurely closed by the February 8, 1994 Determination Order. Inasmuch as the compensable knee replacement surgery was not considered at the closure, and the medical evidence establishes that claimant's knee condition was not medically stationary at that time, we agree that February 8, 1994 Determination Order was prematurely issued.

WCB Case No. 94-11703

In WCB Case No. 94-11703, ALJ Neal found that, even if the February 8, 1994 Determination Order was a valid closure pursuant to ALJ Menashe's order, the May 5, 1994 Determination Order was properly issued. ALJ Neal reasoned that claimant was entitled to a rating of permanent disability after his left knee condition became medically stationary after knee replacement surgery, irrespective of the fact that claimant did not request reconsideration of the February 8, 1994 Determination Order prior to its issuance. Of course, ALJ Neal did not have benefit of this order in which we have affirmed the March 1, 1994 reconsideration order setting aside the February 8, 1994 Determination Order as premature. Given our finding in WCB Case No. 94-06920, we affirm ALJ Neal's decision in WCB Case No. 94-11703.

Alternatively, even if claimant's reconsideration request in WCB Case No. 94-06920 was premature (thereby invalidating the March 1, 1994 reconsideration order setting aside the February 8, 1994 Determination Order), we would still conclude that the May 5, 1994 Determination Order was properly issued. We would base this conclusion on the following reasoning.

¹ To hold otherwise would result in manifest injustice to claimant. Until ALJ Menashe found his reconsideration request to be premature, claimant had no reason to assume that this request was invalid. The Department clearly considered the reconsideration request to have been proper inasmuch as it reconsidered the February 8, 1994 Determination Order and rescinded it upon learning that the insurer's surgery denial had been set aside and finding that there was no medical evidence that claimant was medically stationary when the claim was closed. Moreover, despite its right to seek correction of the Department's alleged "error," see former OAR 436-30-008(1), (3), the insurer did not object to the Department's authority to proceed with its reconsideration until the September 9, 1994 hearing. To now affirm the ALJ's conclusion that the March 1, 1994 reconsideration order was invalid would effectively leave claimant without the option of requesting reconsideration of the February 1994 Determination Order because the ALJ's September 26, 1994 order was issued more than 180 days from the date of the closure. See ORS 656.268(6)(b).

² We caution, however, that our holding in this case should in no way be construed as authority for routinely requesting reconsideration prior to issuance of a Determination Order or Notice of Closure. While we have found that, under the particular circumstances of this claim, a reconsideration request was valid even though it preceded issuance of the Determination Order, our holding is limited to the particular facts and circumstances presented here.

Based on the evaluator's worksheet that accompanied the February 8, 1994 Determination Order, it is undisputed that the disabling effects of the compensable knee replacement surgery were not considered by the closure order. Yet, pursuant to the prior ALJ's order setting aside the insurer's denial of surgery, the insurer was expressly ordered to process the claim according to law. Inasmuch as the insurer was required to process the claim, and because the February 8, 1994 Determination Order did not consider the effects of claimant's surgery, the insurer was obligated to process and re-close the surgery portion of the claim after claimant's compensable condition had become medically stationary. ORS 656.262(1); 656.268(2)(a); see Richard N. Wigert, 46 Van Natta 486 (1994). Such reprocessing and reclosure would result in the May 5, 1994 Determination Order.

Attorney Fees

By virtue of this order, claimant has prevailed against the insurer's request for hearing in WCB Case No. 94-06920 before ALJ Menashe in that his compensation was not disallowed or reduced. Claimant's counsel is therefore entitled to an assessed attorney fee for services at hearing. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is \$2,000, payable by the insurer. 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.

Also in WCB Case No. 94-06920, claimant's counsel is entitled to an attorney fee payable from any increased compensation created by this order. ORS 656.386(2); OAR 438-15-055. Consequently, that award shall equal 25 percent of any increased compensation created by our order in WCB Case No. 94-06920, not to exceed \$3,800, payable directly to claimant's counsel. In the event that compensation resulting from this order 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).

Finally, claimant has prevailed against the insurer's request for review in WCB Case No. 94-11703. 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 issue, and the value of the interest involved.

ORDER

In WCB Case No. 94-06920, ALJ Menashe's order dated September 26, 1994, as reconsidered on October 11, 1994, is reversed. The March 1, 1994 Order on Reconsideration is reinstated and affirmed. For services at hearing, claimant's counsel is awarded an assessed attorney fee of \$2,000, payable by the insurer. Claimant's attorney is also awarded 25 percent of the increased compensation created by our order in WCB Case No. 94-06920, not to exceed \$3,800, payable directly to claimant's attorney. In the event the increased compensation 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.

In WCB Case No. 94-11703, ALJ Neals' order dated December 2, 1994 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,000, payable by the insurer.

In the Matter of the Compensation of
THOMAS R. YON, JR., Claimant
WCB Case Nos. 94-07397 & 94-07517
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brown's order that: (1) set aside an Order on Reconsideration which had found that claimant's right hand claim was prematurely closed; and (2) declined to assess a penalty for an allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are premature closure and penalties. We reverse.

FINDINGS OF FACT

Claimant worked in the employer's manufacturing plant as a laborer. On August 31, 1992, he sustained an injury to his right hand when it was pinned between two heavy boxes. Claimant sought treatment for this injury from Dr. Gargaro who diagnosed a soft tissue injury of the right hand. The insurer accepted claimant's injury as a disabling right hand contusion. As a result of the injury, Dr. Gargaro performed an excision of the hook of hamate on claimant's right hand in February 1993.

Following the surgery, claimant continued to experience right hand symptoms. Because of these ongoing symptoms, Dr. Gargaro referred claimant to Dr. Young, hand surgeon, who recommended that claimant undergo right hand neurolysis surgery. At that time, Dr. Gargaro indicated that claimant would be considered medically stationary if he decided not to have the surgery. Claimant agreed to undergo the surgical procedure which was scheduled for November 1993. However, the insurer issued a denial of the surgery on the basis that the procedure was not reasonable and necessary.

Claimant's claim was closed by an April 1, 1994 Determination Order which found him medically stationary as of March 11, 1994. The Determination Order indicated that it was not a determination of any denials issued by the insurer. Claimant requested reconsideration of the Determination Order, and the May 31, 1994 Order on Reconsideration set aside the Determination Order as premature. The insurer did not resume the payment of temporary disability benefits following the May 31, 1994 Order on Reconsideration.

Claimant requested a hearing concerning the insurer's denial of surgery and by a May 4, 1994 Opinion and Order, ALJ Mongrain found that the surgery was reasonable and necessary and set aside the denial. The insurer appealed ALJ Mongrain's order to the Board. By an October 11, 1994 Order on Review, the Board affirmed ALJ Mongrain's order. Thomas R. Yon, Jr., 46 Van Natta 2187 (1994).

FINDINGS OF ULTIMATE FACT

At the time of claim closure, there was a reasonable expectation that claimant's compensable condition would improve due to the proposed surgery.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

As a preliminary matter, claimant contends that the ALJ did not have jurisdiction to "close" his claim because the Order on Reconsideration had set aside the Determination Order as premature. We disagree. The ALJ did not "close" claimant's claim. That was accomplished by the April 1, 1994 Determination Order which was reinstated and modified by the ALJ's order. Moreover, former ORS 656.268(6)(b) (now ORS 656.268(6)(f)) allows any party to request a hearing under ORS 656.283 if the party objects to a reconsideration order. Here, the insurer requested a hearing concerning the reconsideration order under former ORS 656.268(6)(b). Under these circumstances, the ALJ had jurisdiction to reinstate the Determination Order. We now turn to the merits.

The ALJ concluded that claimant's claim had not been prematurely closed. We disagree.

The propriety of a closure turns on whether claimant's condition was medically stationary at the time of the April 1, 1994 Determination Order, considering claimant's condition at the time of closure and not subsequent developments. Scheuning v. J. R. Simplot & Co., 84 Or App 622 (1987). "Medically stationary" means that no further 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).

In a December 1993 report, Dr. Young noted that claimant was suffering from disabling pain in his right hand. (Ex. 16). He opined that further conservative treatment would be of no benefit, but that the proposed surgical procedure could lead to an improvement in claimant's condition. (Ex. 16). In a January 5, 1994 letter, Dr. Gargaro indicated that claimant was not medically stationary because there was still a chance that the proposed surgery could help claimant. (Ex. 18). Dr. Gargaro did allow for the possibility that the surgery might not be successful. (Ex. 18). In a March 11, 1994 letter, Dr. Gargaro reiterated that the proposed surgery might not be successful, but opined that if successful, it would be of "infinite benefit" to claimant. (Ex. 21). Based on the chronicity of claimant's symptoms and his inability to work with his right hand, Dr. Gargaro opined that the proposed surgery was reasonable. (Ex. 21). Finally, in a September 9, 1994 letter, Dr. Gargaro acknowledged that he had never performed the proposed surgical procedure and opined that the surgery would probably not succeed. (Ex. 27).

Dr. Young's opinion establishes that the proposed surgery offers a reasonable expectation of further improvement of claimant's compensable condition. To the extent that Dr. Gargaro's opinion can be interpreted to the contrary, we do not find it persuasive. Although expressing some doubt, Dr. Gargaro's initial opinions indicated that the surgery could reasonably be expected to bring claimant some improvement. His later opinion indicates that the surgery would not prove beneficial to claimant. Dr. Gargaro does not sufficiently explain this inconsistency in his opinions. Moreover, he acknowledges that he has never performed the proposed surgical procedure. Finally, to the extent that Dr. Gargaro now thinks that the surgery is not reasonable, that opinion is contrary to the law of the case as ALJ Mongrain and the Board have found that the proposed surgery is reasonable and necessary.¹ For these reasons, we do not rely on Dr. Gargaro's opinion.

Accordingly, based on Dr. Young's opinion, we conclude that the record establishes that there is a reasonable expectation of further improvement of claimant's condition. Therefore, his compensable condition was not medically stationary and the April 1, 1994 Determination Order prematurely closed claimant's claim.

Penalty

Claimant asserts that he is entitled to a penalty based on the insurer's allegedly unreasonable failure to pay temporary disability compensation pursuant to the May 31, 1994 Order on Reconsideration which reopened his claim. Because of his finding that claimant's claim was not prematurely closed, the ALJ did not address this issue.

A carrier's actions are unreasonable if it does not have a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

The insurer contends that it was not obligated to pay temporary disability compensation because it had appealed ALJ Mongrain's order and the Board's order finding that the surgery was reasonable and necessary. It is questionable whether the appeal of an order concerning the reasonableness and necessity of a surgery, as opposed to compensability, would operate to stay temporary disability compensation. However, even assuming that the insurer could stay payment of temporary disability compensation, it can only stay those amounts that accrue prior to the litigation order.

¹ We acknowledge that the insurer has appealed the Board's order to the Court of Appeals. However, we have previously held that for purposes of administrative efficiency, it is appropriate to give precedential effect to a prior order, notwithstanding the fact that the prior order remained on appeal. See Michael S. Barlow, 46 Van Natta 1627 (1994). In any event, that was not our sole reason for finding Dr. Gargaro's opinion not persuasive.

ORS 656.313(1)(a)(A) specifically provides that temporary disability benefits which accrue from the date of the order appealed are not stayed and must be paid until claim closure or until the order appealed from is itself reversed. Moreover, a carrier is required to pay the temporary disability benefits that accrue during the pendency of the appeal, regardless of the outcome of the appeal. Anodizing, Inc. v. Heath, 129 Or App 356-57 (1994). Consequently, neither the insurer's appeal of ALJ's Mongrain's order nor its appeal of the Order on Reconsideration would relieve it of its obligation to pay temporary disability benefits accruing after the date of the Order on Reconsideration to the date of the instant ALJ's order.

Accordingly, we find that the insurer's failure to pay temporary disability benefits which accrued after the Order on Reconsideration was unreasonable, and assess a penalty equal to 25 percent of the temporary disability compensation due between the May 31, 1994 Order on Reconsideration and the October 24, 1994 ALJ's order (the date the Order on Reconsideration was reversed). The penalty shall be equally divided between claimant and his counsel. ORS 656.262(10).

ORDER

The ALJ's order dated October 24, 1994 is reversed. The Order on Reconsideration dated May 31, 1994 is reinstated and affirmed. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney. The insurer is assessed a penalty equal to 25 percent of the temporary disability compensation due between May 31, 1994 and October 24, 1994, to be paid in equal shares to claimant and his counsel.

June 23, 1995

Cite as 47 Van Natta 1091 (1995)

In the Matter of the Compensation of
RAYMOND J. DOMINIAK, Claimant
WCB Case No. 94-03807
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Hazelett's order which dismissed claimant's request for hearing for lack of jurisdiction. On review, the issues are jurisdiction, if jurisdiction, claimant's entitlement to temporary disability and penalty.

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

Subsequent to the Referee's order, in James C. Schultz, 47 Van Natta 295 (1995), we distinguished under what circumstances the Hearings Division had jurisdiction to determine a claimant's entitlement to procedural temporary disability. We stated that "the question to be resolved is whether claimant's request for hearing regarding his procedural entitlement to temporary disability benefits is directed to the insurer's 'pre-closure' conduct or whether it is a matter that should be analyzed as an issue regarding the resumption of temporary disability." *Id.*; see also Michael J. Drake, 45 Van Natta 1117 (1993); Galvin C. Yoakum, 44 Van Natta 2403, on recon 44 Van Natta 2492 (1992). Cf. Kenneth W. Metzker, 45 Van Natta 1631 (1993).

Here, in November 1993, the parties entered into a stipulation in which the employer agreed to accept claimant's April 1993 left wrist claim and to process the claim for closure. Claimant agreed that his condition was medically stationary on August 10, 1993. A March 10, 1994 Determination Order closed the claim awarding permanent disability and temporary disability from April 28, 1993 through August 10, 1993. On March 25, 1994, claimant filed a request for hearing contending entitlement to procedural temporary disability.

At hearing, and on Board review, claimant did not contend that the employer allegedly unilaterally terminated temporary disability benefits under ORS 656.268(3). Rather, claimant alleges

that, under the terms of the November 1993 stipulation, he was entitled to the commencement of temporary disability benefits while his claim was in open status. Arguably, the "procedural" temporary disability issue concerns the employer's "pre-closure" conduct; *i.e.*, failure to pay temporary disability after the medically stationary date while the claim was in open status. However, claimant's request for hearing was filed after the claim was closed, and claimant seeks a greater temporary disability award than that granted by the Determination Order. Accordingly, under these circumstances, we conclude that the Hearings Division lacked jurisdiction.¹ Galvin C. Yoakum, supra. The appropriate route of appeal rests with the Director's reconsideration process. Michael J. Drake, supra.

ORDER

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

¹ Because we have held that the Hearings Division lacked jurisdiction to determine claimant's entitlement to temporary disability, we do not address the merits. Specifically, we need not determine whether or not the settlement stipulation is ambiguous or whether claimant's entitlement to procedural temporary disability was an issue that could have been negotiated before approval of the settlement. Therefore, Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994) is inapplicable.

Board Member Hall specially concurring.

While I agree that claimant cannot look to the Board for the award of procedural temporary disability benefits which he seeks, I write separately to address the jurisdictional issue.

If claimant were merely seeking enforcement of the settlement stipulation, I would find that we do have jurisdiction over this matter. See Howard v. Liberty Northwest Ins., 94 Or App 283 (1988) (because settlement resolved a dispute regarding a matter concerning a claim, the Board had jurisdiction to enforce the settlement agreement). However, to the extent that claimant is attempting to collaterally attack and amend the terms of the settlement stipulation in order to obtain greater temporary disability compensation, we lack jurisdiction over this matter. The appropriate route to challenge the terms and conditions of a referee-approved stipulation (*i.e.*, seek amendment of the terms) is to request Board review. Dennis Entriken, 46 Van Natta 1439 (1994). However, the request must be filed within 30 days of the stipulated order. Here, claimant did not timely file such a request for review. Accordingly, the November 1993 stipulation became final. See Fred W. Miller, 46 Van Natta 2457 (1994).

I find the terms of the stipulation ambiguous. The November 1993 stipulated order states that claimant's condition was medically stationary on August 10, 1993 and that the employer will immediately process the claim for closure. Generally, an employer or insurer is required to pay procedural temporary disability compensation until the claim is closed. See ORS 656.268. A worker can be medically stationary, yet still be entitled to procedural temporary disability until claim closure or until terminated pursuant to ORS 656.268(3). Thus, I construe the stipulation as stating that the parties agreed that claimant was entitled to procedural temporary disability until claim closure. See Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994) (the issue was an issue that could have been raised before the approval of the stipulation). Here, claimant was released to modified work on August 10, 1993, but did not return to work until November 9, 1993. Accordingly, the employer should have paid procedural temporary disability compensation through November 9, 1993.

However, in this case, claimant waited too long to seek payment of his procedural temporary disability compensation. Claimant requested a hearing after the Determination Order issued. The Determination Order awarded substantive temporary disability benefits to the August 10, 1993 medically stationary date. Claimant, thus, is attempting to obtain greater temporary disability benefits than that granted by the Determination Order. As discussed and found by the majority, under the Drake, supra decision, claimant must seek his relief through the reconsideration process. Therefore, I agree that the Hearings Division and the Board lack jurisdiction.

In the Matter of the Compensation of
LINDA L. KLINGE, Claimant
WCB Case No. C5-01414
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Kasia Quillinan, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Hall .

On May 23, 1995, the Board received the parties' Claim Disposition Agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed CDA provides:

"Claimant understands this is a full settlement and release of all workers' compensation claims she may have for left shoulder injury or any other related problem alleged to result from her accepted claim, except for retention of the specific rights listed in this agreement for medical care and preferred worker status." (Pg. 5).

We recently approved a CDA, in which a claimant released his rights to benefits under the claim, including "any later-diagnosed conditions" which were related to the claim. See Terry M. Bleth, 47 Van Natta 901 (1995). We reasoned that the proposed CDA was consistent with our holding in Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), which permits the full release of benefits under the claim. However, in Bleth, we distinguished between subsequently identified conditions versus claims. We determined that the CDA in Bleth could be approved because it did not attempt to resolve any claim but that addressed by the CDA. See also Christopher J. Kaufman, 47 Van Natta 433 (1995) ("new injury" claim not barred by CDA because, as a separate and distinct claim, it could not have been subject to the CDA).

Here, although the proposed CDA refers to a "release of all workers' compensation claims," we interpret the parties' intention to be consistent with the Board's holdings in Bleth, Kaufman and Trevitts. Specifically, we interpret the parties' intention to be to release all claims for conditions related to the accepted claim, except for the retention of the rights specifically identified in the CDA. In particular, we interpret the parties' agreement not to encompass any potential "new injury" claims that may involve the left shoulder. Such an interpretation is consistent with other provisions which describe the "released claims" as resulting from claimant's "accepted [left shoulder] claim."

Consequently, we hold that the CDA is in accordance with the terms and conditions prescribed by the Director. ORS 656.236(1). Therefore, the parties' CDA is approved. An attorney fee of \$3,750, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

Board Member Hall dissenting.

Since this proposed disposition can be interpreted as attempting to resolve future claims, I would disapprove it. Therefore, I respectfully offer this dissenting opinion.

As expressed in my dissenting opinions in Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), and Terry M. Bleth, 47 Van Natta 901 (1995), this Board exceeds its statutory authority when it approves a Claim Disposition Agreement (CDA) which purports to resolve future unaccepted claims.

Here, the CDA unequivocally states that claimant releases "all workers' compensation claims she may have for left shoulder injury or any other related problem alleged to result from her accepted claim . . ." The majority interprets this provision as limiting claimant's release of future benefits to her accepted left shoulder claim.

Because the aforementioned CDA provision could also be interpreted as pertaining to future unaccepted claims, I would disapprove the proposed disposition as unreasonable as a matter of law. In this way, the parties could then revise their proposal in a manner which clarified their intentions and complied with statutory requirements.

My suggested approach would not only better serve the interests of these particular parties, but it would also maintain a "bright line" for future parties when preparing proposed CDAs. In other words, parties would be placed on notice that their disposition may only limit the release of future benefits to those related to the accepted claim. Consistent with this rationale, any proposal which is unclear regarding its potential impact on potential "new injury" claims would be unacceptable. Because the majority's approval of this CDA "blurs" the aforementioned "bright line," I respectfully dissent.

June 23, 1995

Cite as 47 Van Natta 1094 (1995)

In the Matter of the Compensation of
COLIN J. McINTOSH, Claimant
WCB Case No. 94-08299
ORDER OF ABATEMENT
Coons, Cole & Cary, Claimant Attorneys
Roberts, et al, Defense Attorneys

The insurer requests reconsideration of our June 7, 1995 order which affirmed the Administrative Law Judge's order that: (1) set aside its denial of claimant's psychological condition; and (2) assessed a penalty for an allegedly untimely denial. Contending that §3 of SB 369 applies to this dispute and "mandates a reversal," the insurer seeks reconsideration of our June 7, 1995 decision.

In order to further consider the insurer's motion, we withdraw our June 7, 1995 order. In addition, we implement the following supplemental briefing schedule. Claimant's supplemental response must be filed within 21 days from the date of this order. The insurer's supplemental reply shall be due 14 days from the date of mailing of claimant's response. Thereafter, this matter shall be taken under advisement.

In submitting their respective arguments, the parties are requested to address the effect, if any, of § 3 of SB 369, as well as any other allegedly applicable sections of the recently enacted law.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY NASH, Claimant
WCB Case No. C5-01612
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Philip F. Schuster II, Claimant Attorney
Bruce A. Bottini, Defense Attorney

Reviewed by Board Members Haynes and Hall.

On June 14, 1995, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The agreement contains a provision that, "pursuant to ORS 656.236(1)(b), claimant waives the 30 day 'cooling off' provision of 656.236(1)(a)(C) and forgoes any right to request Board disapproval of this disposition."

Before the enactment of recent legislation, the worker could disapprove the CDA within 30 days of submitting the disposition for approval to the Board. Former ORS 656.236(1)(c). In light of that provision, we previously held that approval of a CDA must await the expiration of the 30-day period. Louis R. Anaya, 42 Van Natta 1843 (1990). Effective June 7, 1995, ORS 656.236 was amended so that "a disposition may provide for waiver of the [30-day period] if the worker was represented by an attorney at the time the worker signed the disposition." SB 369, 68th Leg., Reg. Sess., §§ 24(1)(b), 66 (June 7, 1995).

Based on amended ORS 656.236(1)(b), we recently approved a CDA which included an addendum providing for the waiver of the 30-day period. Jeanne P. Morgan, 47 Van Natta 1062 (1995). The claimant was represented by an attorney at the time she signed the CDA, and the addendum was signed by claimant, her attorney, and the insurer's attorney. Under those facts, we concluded that the CDA conformed with amended ORS 656.236(1)(b).

Here, the CDA provides that "claimant" waives the 30-day period. However, inasmuch as claimant's attorney and the insurer's attorney, along with claimant, signed the disposition, we consider all the parties as having agreed to the waiver.¹ Thus, we conclude that the CDA satisfies amended ORS 656.236(1)(b).

Furthermore, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. Amended ORS 656.236(1)(a); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of \$4,250, payable to claimant's counsel, also is approved.

IT IS SO ORDERED.

¹ In this regard, we note that amended ORS 656.236(1)(a)(C) now provides that, along with claimant, the insurer and self-insured employer may disapprove the CDA within 30 days of its submission to the Board. Furthermore, amended ORS 656.236(1)(b) does not limit waiver of the 30 day period to claimant. In light of such language, we consider it necessary for all parties, including claimant and the insurer or self-insured employer (or their legal representatives), to agree to the waiver in order to satisfy amended ORS 656.236(1)(b).

In the Matter of the Compensation of
DENNIS D. SCHLABACH, Claimant
WCB Case Nos. 93-13815 & 93-07974
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Garaventa's order that set aside its denials of claimant's occupational disease claims for his right wrist conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order¹, with the following supplementation.

We agree with the ALJ that Dr. Warren's opinion is the most persuasive, because it is the best-reasoned and is based on the most accurate and complete history regarding claimant's condition, symptoms, and work and off-work activities. See Somers v. SAIF, 77 Or App 259 (1986).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,400 payable 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 and his attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 7, 1994 is affirmed. For services on review, claimant's counsel is awarded a \$1,400 attorney fee, payable by the self-insured employer.

¹ Assuming that Section 56 of Senate Bill 369 applies to this case, we would reach the same result. See SB 369, 68th Leg., Reg. Sess., § 56 (June 7, 1995).

In the Matter of the Compensation of
DONALD J. BIDNEY, Claimant
WCB Case Nos. 91-13048, 91-01028 & 91-01029
ORDER DENYING RECONSIDERATION
Richard A. Sly, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

On March 28, 1995, we issued an Order on Remand which affirmed an Administrative Law Judge's order that had found claimant's cervical surgery compensable. Noting that a portion of our order incorrectly refers to "claimant's claim for low back surgery," claimant seeks correction of this typographical error. Inasmuch as our order has become final, we lack authority to alter our March 28, 1995 order.

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

Here, our March 28, 1995 order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties. Consequently, we are without authority to "correct" our order as claimant requests. ORS 656.295(8); International Paper v. Wright, supra; Fischer v. SAIF, supra.

Accordingly, the request for "clerical correction" of our March 28, 1995 order is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAN D. CONE, Claimant
WCB Case Nos. 94-01799 & 94-01423
ORDER OF ABATEMENT
Terry & Wren, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

The self-insured employer requests reconsideration of that portion of our May 26, 1995 Order on Review that set aside the employer's denial of claimant's occupational disease claim for his current low back condition. Specifically, the employer requests that we reconsider our decision under the the new statutory standards established by Senate Bill 369, which took effect on June 7, 1995. The employer also requests an immediate abatement of our May 26, 1995 order for the purpose of allowing us additional time for reconsideration.

In order to allow us sufficient time to consider the employer's motion, we grant the motion for abatement and withdraw our May 26, 1995 order. Claimant is requested to submit a response to the employer's motion within 21 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
DANNY R. DEGRANDE, Claimant
WCB Case No. C5-01435
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Kenneth P. Russell (Saif), Defense Attorney

On May 24, 1995, the Board received the parties' Claim Disposition Agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed CDA provides:

"Pursuant to ORS 656.236, the parties have agreed to settle claimant's claim for compensation and payments of any kind due or claimed for all past, present, and future conditions, except compensable medical services. . . ." (Pg. 2, lines 22-24).

We recently approved a CDA, in which a claimant released his rights to benefits under the claim, including "any later-diagnosed conditions" which were related to the claim. Terry M. Bleth, 47 Van Natta 901 (1995). We reasoned that the proposed CDA was consistent with our holding in Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), which permits the full release of benefits under the claim. Here, inasmuch as we interpret the above-quoted provision as pertaining to all past, present and future conditions related to the claim being disposed, we find the above-quoted language consistent with our decisions in Bleth and Trevitts.

Moreover, ORS 656.236(1)(a) was amended by the 1995 legislature, to provide as follows in pertinent part:

"Unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement." SB 369, 68th Leg., Reg. Sess., § 24(1)(a) (June 7, 1995).

We interpret the above-quoted CDA language as being consistent with amended ORS 656.236(1)(a). We find that the statute provides that a CDA resolves all matters related to a claim, including related conditions not explicitly identified in the CDA. However, at the same time, it resolves only conditions or other matters related to a claim, not unrelated claims or conditions. See Christopher J. Kaufman, 47 Van Natta 433 (1995) ("new injury" claim not barred by CDA because, as a separate and distinct claim, it could not have been subject to the CDA). Accordingly, we interpret the parties' intention to be to release all claims for conditions related to the accepted claim, except for those rights specifically retained in the CDA.

Consequently, we hold that the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. SB 369, 68th Leg., Reg. Sess., 24(1)(a) (June 7, 1995); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
KEVIN C. BLONDELL, Claimant
WCB Case Nos. 94-03141 & 94-02861
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Bostwick, et al, Claimant Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order which found that claimant's lumbar claim was not prematurely closed. On review, the issue is premature closure.

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

Because the Order on Reconsideration is reversed and the employer's October 11, 1993 Notice of Closure is reinstated, the employer's subsequent April 1994 Notice of Closure is moot. Accordingly, the issue of extent of disability is ripe for determination. We find the record adequately developed, and therefore, proceed to determine the extent issue.

ORS 656.268(7) provides that, if a medical arbiter is appointed, and the arbiter's findings are submitted to the Department for reconsideration, no subsequent medical evidence of impairment is admissible for purposes of making findings of impairment. Here, a medical arbiter was appointed, and his report was submitted to the Department's Appellate Unit for reconsideration of the October 1993 Notice of Closure.

However, we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. See Raymond L. Owen, 45 Van Natta 1528 (1993) (impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993). In this case, we find the opinion of Dr. Herscher, claimant's treating physician, to constitute the most thorough and accurate evaluation of claimant's permanent impairment.

Unlike Dr. Fitzsimmons, the medical arbiter, Dr. Herscher had the opportunity to view surveillance video, in which Dr. Herscher described claimant's activities as "grossly normal." Based on his examinations and on the surveillance video, Dr. Herscher opined that claimant had no permanent impairment. Claimant, therefore, is not entitled to an award of permanent disability. See former OAR 436-35-270(2).

ORDER

The ALJ's order dated June 28, 1994 is affirmed.

In the Matter of the Compensation of
JEAN K. ELLIOTT-MOMAN, Claimant
WCB Case No. 94-14327
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that dismissed her request for hearing with prejudice by terms of a Stipulation signed by the parties. Claimant contends that the Board should consider extrinsic evidence of the parties' intent in entering into the Stipulation. On review, the issue is dismissal.

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

On September 2, 1994, the insurer filed a determination request with the Department and discontinued temporary disability payments.

On September 27, 1994, claimant requested a hearing on temporary disability benefits, penalties and attorney fees. On November 25, 1994, claimant requested a hearing on a Director's order approving a fifth insurer-requested medical examination.

Claimant and the insurer subsequently entered into a Stipulation and Order that, inter alia, stated:

"The parties agree to settle all issue(s) raised or raisable at this time as follows:

* * * *

"c. In consideration of the promise by CLAS to pay the aforementioned penalty, claimant hereby withdraws all requests for hearing regarding these matters and the parties agree that all requests for hearing shall be dismissed with prejudice as to all issues which were raised and with prejudice as to all issues which could have been raised as of the date of the [ALJ's] signature below, including any issues made raisable by this document."

The Stipulation was approved by a prior ALJ on December 13, 1994.

Claimant argues that the stipulation agreement is ambiguous on a material matter, and that, therefore, the parties' intentions and the circumstances under which the agreement was reached are relevant to ascertain the meaning of the agreement. Specifically, claimant contends that the term "all issues" was intended to include only issues related to temporary partial disability, and, had the parties intended to include other issues, e.g., the medical examinations issue, they, or the ALJ approving the Stipulation, would have so indicated. Accordingly, claimant asks the Board to consider extrinsic evidence of the parties' intent in interpreting the Stipulation.

At the time the parties entered into the stipulation, the medical examinations issue was pending before the Hearings Division. Although the Stipulation is silent as to that issue, we read it as providing that claimant expressly agreed to withdraw all pending requests for hearing as well as all issues which were raised or which could have been raised as of the date of the ALJ's signature.

The parties' agreement was expressly intended to fully settle "all issues raised or raisable at this time," and claimant expressly agreed to withdraw all requests for hearing. Moreover, the parties agreed that all requests for hearing shall be dismissed with prejudice as to all issues which were raised or could have been raised as of the date of the ALJ's signature, including any issues made raisable by the Stipulation document itself. In light of such circumstances, it follows that the Stipulation was intended to be a complete and unambiguous statement of the parties' rights and obligations regarding issues "raised or raisable" at that time, including the medical examinations issue.

Thus, because we find no ambiguity in the document, we decline to consider extrinsic evidence of the parties' intent in interpreting the Stipulation. See Sisters of St. Joseph v. Russell, 318 Or 370 (1994) (Unambiguous contracts must be enforced according to their terms).

We distinguish this case from Mary M. Mitchell, 47 Van Natta 300 (1995), in which we concluded that an agreement should be augmented with extrinsic evidence of the parties' intent.

In Mitchell, an insurer paid medical bills of over \$900 for a claim it later denied. The insurer requested reimbursement for the medical billings from the medical provider on several occasions without informing the claimant. Subsequently, the claimant and the insurer entered into an agreement for \$500 whereby the claimant agreed that the claim would remain denied. The agreement also provided that claimant would be responsible for medical billings and any claims for reimbursement from medical providers. The insurer did not seek reimbursement again. After the agreement was signed, the provider reimbursed the insurer and billed claimant for the amount.

We found that the agreement was intended to be a complete and unambiguous statement of the parties' rights and obligations regarding the denied claim. We further found that the agreement provided that the claimant would be responsible for any outstanding claims for reimbursement from medical providers, but was silent as to the claimant's obligation to reimburse the insurer for past medical payments made to the provider. We concluded that the terms of the agreement were incomplete and should be augmented with extrinsic evidence of the parties' intent. Moreover, we reasoned that if the obligation to pay the provider's bill for \$900 was inconsistent with the parties' intent, the consideration (\$500) supporting the bargained-for exchange would effectively be eliminated, thus qualifying as an extreme situation where, in the interest of substantial justice, the agreement should be interpreted consistent with the intent of the parties. See Kenneth L. Orr, 44 Van Natta 1821 (1992).

Here, in contrast, although the Stipulation is silent as to the medical examinations issue, that issue had been raised by a prior request for hearing. Given the terms of the Stipulation discussed above (particularly the unqualified settlement of all issues raised or raisable provision), we find no reason not to apply the parol evidence rule to interpret the agreement. Moreover, we conclude that this is not an extreme situation in violation of substantial justice.

Thus, because we find no ambiguity in the document, the proper inquiry is whether claimant's November 25, 1994 request for hearing on a Director's order approving a fifth insurer-requested medical examination could have been negotiated before approval of the stipulation. See Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73 (1994).

The agreement unequivocally settles all issues that relate to the 1988 injury that could have been raised before December 13, 1994. The Director's order had issued and claimant had requested a hearing on the medical examiner issue before the Stipulation was signed by the prior ALJ. Consequently, the fifth insurer-requested medical examination issue could have been raised before December 13, 1994, and, therefore, that issue is barred by the Stipulation. Moreover, we conclude that the terms of the Stipulation encompassed claimant's pending request for hearing on the fifth insurer-requested medical examination issue, which the ALJ properly dismissed. Stoddard, *supra*.

ORDER

The ALJ's order dated December 22, 1994, as corrected December 28, 1994, is affirmed.

In the Matter of the Compensation of
MARY D. GULLICKSON, Claimant
WCB Case Nos. 94-07892 & 94-05100
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our May 31, 1995 Order on Review that upheld the self-insured employer's denial of her occupational disease claim for a left shoulder condition. For the following reasons, we adhere to our prior conclusion.

In our previous order, we did not find Dr. Fletchall's opinion persuasive because he did not have an accurate history of claimant's work activities. We said that although Dr. Fletchall authorized light duty on April 5, 1994 and reported that claimant was having left shoulder symptoms in connection with her work, there was no indication that Dr. Fletchall was aware that claimant was no longer working for the employer at that time. Claimant testified that she left work on February 18, 1994 because of her shoulders and had not returned to work. (Tr. 40-41).

Claimant argues that our finding that Dr. Fletchall did not have an accurate history of her work activities is not supported by the record. Claimant contends that Dr. Fletchall's March 25, 1994 chart note conclusively proves that he was aware that claimant was not working. On March 25, 1994, Dr. Fletchall treated claimant for an unrelated condition and noted that she had been "off work for the last five weeks because she can't drive and get to work." (Ex. 4-16). Although Dr. Fletchall's March 25, 1994 chart note indicates he knew claimant had been "off work" for five weeks, we are not persuaded that he was aware that she was no longer working for the employer when he authorized light duty on April 5, 1994.

In any event, even if we assume that Dr. Fletchall had an accurate work history, we do not find his opinion persuasive. In a report summarizing a conversation with the employer, Dr. Fletchall agreed that "the left shoulder condition was caused in major part by overuse due to the inability to use the right shoulder." (Ex. 28). Although Dr. Fletchall associated claimant's left shoulder condition with "overuse due to the inability to use the right shoulder," that does not support an occupational disease theory.¹ Moreover, he did not expressly connect the "overuse" with work activities. Although "magic words" are not required, Dr. Fletchall's conclusory opinion is not sufficient to establish a compensable occupational disease claim.

We adhere to our previous conclusion that the remaining medical opinions on causation do not support compensability of claimant's left shoulder occupational disease claim.

We withdraw our May 31, 1995 order. On reconsideration, as supplemented herein, we republish our May 31, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

¹ We note that claimant's left shoulder condition cannot be based on a "consequential condition" theory because her right shoulder condition is not compensable. See ORS 656.005(7)(a)(A).

In the Matter of the Compensation of
CHARLES R. HODGES, Claimant
WCB Case No. 94-03691
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Turner-Christian.

Claimant requests review of that portion of Administrative Law Judge Peterson's order which affirmed an Order on Reconsideration's award of 13 percent (41.6 degrees) unscheduled permanent disability for claimant's burn injuries. On review, the issue is extent of unscheduled permanent disability.

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

In affirming the Order on Reconsideration's award of permanent disability for claimant's burn injuries to his shoulders, upper and lower back, the ALJ relied on the impairment rating of the medical arbiter, a burn specialist, Dr. Weed, who rated claimant's unscheduled permanent impairment under OAR 436-35-440(2) as Class 1 (3 percent). In accordance with the aforementioned rule, the ALJ declined claimant's request that a separate impairment rating be made for each of the unscheduled body parts affected by his burn injuries.

On review, claimant contends that the ALJ erred in not providing a separate impairment rating for each unscheduled body part affected by his burn injury. Alternatively, claimant requests that we remand the claim to the Director for adoption of a temporary rule, asserting that there is no rational reason why unscheduled body parts under OAR 436-35-440(2) should be rated differently from scheduled body parts under OAR 436-35-230(6) and OAR 436-35-110(5). Pursuant to the latter rules, separate impairment ratings can be made for each scheduled body part affected by a dermatological condition, including burns.

At the outset, we reject claimant's request for a separate impairment rating for each unscheduled body part instead of the ALJ's single rating for impairment of the integumentary system.¹ We also reject claimant's request for remand.

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, 124 Or App 538 (1994). 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).

¹ While we agree with the ALJ that OAR 436-35-440 provides for only one flat rating for all unscheduled areas affected by damage to the integumentary system, this does not negate the possibility of a claimant receiving separate awards for resulting impairment (e.g. loss of range of motion) to each unscheduled body part. For instance, Dr. Oltman, claimant's attending physician, opined that claimant has a limitation in lumbar flexion due to his burns. (Exs. 4-7, 14-1).

However, Dr. Oltman did not feel qualified to evaluate claimant's impairment and recommended that a burn specialist rate claimant's permanent disability. (Ex. 4-7). Dr. Weed, a burn specialist who performed an arbiter's examination, concluded that any limitation in back function was not related to claimant's skin condition. (Ex. 34-1). On this record, we are unable to conclude that claimant's reduced low back range of motion is due to the burn injury.

Finally, we note Dr. Oltman's comment that claimant demonstrated less than full shoulder rotation in an August 20, 1993 examination that "seems" to have been due to scarring in around the shoulder and upper back. (Ex. 29-1). Inasmuch as Dr. Oltman does not relate this limitation to claimant's burn injury to a degree of medical probability, we are not persuaded that the reduced range of shoulder motion reported in this examination is due to the compensable injury. See Lenox v. SAIF, 54 Or App 551 (1981).

Inasmuch as the standards include a rule which addresses claimant's permanent impairment, it is arguable whether this is an appropriate claim to remand to the Director for adoption of a temporary rule. However, we need not address that question because claimant did not preserve this issue for our review.

Unlike the circumstances of Gallino, there is no evidence here that claimant requested the Director to adopt a temporary rule. Claimant also failed to make a remand request to the ALJ. Rather, claimant's remand request is made for the first time on review. However, we do not consider issues raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Robert E. Roy, 46 Van Natta 1909, 1910 (1994) ; Brian G. Vogel, 46 Van Natta 225 (1994).

Claimant also asserts that the ALJ erred in relying on Dr. Weed's opinion in rating claimant's permanent impairment due to his burn injuries. However, Dr. Weed was the only physician to rate claimant's impairment according to OAR 436-35-440(2). Thus, the ALJ properly relied on Dr. Weed's medical opinion in evaluating the extent of claimant's permanent impairment.

ORDER

The ALJ's order dated June 27, 1994 is affirmed.

June 27, 1995

Cite as 47 Van Natta 1104 (1995)

In the Matter of the Compensation of
CHRISTOPHER E. LINDON, Claimant
 WCB Case No. 94-01250
 ORDER ON RECONSIDERATION
 Bottini, et al, Claimant Attorneys
 Scott Terrall & Associates, Defense Attorneys

The insurer requests reconsideration of that portion of our June 14, 1995 order that awarded an insurer-paid attorney fee under ORS 656.382(2) for his counsel's services on review concerning the defense of the Administrative Law Judge's award of 9 percent (28.8 degrees) unscheduled permanent disability. Noting that its cross-request for review only challenged the ALJ's "out-of-compensation" attorney fee award, the insurer asserts that we erred in finding that it contested claimant's unscheduled permanent disability award.

We acknowledge that the insurer's cross-request only raises the ALJ's attorney fee award as an issue on review. Nevertheless, in its respondent's / cross-appellant's brief, the insurer argued that the ALJ's unscheduled permanent disability award should be reversed and the Determination Order (which awarded no permanent disability) should be reinstated. (Respondent / cross-appellant brief, Page 8, Lines 21 - 24; Page 10, Lines 11 - 14). It is well-settled that ORS 656.382(2) is applicable whenever a claimant's compensation award is challenged on Board review, regardless of whether that challenge arises in the carrier's formal cross-request or informally in the carrier's respondent's brief. Kordon v. Mercer Industries, 308 Or 290 (1989).

Here, since the insurer sought reduction or disallowance of claimant's unscheduled permanent disability award, he is entitled to an insurer-paid attorney fee under ORS 656.382(2) because we affirmed that award. Consequently, we reject the insurer's contention that we erred in granting such an attorney fee for claimant's counsel's services on review regarding the insurer's challenge to the unscheduled permanent disability award.

Accordingly, our June 14, 1995 order is withdrawn. On reconsideration, as supplemented herein, we republish our June 14, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN A. LOCKWOOD, JR., Claimant
WCB Case No. C5-01663
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Dennis H. Henninger, Claimant Attorney

Reviewed by Board Members Neidig and Gunn.

On June 13, 1995, the Board acknowledged receipt of the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

Carrier attorney signature

Here, the CDA contains signature lines for claimant, counsel for claimant, and the insurer's claims examiner. There is no signature line for counsel for the insurer, and no attorney has signed the CDA on the insurer's behalf.

ORS 656.236 provides that "parties" to a claim, by agreement, may make such disposition of any or all matters regarding a claim. Additionally, a CDA must be executed by all the "parties" to the agreement. OAR 439-09-001(1).

We have previously held that, while under ORS 9.230 a corporation must appear through an attorney in any action, suit or proceeding, a CDA is not an "action, suit or proceeding" requiring attorney representation. Allen Ehr, 47 Van Natta 870 (1995). We reasoned that, whereas a contested case "hearing" is a proceeding, and the concern over representation arises where the layperson is participating in activities such as cross-examining witnesses and making evidentiary objections, a CDA which has been submitted to the Board for approval does not constitute a hearing and is not an "action, suit or proceeding." Thus, we held that, because the CDA did not involve a "proceeding" as contemplated by ORS 9.230, an attorney for the corporate insurer was not required to sign the proposed agreement.

No attorney for the corporation (the insurer) has signed this CDA. However, based on Ehr, we conclude that it is also unnecessary for an attorney for the corporate insurer to sign the CDA in this case. See Allen Ehr, supra.

Release of benefits

The summary page of the CDA indicates by the mark "X" that all benefits are fully released, except survivor's benefits. (Pg. 1). However, the body of the CDA provides that "claimant released his rights to the following past, present, and future workers' compensation payments and benefits for the life of the claim including aggravations and future/consequential conditions: . . . survivor's benefits. . . and all other payments and benefits with the exception of medical benefits." (Pg. 3, item 13) (emphasis added).

Although the summary page is inconsistent with the body of the CDA, we interpret the parties' intent to be to release all benefits related to this claim, including survivor's benefits. If either disagrees with this interpretation, they should immediately seek reconsideration of this order in accordance with OAR 438-09-035.

Waiver of 30-day period

On June 20, 1995, the Board received an "addendum" submitted by the parties whereby the parties waived the 30-day waiting period. The addendum also provides that, other than the waiver, the CDA originally submitted by the parties remains unchanged. The addendum was signed by claimant, claimant's attorney, and the claims examiner.

Before the enactment of recent legislation, the worker could disapprove the CDA within 30 days of submitting the disposition for approval to the Board. Former ORS 656.236(1)(c). In light of that provision, we previously held that approval of a CDA must await the expiration of the 30-day period. Louis R. Anaya, 42 Van Natta 1843 (1990). Effective June 7, 1995, ORS 656.236 was amended so that "a disposition may provide for waiver of the [30-day period] if the worker was represented by an attorney at the time the worker signed the disposition." SB 369, 68th Leg., Reg. Sess., § 24(1)(b), § 66 (June 7, 1995).

Inasmuch as the addendum provides for the waiver of the 30-day period, claimant was represented by an attorney at the time she signed the CDA, and the addendum is signed by claimant, his attorney, and the claims examiner, we conclude that it conforms with the new law. Jeanne P. Morgan, 47 Van Natta 1062 (1995).

Accordingly, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. SB 369, § 24 (1)(a); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of \$3,475, payable to claimant's counsel, also is approved.

IT IS SO ORDERED.

June 27, 1995

Cite as 47 Van Natta 1106 (1995)

In the Matter of the Compensation of
KATHRYN N. OLIVER, Claimant
WCB Case No. 94-06231
ORDER ON REVIEW
Richard Maizels, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order which upheld the insurer's denial of claimant's current right hand/wrist condition. In her brief, claimant contends that the ALJ erred in failing to admit a report from her physical therapist. On review, the issues are evidence and compensability.

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

The ALJ determined that, without a proper foundation, a letter from Mr. Bonica (a physical therapist) could not be construed as a medical report since claimant's treating physician had not referred her to Mr. Bonica. (Tr. 7). Consequently, the ALJ declined to admit the letter (Exhibit 42) into evidence.

Claimant contends that the ALJ erred in refusing to admit the letter. We need not resolve that issue because, even if we considered the excluded exhibit, we would still find that the preponderance of the medical evidence (particularly the reliable and accurate opinion authored by Dr. Barnhouse) does not support the compensability of claimant's current right wrist/hand condition.

ORDER

The ALJ's order dated August 30, 1994 is affirmed.

In the Matter of the Compensation of
JAMES RYDBERG, Claimant
WCB Case No. C5-01211
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Nancy F.A. Chapman, Claimant Attorney
Les Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On May 4, 1995, the Board acknowledged receipt of the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed agreement provides that claimant was working for a noncomplying employer (NCE) at the time of his injury or occupational disease. Parties to the agreement include the Department of Consumer and Business Services (DCBS) and the SAIF Corporation, as the processing agent for DCBS. Both entities, as well as claimant and claimant's attorney, signed the CDA. There is no signature from the NCE. A letter from DCBS accompanying the CDA states that the NCE approved the CDA during a telephone conversation and that his "signature is not included because of availability" from working as a longhaul truck driver. The letter further states that the NCE "understands the settlement, and understands his responsibility for repayment to DCBS" and that "DCBS does not waive its right to recovery."

We requested that the parties submit an addendum providing the NCE's signature. In making the request, we discussed a prior holding, based on Astleford v. SAIF, 319 Or 225 (1994), that a NCE is a "party" to a CDA agreement. Isabel Campa, 47 Van Natta 217 (1995). In Campa, however, we further held that the NCE's signature was not necessary because, based on DCBS's representation that it would not seek claim costs from the NCE, it had no pecuniary interest in the CDA. Here, we found Campa distinguishable because DCBS had indicated that it would seek claim costs from the NCE and, therefore, the NCE not only was a party to the CDA but also had a pecuniary interest in it.

Subsequent to our request, on June 7, 1995, the legislature enacted Senate Bill 369 that amended ORS 656.236. SB 369, 68th Leg., Reg. Sess., § 24, § 66 (June 7, 1995). In particular, the new law now provides that a "party" to a CDA does not include a noncomplying employer. Id. at § 24(9). We find that this provision overrules our previous holding in Isabel Campa, supra, that a NCE is a party to a CDA.

Therefore, we conclude that, inasmuch as a NCE is not a "party" to a CDA, its signature is not necessary for Board approval of the disposition. Furthermore, the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. ORS 656.236(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of \$3,875 also is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELVIN D. MANIRE, Claimant
Own Motion No. 94-0591M
OWN MOTION ORDER
Welch, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable bilateral carpal tunnel injury. Claimant's aggravation rights expired on August 3, 1993. Claimant requested temporary disability compensation for his current left carpal tunnel condition and subsequent request for left carpal tunnel release.

On September 24, 1994, SAIF issued an amended denial of responsibility and compensability for claimant's current condition and need for treatment. Claimant requested a hearing with the Hearings Division. (WCB Case No. 94-10473). In addition, SAIF opposed reopening on the grounds that: (1) no surgery has been requested; (2) surgery or hospitalization is not reasonable and necessary for the compensable injury; (3) claimant has not sustained a worsening of the compensable injury; and (4) claimant was not in the work force at the time of disability.

By letter dated March 28, 1995, SAIF advised claimant that it was "rescinding" its denial of current care and treatment for the left carpal tunnel condition. Subsequently, on May 12, 1995, Administrative Law Judge (ALJ) Johnstone approved a "Stipulation and Order" which resolved the parties' dispute pending before the Hearings Division. The parties agreed that: "As of March 28, 1995, SAIF Corporation agrees to reopen the claim for Own Motion benefits and rescind its denials of compensability and responsibility. Claimant will receive Own Motion benefits for compensation as provided by law." In addition, claimant's hearing request was dismissed with prejudice.

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).

On June 7, 1994, Dr. Heusch, claimant's treating physician, recommended claimant's left carpal tunnel release and related it, in major part, to the accepted 1988 injury. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

On June 7, 1995, SAIF advised the Board of the following:

"We still object to time loss [for claimant] at the present time because neither the worker nor his attorney have furnished us with documentation to prove that he is in the work force at the time of worsening.

"Also we have requested that the treating doctor, Ray N. Miller, M.D. have a reasonable and necessary assessment done through Caremark, the managed care organization in which the worker is enrolled.

"Once all of the above mentioned information is received we will be in a better position to determine if surgery is reasonable and necessary."

Although it appears that SAIF currently objects to the reopening of claimant's claim under the Board's own motion authority, the May 12, 1995 Stipulation and Order is clear in its resolution of that dispute. Pursuant to that agreement, the parties agreed to "settle all issue(s) raised or raisable" upon approval of the Stipulation and Order; SAIF agreed to reopen claimant's 1988 injury claim for the payment of "Own Motion benefits for compensation as provided by law"; and the matter was dismissed with prejudice.

The stipulation is a negotiated, signed meeting of minds, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party. See Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993). Once approved by the ALJ, it has the finality and effect of a judgment. Id. Here, although the ALJ had authority to approve only that portion of the stipulation which rescinded the "current condition" denial, the ALJ's approval of the stipulation also acknowledged SAIF's unambiguous agreement to voluntarily reopen the claim and provide Own Motion benefits (i.e., temporary disability upon claimant's surgery or hospitalization). SAIF was authorized to voluntarily reopen the claim, see amended ORS 656.278(5), and is therefore bound by its stipulation to do so. Inasmuch as SAIF's defense to the approval of the left carpal tunnel release could have been raised

before approval of the stipulation, it is now barred from raising those defenses at this time. See Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993).

Accordingly, we authorize the reopening of claimant's 1988 injury claim for the payment of temporary disability compensation beginning the date he enters the hospital for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

June 29, 1995

Cite as 47 Van Natta 1109 (1995)

In the Matter of the Compensation of
CARMEN C. NEILL, Claimant
WCB Case No. 93-04858
ORDER OF ABATEMENT
Bischoff & Strooband, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Claimant has requested reconsideration of our June 7, 1995 Order on Review. Specifically, claimant contends that we erred by: (1) finding that the self-insured employer's aggravation denial was moot by virtue of our resolution of the classification issue; and (2) failing to award a penalty or related attorney fee for the employer's allegedly unreasonable claims processing. The self-insured employer has also requested reconsideration of those portions of our order which directed it to reclassify claimant's claim as disabling. Specifically, the employer contends that Senate Bill 369 compels a different result. See amended ORS 656.319(6); amended 656.005(7)(c); amended ORS 656.212(2); amended ORS 656.210(2)(b)(A).

In order to allow sufficient time to consider the parties' motions, we withdraw our June 7, 1995 order. The employer has responded to claimant's motion, however, claimant has not had an opportunity to respond to the employer's motion. Therefore, claimant is allowed 21 days from the date of this order to submit a response to the motion. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

June 29, 1995

Cite as 47 Van Natta 1109 (1995)

In the Matter of the Compensation of
GUILLERMO RIVERA, Claimant
WCB Case No. 94-00923
ORDER OF ABATEMENT
Steven M. Schoenfeld, Claimant Attorney
Roberts, et al, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our June 7, 1995 Order on Review that affirmed an Administrative Law Judge's order that awarded claimant's counsel an assessed attorney fee of \$2,200 for prevailing over the employer's "de facto" denial of claimant's cervical and lumbar strains. The employer challenges the propriety of the award as to the cervical strain based on the recent amendments to ORS 656.386(1). SB 369, 68th Leg., Reg. Sess., § 43 (June 7, 1995). In response, claimant opposes the employer's motion.

In order to further consider this matter, we withdraw our order. In addition, we implement the following supplemental briefing schedule. The employer's opening supplemental brief shall be due within 14 days from the date of this order. Claimant's supplemental response shall be due within 14 days from the date of mailing of the employer's brief. The employer's reply shall be due within 7 days from the date of mailing of claimant's response. Thereafter, we shall take this matter under advisement. In submitting their respective positions, the parties are requested to address the effect, if any, amended ORS 656.262(6)(d) (Section 28), amended ORS 656.386(1) (Section 43), and Section 66 have on this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORI A. BENNETT, Claimant
WCB Case No. 93-07295
ORDER ON REVIEW
Olson Law Firm, Claimant Attorneys
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Holtan's order which upheld the self-insured employer's denial of her current low back condition. Claimant also moves to strike the employer's respondent's brief as untimely. On review, the issues are motion to strike and compensability.

We adopt and affirm the ALJ's order with the following comment:

Claimant moves to strike the employer's respondent's brief as untimely on the ground it was not filed until more than 21 days after she submitted her appellant's brief on January 9, 1995. Alternatively, claimant requests that we grant an extension of time in which to file her reply brief.

It appears from the employer's response to claimant's motion that its respondent's brief was timely mailed to the appropriate address, but was inadvertently forwarded to a former attorney in claimant's attorney's firm. In light of such circumstances, rather than striking the employer's brief, we have considered claimant's reply brief.

ORDER

The ALJ's order dated October 17, 1994 is affirmed.

In the Matter of the Compensation of
RICKY R. DEEDS, Claimant
WCB Case No. 93-13356
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that found that his claim was not prematurely closed. On review, the issue is premature closure.

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

The dispositive issue is whether there was a reasonable expectation of material improvement in claimant's compensable condition at the time of claim closure (July 6, 1993). See ORS 656.005(17).¹ Post-closure medical evidence on this issue may be properly considered, only if it addresses the condition at claim closure or a condition which has not changed since claim closure. See Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987).

Here, claimant relies on the post-closure opinions of Dr. Long, attending physician, in support of his contention that the claim was prematurely closed. (See Exs. 35-3, 37-1, 38A-5, 39).

¹ The 1995 changes to ORS Chapter 656 do not affect the outcome of this case. See ORS 656.005(17), SB 369, 68th Leg. Reg. Sess., § 1 (June 7, 1995).

On September 28, 1993, Dr. Long opined that: claimant was not medically stationary; he had not been medically stationary since claim closure; he was not medically stationary on a certain date; and "his condition had worsened on a later date, making him not medically stationary again." (Ex. 39-1-2; see also Ex. 38-5). In our view, these descriptions of claimant's medically stationary status (or lack thereof) are inconsistent with one another. Under these circumstances, we cannot say that Dr. Long's opinions regarding whether or when claimant was medically stationary persuasively demonstrate reasonable expectations of material improvement in claimant's condition at the time of claim closure. See ORS 656.005(17). Accordingly, we agree with the ALJ that claimant has not carried his burden of proof. See *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

ORDER

The ALJ's order dated December 22, 1994, as amended December 29, 1994, is affirmed.

June 30, 1995

Cite as 47 Van Natta 1111 (1995)

In the Matter of the Compensation of
MICHELLE K. DIBRITO, Claimant
WCB Case No. 91-13969
SECOND ORDER ON REMAND
Black, Chapman, et al, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

On June 2, 1995, we issued an Order on Remand which upheld the SAIF Corporation's denial of claimant's injury claim for a colitis condition. Contending that our decision contains legal and factual errors, claimant seeks reconsideration.

To begin, claimant argues that we erroneously required her to establish that her work injury "is and remains" the major contributing cause of her resultant colitis condition because SAIF's denial only pertained to the date of claimant's injury claim. Assuming without deciding that we agreed with claimant's theory that our analysis should be confined to whether the work injury "is" the major contributing cause of claimant's current colitis condition, we would continue to find that the preponderance of the persuasive evidence does not satisfy such a standard.¹

Secondly, claimant challenges our decision to reject the medical opinion offered by Dr. Marx, her treating physician, and our interpretation of the opinion from Dr. Thompson, an examining psychiatrist. Specifically, claimant argues that, considering the length of his association with claimant, Dr. Marx has an enhanced position from which to assess the relationship between claimant's colitis condition and her work. In addition, claimant asserts that we have misinterpreted Dr. Thompson's opinion. For the following reasons, we adhere to our prior conclusions.

Considering the number of potential causes for claimant's current colitis condition, we continue to find that resolution of this dispute rests on medical expert analysis. Thus, we are not inclined to defer to Dr. Marx's opinion as the treating physician. In any event, even if we were so inclined, we would still find persuasive reasons to reject his opinion due to his failure to provide an assessment of the relative contribution of the variety of potential causes for claimant's condition.

Finally, claimant notes that we adopted the Administrative Law Judge's findings, which she contends confirms that she did not misperceive her stressful work situation. Consequently, claimant contends that we erred in declining to rely on Dr. Thompson's opinion that (assuming that claimant's work stress was based on real events and not generally inherent in every work situation) claimant's work stress was the major cause of the exacerbation of her bowel symptoms.

¹ On June 7, 1995, several legislative amendments to the Workers' Compensation Law were enacted. SB 369, 68th Leg., Reg. Sess., Sections 1, 66 (June 7, 1995). Pursuant to this Act, ORS 656.005(7)(a)(B) was amended. We need not address the applicability of this amendment because under either version of the statute we would reach the same result.

As we have previously explained, notwithstanding his hypothetical opinion, we interpret Dr. Thompson's ultimate conclusion to be that the primary cause of claimant's current disability and need for medical treatment are non-work factors. In any event, assuming for the sake of argument that claimant's perceptions of all of her alleged work stress were real, Dr. Thompson also referred to claimant's preexisting "neurotic problems" as a contributor to her stress. In light of such considerations, we are unable to find that Dr. Thompson supported a conclusion that claimant's work stress was the major contributing cause of her current colitis condition.

Accordingly, we withdraw our June 2, 1995 order. On reconsideration, as supplemented herein, we republish our June 2, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 30, 1995

Cite as 47 Van Natta 1112 (1995)

In the Matter of the Compensation of
EVERY MENDENHALL, Claimant
WCB Case Nos. 91-10150 & 91-05946
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Tooze, Shenker, et al, Defense Attorneys

This matter is on remand from the Court of Appeals. Reynolds Metals v. Mendenhall, 133 Or App 428 (1995). The court has reversed our order, Every Mendenhall, 45 Van Natta 567, on recon 45 Van Natta 1081 (1993), that set aside the insurer's partial denial of claimant's L5-S1 and right antalgia (gait disturbance) conditions. Concluding that our order improperly found that portion of the insurer's denial to be "premature," the court has remanded for reconsideration of the compensability of claimant's L5-S1 and right leg conditions.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact and the "Findings of Fact" and the "Findings of Ultimate Fact" contained in our March 31, 1993 Order on Review, with the following supplementation.

Claimant's December 30, 1990 compensable low back injury was the major contributing cause of his subsequent disability and need for treatment for his L5-S1 and right antalgia conditions.

CONCLUSIONS OF LAW AND OPINION

The issue on remand is whether claimant's L5-S1 and right antalgia conditions are compensably related to his December 30, 1990 work injury. Because claimant had a preexisting low back condition which combined with his compensable injury to allegedly cause his disability and need for treatment, claimant must show that his compensable injury is the major contributing cause of his resultant disability or need for medical treatment. Former ORS 656.005(7)(a)(B).¹

The insurer argues that claimant's L5-S1 and right antalgia conditions cannot be compensable because there is no medical evidence expressly relating these conditions to the December 30, 1990 compensable injury. We disagree.

¹ ORS 656.005(7)(a)(B) was amended by Senate Bill 369. See SB 369, 68th Leg., Reg. Sess., §§ 1, 66 (1) (June 7, 1995). It now provides that where a compensable injury combines with the preexisting condition, the injury is not compensable unless the "otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition." Since the medical evidence establishes that claimant's current condition would be compensable under either version of the statute, we need not determine which version is applicable.

Dr. Berkeley, treating physician, followed claimant's post-December 1990 back problems, including those arising from claimant's low back. On January 9, 1991, Dr. Berkeley examined claimant and noted that claimant had "developed pain in the right lumbar region with pain radiating to the right buttock and leg with increasing back stiffness and inability to move." (Ex. 74). He noted that claimant was tender in the lumbosacral region, had "severe right antalgia and walked with a limp," and "diffuse sensory loss in the right leg." (*Id.*) In his January 14-17, 1991 chart notes, Dr. Berkeley again recorded lumbosacral, right hip, and right leg pain, with "L5-S1" specifically identified as its source. (Ex. 75-1).

On February 1, 1991, Dr. Berkeley reported that claimant's condition was "worse rather than better." (Ex. 79). He recorded "increasing low back ache, right sacroiliac joint pain, right leg ache, weakness and 'feeling of deadness' in the right leg with parathesiae in the right thigh and calf, which [claimant] describes as 'my leg being on fire.'" (*Id.*) Dr. Berkeley noted that claimant walked with a right antalgia and limp and that he had sensory diminution in the right L4 and S1 dermatomes. (*Id.*) Lumbar spine x-rays and a lumbar CT scan revealed a broadbased disc bulge at L4-5 and a suspected eccentrically bulging disc at L5-S1.² On February 13, 1991, Dr. Berkeley again noted that claimant had "residual sensory diminution in the right L4 and S1 dermatomes as before" and continued claimant's conservative treatment. (Ex. 82).

Dr. Berkeley's treatment of claimant addressed claimant's L5-S1 condition and right antalgia as well as problems associated with other disc levels, including the superimposition of a work injury upon a preexisting degenerative condition. Thus, the doctor treated claimant's entire low back condition (including those problems arising from the L5-S1 area and the right antalgia) as one condition, for which he prescribed conservative treatment (physical therapy,³ bed rest, and medication). (Ex. 79).

On February 15, 1991, Dr. Berkeley opined (without specifically mentioning claimant's L5-S1 and right antalgia problems) that claimant's December 1990 work injury, together with subsequent increasing repetitive hard work, "have been the major contributing factors in aggravating his condition" and the "aforementioned accident" produced the symptomatology which requires medical treatment." (Ex. 83).

Finally, on August 1, 1991, Dr. Berkeley responded to claimant's attorney's inquiries regarding whether the December 30, 1990 work injury was the major contributing cause of claimant's low back and lower extremity conditions or, if those conditions were preexisting, whether the work injury was the major contributing cause of claimant's present disability. (Ex. 95-2). Dr. Berkeley answered affirmatively, and explained his conclusions. (Exs. 95-2, 96).

Dr. Berkeley first noted that, despite chronic lumbar degenerative changes, claimant's low back had been essentially asymptomatic (except for two relatively minor prior incidents) until the December 30, 1990 work injury. He further noted that claimant's prior low back symptoms were never as severe as those following the most recent injury, had not involved radicular symptoms, and had resolved with conservative treatment. These observations appear in striking contrast to claimant's post December 1990 severe low back ache and right leg ache. (Ex. 96).

Dr. Berkeley also explained the mechanism of claimant's low back injury as an injury superimposed on a preexisting degenerative condition. According to the doctor, a soft tissue injury with an inflammatory process immediately causes joint dysfunction (as well as localized and peripheral pain from involved nerve roots) and the trauma accelerates the underlying condition, with attendant increased symptoms. (*Id.*)

In our view, Dr. Berkeley's opinion, as a whole, supports a conclusion that claimant's December 30, 1990 work injury is the major contributing cause of claimant's current L5-S1 and antalgia conditions. Dr. Berkeley's opinion is also well-reasoned, based on an accurate history, and uncontradicted. Under these circumstances, we rely on it and conclude that claimant has carried his burden of proving that his L5-S1 and antalgia conditions are compensable.

² The latter disc condition was not confirmed. A subsequent MRI report stated, "The L5-S1 region fails to reveal any spondylolysis or spondylolisthesis. The internal disc signal is preserved." (Ex. 80).

³ Dr. Berkeley prescribed physical therapy in hopes of strengthening and stabilizing claimant's lumbosacral area (Ex. 75). Conservative treatment was generally intended to alleviate claimant's paralumbar pain, radiculopathy, and resultant right antalgia.

Claimant has finally prevailed after remand with respect to the compensability of the L5-S1 and antalgia conditions. Under the circumstances, he is entitled to a reasonable attorney fee for services before every prior forum. See amended ORS 656.388(1). Since claimant's counsel provided services at hearing, on Board review, before the court and on remand, a reasonable fee for such efforts shall be awarded.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services is \$4,000 (\$1,000 for services at hearing, as previously awarded,⁴ and \$3,000 for services before the court and on remand), to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability 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 of our March 31, 1993 and June 18, 1993 orders, the insurer's partial denial of claimant's claim for L5-S1 and right antalgia conditions is set aside and the claim is remanded to it for processing according to law. Our prior \$1,000 attorney fee award is reinstated. For services before the appellate court and on remand concerning the compensability of the L5-S1 and right antalgia conditions, claimant's attorney is awarded a \$3,000 attorney fee, payable by the insurer.

IT IS SO ORDERED.

⁴ We note that claimant did not object to our prior fee award before the court.

June 30, 1995

Cite as 47 Van Natta 1114 (1995)

In the Matter of the Compensation of
NANCIE A. STIMLER, Claimant
 WCB Case No. 93-11087
 ORDER ON REVIEW
 Pozzi, Wilson, et al, Claimant Attorneys
 Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's partial denial of claimant's other respiratory conditions, including infectious paranasal sinusitis, chronic bronchial asthma and chronic allergic rhinitis conditions; and (2) declined to assess a penalty under former ORS 656.262(10) for an allegedly unreasonable denial. On review, the issues are scope of acceptance, compensability and penalties.

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

Claimant had asthma as a child and she also has allergies. (Tr. 32, 37). She started smoking when she was 18 years old, but she quit smoking in 1984. (Tr. 34). Approximately six months after she quit smoking, she began having sinus and respiratory problems. (Tr. 35). Claimant had recurrent sinusitis and nasal polyposis and had nasal surgery in November 1991. (Exs. 55, 57 & 60).

Claimant has worked for the employer since 1983. She has filed three claims for respiratory problems due to chemical exposure in connection with her employment as an x-ray technician. In July 1992, she filed a claim for respiratory problems, alleging breathing difficulties because an x-ray processor had been leaking chemical fumes. (Exs. 65 & 66). On October 8, 1992, the employer accepted a claim for "disabling resolved respiratory irritant reaction secondary to leak of film developer." (Ex. 102).

In December 1992, claimant filed a second claim for a respiratory condition due to chemical exposure. (Exs. 106-108). On March 26, 1993, the employer accepted a claim for "disabling resolved upper respiratory irritant infection." (Ex. 119).

On June 15, 1993, claimant filed a claim for respiratory problems when chemical fumes caused breathing problems. (Ex. 130). The employer denied the "upper respiratory condition" claim on September 7, 1993. (Ex. 144). In late March 1994, the employer notified claimant that it was partially rescinding its September 7, 1993 denial and was accepting a "disabling temporary irritant reaction condition." (Ex. 153). In addition, the employer notified claimant that it denied all other upper respiratory conditions, including infectious paranasal sinusitis, chronic bronchial asthma and chronic allergic rhinitis. (Ex. 152).

Claimant argues that the employer's prior acceptances of her "resolved" respiratory irritant condition on October 8, 1992 and March 26, 1993 were prohibited preclosure denials. According to claimant, the prohibited preclosure denials were followed by the employer's September 7, 1993 denial of her "upper respiratory condition." Claimant contends that the employer's September 7, 1993 denial was a "backup" denial of the respiratory condition accepted twice before. We disagree.

A carrier is bound by the express language of the acceptance. SAIF v. Mize, 129 Or App 636 (1994). For purposes of adjudicating a backup denial, acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. SAIF v. Allen, 320 Or 192, 215 (1994); Johnson v. Spectra Physics, 303 Or 49 (1987).

Claimant filed her first claim in July 1992, alleging breathing difficulties because an x-ray processor had been leaking chemical fumes. On September 9, 1992, Dr. Montanaro examined claimant and reported that she had a history of chronic allergic rhinitis, chronic bronchial asthma and chronic paranasal sinusitis. (Ex. 98). He diagnosed "[p]robable respiratory irritant reaction secondary to leak of film developer - resolved." (Id.) Dr. Montanaro reported that none of claimant's conditions were related to her work activities with the exception of the occupational irritant reactions. He found no evidence that claimant's work activities resulted in a pathologic worsening of any underlying conditions. (Id.) Dr. Browning concurred with Dr. Montanaro's report. (Ex. 100). On October 8, 1992, the employer accepted a claim for "disabling resolved respiratory irritant reaction secondary to leak of film developer." (Ex. 102).

Claimant's second claim was filed in December 1992, alleging a respiratory condition due to chemical exposure. On January 12, 1993, Dr. Browning diagnosed claimant with "[e]xposure to radiologic developer and fixer fumes * * * with symptoms of headache, dizziness and shortness of breath - resolved." (Ex. 116). On March 26, 1993, the employer accepted a claim for "disabling resolved upper respiratory irritant infection." (Ex. 119).

We conclude that the scope of the employer's acceptances were specifically limited to a temporary irritant reaction condition and the employer did not accept the underlying conditions or a worsening of the underlying conditions.¹ Under these circumstances, we conclude that the employer's September 7, 1993 denial of claimant's "upper respiratory condition" was not a "backup" denial and was procedurally proper. See Daniel R. Bakke, 44 Van Natta 831 (1992) (scope of the carrier's acceptance was limited to the temporary exacerbation of the seizure disorder and did not include the preexisting seizure disorder itself); Mark S. Hogland, 43 Van Natta 2311 (1991) (the carrier's acceptance was specifically limited to temporary bilateral knee symptoms); Kenneth L. Orr, 43 Van Natta 1432 (1991) (the carrier did not accept the underlying asthma condition when it accepted the acute asthma attacks).

In regard to her June 1993 claim, claimant asserts that the employer erroneously accepted a "temporary" condition and she argues that her "system complex" is compensable. Citing Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989), and Gary L. Best, 46 Van Natta 1694 (1994), she contends that the employer's acceptance of her "temporary" irritant reaction condition improperly allows the employer to deny future medical treatment or disability arising from claimant's work exposure. We disagree.

¹ After the ALJ's order, the legislature enacted Senate Bill 369. SB 369, 68th Leg., Reg. Sess., § 66 (June 7, 1995). ORS 656.262(6)(d), as amended, provides, inter alia, that a worker who believes a condition has been incorrectly omitted from a notice of acceptance first must communicate in writing to the carrier the worker's objections to the notice. SB 369, 68th Leg., Reg. Sess., § 28(6)(d) (June 7, 1995).

We need not decide whether the amendments in ORS 656.262 apply retroactively in this case because the medical evidence does not support an argument that any conditions were incorrectly omitted from the acceptance notices.

In Gary L. Best, supra, we held that a carrier's acceptance of a so-called "resolved" condition implied that the carrier was no longer responsible for future benefits for the condition. We reasoned that the acceptance represented a denial of future responsibility relating to an accepted claim. Consequently, notwithstanding the carrier's payment of all present compensation, we held that the acceptance constituted an invalid prospective denial.

Here, in contrast, the employer's use of the term "temporary" in its acceptance of a "disabling temporary irritant reaction condition" was based on the medical evidence. The medical reports referred to a "transient," "temporary," and "resolved" condition. (Exs. 145, 146, 147 & 148). Unlike Gary L. Best, supra, the employer's reference to a "temporary" condition is permissible and does not represent a conclusion that the employer is no longer responsible for future benefits for the compensable condition. The employer's characterization of the accepted condition as "temporary," although properly based on the medical evidence in existence at the time of acceptance, would not preclude claimant from subsequently proving that future disability or need for treatment is compensably related to the accepted condition.

On September 13, 1993, Dr. Montanaro examined claimant and diagnosed "[p]robable respiratory irritant reaction secondary to leak of film developer - resolved." (Ex. 145). He noted that the June 1993 incident appeared to be similar to the December 1992 incident, but he believed that the exposures were distinct in nature. Dr. Montanaro did not believe that the major cause of claimant's conditions were due to work exposures and there was no evidence that her work activities led to a pathologic worsening of her underlying condition. (Id.)

Dr. Ushman agreed with Dr. Montanaro that claimant suffered a transient irritant effect from her exposure to chemicals at work. (Ex. 146). Dr. Ushman reported that claimant had previous underlying asthma and allergic rhinitis that were not caused by her employment and were not materially worsened on a permanent basis by her employment. Dr. Ushman believed that there was only a temporary aggravation with each exposure and that the symptoms resolved with conservative management.

Dr. Browning opined that claimant's exposure to chemicals at work temporarily aggravated her preexisting reactive airway disease and her asthmatic condition. (Ex. 147). She reported that claimant's asthmatic condition had returned to its chronic baseline and there was no permanent worsening of her underlying reactive airway disease attributable to her work activities. Dr. Browning recommended that claimant be permanently restricted from working in the radiology department based upon her preexisting asthmatic condition, which predated her work at the employer. (Id.)

Based on the opinions of Drs. Montanaro, Ushman and Browning, we conclude claimant experienced a temporary, symptomatic episode of respiratory irritation due to chemical exposure at work. Under these circumstances, the use of the term "temporary" in the employer's acceptance of a "disabling temporary irritant reaction condition" is based on the medical evidence and does not constitute a prohibited prospective denial under Striplin.

In any event, even if the employer's acceptance was improper, claimant must still establish compensability of her "system complex" condition. We agree with the ALJ that claimant has not established that her chemical exposures at work have caused or worsened her diagnosed respiratory conditions.

Finally, since we have found that the employer's partial denial of claimant's other respiratory conditions 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 ALJ's order dated November 1, 1994 is affirmed.

In the Matter of the Compensation of
ESTELA VELAZQUEZ, Claimant
WCB Case No. 94-05931
ORDER ON REVIEW
Brad L. Larson, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the insurer's denial of claimant's occupational disease claim for a facial contact dermatitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer, a dry cleaning business, in June 1992. She was exposed to chemicals and steam at work.

In September 1993, claimant began noticing an itching rash on her face, which worsened gradually. She treated with Dr. Meckland.

Dr. Meckland diagnosed contact dermatitis and prescribed hydrocortisone cream. Claimant's condition improved gradually, but not completely. In November 1993, Dr. Meckland advised claimant to seek other employment.

In February 1994, claimant filed a claim for contact dermatitis. She also has a Rosacea condition, for which no claim has been filed.

In March 1994, claimant stopped working for the employer and began working for a different employer.

In May 1994, the insurer denied claimant's claim.

Claimant's contact dermatitis condition resolved sometime before Dr. Bell's June 22, 1994 examination.

FINDING OF ULTIMATE FACT

Claimant's employment conditions were the major contributing cause of her facial contact dermatitis condition.

CONCLUSIONS OF LAW AND OPINION

Claimant bears the burden of proving that her employment conditions were the major contributing cause of her facial contact dermatitis condition. See former ORS 656.802(1)(a); 656.802(2).¹

The ALJ concluded that claimant failed to carry her burden, based on a finding that the opinion of Dr. Meckland, treating physician, does not persuasively support the claim. The ALJ reasoned that Dr. Meckland's opinion is unpersuasive because he changed it without explanation and because his conclusions are inconsistent and essentially based on a mere temporal relationship between claimant's work and her skin problems. We disagree.

¹ ORS 656.802 was recently amended by the Legislature. SB 369, 68th Leg., Reg. Sess., §§ 56, 66(1) (June 7, 1995). We need not decide whether the amended version of 656.802 applies to this case because we conclude on this record that claimant has established that her work exposure is the major contributing cause of her condition and that is the standard of proof under either version of the statute.

Dr. Meckland was aware of claimant's medical and work history and he had numerous opportunities to examine her. (See Exs. A, 1). Following these examinations, Dr. Meckland repeatedly evaluated the relationship between claimant's exposures, symptoms, and treatment, ruled out other diagnoses (including atopic dermatitis, primary irritant dermatitis, and acne rosacea) and non-work related contributors, and concluded that claimant's contact dermatitis condition was work-related. (Exs. A, 1, 2A, 4A, 4B, 11-6, 11-10-11). His reasoning and conclusions are essentially uncontradicted. Under these circumstances, we find that Dr. Meckland's opinion relating claimant's dermatitis condition to her dry cleaning work is consistent, well-reasoned, and persuasive.

The only other medical evidence is provided by Dr. Bell, who examined claimant once on the insurer's behalf, after the contact dermatitis condition had resolved. Dr. Bell opined claimant probably had suffered an acute episode of contact dermatitis, but stated that vaporized chemicals at work "would certainly be a remote and unlikely cause" of that condition, without further explanation. (Ex. 8-2). However, he recommended, as did Dr. Meckland, that claimant not work under similar circumstances. Dr. Bell's only other comment regarding the causation of the dermatitis condition was "etiology?" (*Id.*).

On July 20, 1994, Dr. Meckland checked a box indicating concurrence with Dr. Bell's report. (Ex. 10). Thereafter, Dr. Meckland explained that he did not "change" his opinion by agreeing with Dr. Bell that the specific source of claimant's has not been identified. Instead, Dr. Meckland further explained that he believed (all along) that claimant's skin condition was related to her work exposure because her course of symptoms indicated that she had become sensitized to "something that she was working with." (Ex. 11-5). Once sensitized (between September 1993, when she began working for the employer and November 1993, when her symptoms prompted her to seek treatment), Dr. Meckland reported that claimant's condition regularly improved when she was away from work irritants.

Dr. Meckland acknowledged that claimant's condition improved somewhat, as expected, with hydrocortisone cream treatment. However, once symptoms were "triggered" and claimant was sensitized, Dr. Meckland anticipated that claimant's symptoms would flare-up again upon exposure to the irritants at work, despite her continued use of hydrocortisone cream). (Exs. 11-10-13). That is exactly what happened in claimant's case.

Thus, we are persuaded that Dr. Meckland's opinion that claimant's contact dermatitis is work related is not based solely on the temporal relationship between work and symptoms. Dr. Meckland's reasoning reveals that his conclusion also arises from knowledge of the mechanism of the disease and the ruling out of other potential causes. See Elizabeth E. Heller, 45 Van Natta 272, 275 (1993) (Where medical conclusions are based in part on doctors' diagnostic expertise and consideration of off-work causes, they are not based solely on a temporal relationship between exposure and symptoms). We further note that a claimant need not identify a particular (*i.e.*, exact) cause, if the persuasive evidence indicates that the condition is work related. See Volk v. Birdseye Division, 16 Or App 349 (1974).

In sum, because Dr. Bell offered no opinion regarding causation, Dr. Meckland's concurrence with Dr. Bell's report cannot be "inconsistent." In fact, Dr. Meckland's well-reasoned opinion that claimant's contact dermatitis condition is work related stands uncontradicted. Under these circumstances, we find Dr. Meckland's opinion persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, based on Dr. Meckland's opinion, we conclude that the claim is compensable.

Claimant's attorney is entitled to an assessed 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 fee for claimant's attorney's services at hearing and on review is \$3,000, payable 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 counsel may go uncompensated.

ORDER

The ALJ's order dated October 19, 1994 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded a \$3,000 attorney fee, payable by the insurer.

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Cite as 320 Or 509 (1995)

February 2, 1995

IN THE SUPREME COURT OF THE STATE OF OREGON

Edwin M. ERRAND, *Petitioner on Review,*

v.

CASCADE STEEL ROLLING MILLS, INC., an Oregon corporation, *Respondent on Review.*
(CC CV91283; CA A80487; SC S41195)

In Banc

On review from the Court of Appeals.*

Argued and submitted September 2, 1994.

Sharon C. Stevens, of Callahan and Stevens, Keizer, argued the cause and filed the petition for petitioner on review.

Ronald W. Atwood, of Williams, Zografos, Peck & Atwood, Portland, argued the cause for respondent on review. With him on the briefs was Brad G. Garber.

Robert Wollheim, of Welch, Bruun, Green & Wollheim, Portland, filed a brief on behalf of *amici curiae* Oregon Trial Lawyers Association and Oregon Workers' Compensation Attorneys.Deborah L. Sather, of Stoel Rives Boley Jones & Grey, Portland, filed a brief on behalf of *amicus curiae* Oregon Self-Insured Association.Jerald P. Keene, of Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland, filed a brief on behalf of *amici curiae* Associated Oregon Industries and Oregon Restaurant Association.

VAN HOOMISSEN, J.

* Appeal from Yamhill County Circuit Court, John W. Hitchcock, Judge. 126 Or App 450, 869 P2d 358 (1994).

320 Or 510 > The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed. The case is remanded to the circuit court for further proceedings.

Graber, J., dissented and filed an opinion, in which Carson, C. J., joined.

320 Or 512 > Plaintiff filed a complaint in circuit court against defendant, his employer, alleging statutory and common law negligence claims and seeking damages for economic losses, past and future medical bills, lost wages, and impairment of earning capacity. The trial court granted defendant's motion for summary judgment on the ground that defendant is immune from liability and that plaintiff's exclusive remedy is under the Workers' Compensation Law. ORS 656.018.¹ The Court of Appeals affirmed. *Errand v. Cascade Steel Rolling Mills, Inc.*, 126 Or App 450, 454-55, 869 P2d 358 (1994). For the reasons that follow, we reverse.

Plaintiff, a worker at defendant's manufacturing plant, had a preexisting condition of chronic infectious para-nasal sinusitis that was not caused by his current work experiences or environment. That preexisting condition, which predisposes plaintiff to experience airway irritation, became symptomatic due to his inhalation of substances in the workplace. Plaintiff sought treatment for his symptoms and

¹ ORS 656.018 provides in part:

"(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in this chapter.

* * * * *

"(2) The rights given to a subject worker and the beneficiaries of the subject worker for compensable injuries under this chapter are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury."

It is undisputed that plaintiff was a subject worker and defendant was a complying employer for purposes of ORS 656.018.

filed a workers' compensation claim. The insurer denied the claim, explaining that "it does not appear your condition was worsened by or arose out of and in the course of your employment, either by accident or occupational disease." Plaintiff appealed that denial.

320 Or 513> A referee defined the issue as whether plaintiff's work exposure caused or worsened his chronic infectious para-nasal sinusitis or "caused a complex of symptoms that would be recognized in workers' compensation law as a disease." After noting that plaintiff's sinusitis predisposed him to experience airway irritation, the referee found:

"Claimant does not have a reactive airway disease or occupational asthma. He does have transient irritation of the upper respiratory tract and paranasal sinuses as a result of inhalation of substances found in his workplace.

"Claimant's work exposure is not the major cause of his chronic infectious paranasal sinusitis.²

320 Or 514> The referee upheld the insurer's denial of the claim. In its final order, the Workers' Compensation Board adopted the referee's order and held that plaintiff had not established that his condition was compensable, because work was not the "major cause" of his condition. Plaintiff did not seek judicial review of the Board's order.

² ORS 656.005(7) provides in part:

"(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

"(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment.

"(b) 'Compensable injury' does not include:

"(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties;

"(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure; or

"(C) Injury the major contributing cause of which is demonstrated to be by clear and convincing evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption."

ORS 656.802 provides parallel provisions regarding "occupational disease":

"(1) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death * * *

* * * * *

"(2) The worker must prove that employment conditions were the major contributing cause of the disease or its worsening. Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings."

ORS 656.804 provides:

"An occupational disease, as defined in ORS 656.802, is considered an injury for employees of employers who have come under this chapter, except as otherwise provided in ORS 656.802 to 656.807."

Plaintiff then brought this action in circuit court against his employer, based on inhalation of and exposure to particulates in the workplace, alleging statutory and common law claims. Defendant moved for summary judgment, arguing that plaintiff's exclusive remedy is under the Workers' Compensation Law and that, under ORS 656.018, defendant is immune from liability. The trial court granted defendant's motion. The Court of Appeals affirmed, holding:

"With certain exceptions not involved here, if the Workers' Compensation Act is applicable, and if the employer has satisfied its obligation to comply with the requirements of the Act, then the employer's liability to the worker for the worker's work-related injury or condition is exclusively under the Act, and the Act is also the exclusive remedy for the injured worker. That is one part of the *quid pro quo* that underlies our workers' compensation system; the other part requires the employer to assume liability for work-related injuries without fault.

* * * * *

"The exclusivity of the Act is not limited to claims that are ultimately determined to be compensable." *Errand v. Cascade Steel Rolling Mills, Inc.*, *supra*, 126 Or App at 453-54 (emphasis in original).

Plaintiff argues on review that the exclusivity provisions of ORS 656.018 do not apply because, although his respiratory symptoms occurred in and were caused by the workplace, he did not have a "compensable injury," as defined in the Workers' Compensation Law and, therefore, he is not entitled to compensation for his condition. See ORS 656.005(7)(a) (defining "compensable injury"); ORS <320 Or 514/515> 656.018(1) (limiting complying employer's liability to that "arising out of compensable injuries"). From this, plaintiff further argues that the undisputed fact that he was not entitled to compensation under the Workers' Compensation Law demonstrates that his injury did not fall within the exclusivity provision of ORS 656.018. That is, plaintiff is arguing that even if he is a subject worker and defendant is a complying employer, ORS 656.018 does not apply in this case because, as a matter of law, his *condition* is not compensable.

Defendant responds that a mechanical application of the statutory definition of "compensable injury" to ORS 656.018 would defeat the legislative intent behind the exclusivity provision by allowing anyone whose claim is found not to be compensable to sue the employer in a civil action. Defendant asks this court to interpret ORS 656.018 as exclusive and in place of all other liability that an employer either has or might have if the employee's condition in question is "work-related" or "occurring at work." We first turn to the text of ORS 656.018 and to the definition of "compensable injury," ORS 656.005(7)(a), in the context of the Workers' Compensation Law, to discern whether the legislature intended that a civil claim such as plaintiff's be barred. See *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993) (to discern intent of legislature, court first examines the text and context of statute).

ORS 656.018(1) provides that a complying employer's liability "is exclusive and in place of all other liability arising out of *compensable injuries* to the subject workers * * *." ORS 656.018(2) likewise provides that the "rights given to a subject worker * * * for *compensable injuries* under this chapter are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, [except as otherwise provided in the Workers' Compensation Law]." (Emphasis added.)

ORS 656.003 provides that, "[e]xcept where the context otherwise requires, the definitions given in this chapter govern its construction." We turn to the issue whether the statutory definition of compensable injury applies to ORS 656.018. The wording of ORS 656.005(7)(a)(A), that "[n]o <320 Or 515/516> injury or disease is compensable as a consequence of a compensable injury," and the language of ORS 656.005(7)(a)(B), that certain conditions may be "compensable only to the extent the compensable injury is and remains the major contributing cause," provide, in essence, that certain injuries, diseases,

or conditions, although related to work, may *not* be "compensable" under certain circumstances, *i.e.*, unless the "major contributing cause" criteria found in sub-paragraph (A) or (B) are met.³

From the foregoing description of the text of the definition of "compensable injury" in ORS 656.005(7)(a), it appears to us that the legislature was using the word "compensable" to convey different meanings. In the main part of ORS 656.005(7)(a), the "compensable injury" referred to may be simply an "accidental injury" "arising out of and in the course of employment." However, the *limitations* set forth in subparagraphs (A) and (B) of ORS 656.005(7)(a) make it clear that one who suffers an "accidental injury" "arising out of and in the course of employment" as described in paragraph (a) nevertheless may have an injury that is not "compensable," unless the "major contributing cause" test has been met. ORS 656.005(7)(a)(A), (B); *see also SAIF v. Drews*, 318 Or 1, 8-9, 860 P2d 254 (1993) ("compensable injury" encompasses an application of the criteria found in ORS 656.005(7)(a), including the limitations found in sub-paragraphs (A) and (B) of that statute, in making initial determination of compensability).

The question is whether the legislature intended the exclusivity provision of ORS 656.018 to refer to some definition of compensable injury other than that set forth in ORS <320 Or 516/517> 656.005(7)(a), as qualified and limited by subparagraphs (A) and (B). *Cf. Dethlefs v. Hyster Co.*, 295 Or 298, 309-10 & n 10, 667 P2d 487 (1983) (in cases decided before the addition of subparagraphs (A) and (B) to ORS 656.005(7)(a), court indicated that legislative intent behind Workers' Compensation Law was to avoid common law litigation and to grant employers immunity against liability for compensable injuries, but also recognized that it "is arguable that an action for damages may be maintained against an employer of the worker if a disease or injury is not 'compensable'").

The definition of "compensable injury" found in ORS 656.005(7)(a), which includes the limitations found in subparagraphs (A) and (B), governs statutory construction of that term as used in the Workers' Compensation Law "[e]xcept where the context otherwise requires." ORS 656.003; *see also Astleford v. SAIF*, 319 Or 225, 232-33, 874 P2d 1329 (1994) (under ORS 656.003, a given statutory definition does not apply when the context, which includes the structure and purpose of the workers' compensation system as a whole, demonstrates that the use of the definition would be inappropriate); *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611 (use of same term throughout a statute generally indicates that the term has the same meaning throughout the statute).

In plaintiff's workers' compensation case, the referee denied compensation because plaintiff's symptoms were not the major contributing cause of his condition. Under ORS 656.802 (defining occupational disease), ORS 656.804 (occupational disease considered "injury" for purposes of Workers' Compensation Law), ORS 656.005(7)(a) (as interpreted by this court in *Drews*), and the facts as found by the referee and adopted by the Board, it has been established that plaintiff did not have the right to be compensated under the Workers' Compensation Law for the injury he suffered, as that term is defined and used in ORS 656.005(7)(a), in the light of the "major contributing cause" limitations found in ORS 656.005(7)(a)(A) and (B). The exclusivity provision of ORS 656.018 specifies that the liability of employers under the workers' compensation scheme "is exclusive and in place of *all other liability* arising out of compensable injuries to the subject workers[.]" ORS 656.018(1)(a) (emphasis added). In <320 Or 518/519> plaintiff's workers' compensation case, it was established that the employer *had no* liability to compensate plaintiff under the Workers' Compensation Law. By providing for an employer's freedom from "other" liability, it may be inferred from the exclusivity provision that there must exist, as a predicate for that freedom, some actual liability under the Workers' Compensation Law before the exclusivity provision may protect the employer from "all other liability." Thus, the text of the exclusivity provision, specifically its use of the term "liability," further supports the conclusion that the statutory definition of "compensable injury" applies to ORS 656.018.

³ In *SAIF v. Drews*, 318 Or 1, 8, 860 P2d 254 (1993), this court stated: "'Compensable injury' encompasses an application of the criteria found in ORS 656.005(7)(a), including the limitations found in subparagraphs (A) and (B) of that statute, in making an initial determination of compensability." Defendant here argues that "this court should interpret the word 'compensable' in ORS 656.018(1), as it recently did in *SAIF v. Drews, supra*, 318 Or at 8-9, to mean 'accidental.'" Defendant misreads this court's ruling in *Drews*. In *Drews*, this court did not find that the words "compensable" and "accidental" were interchangeable as used in ORS 656.005(7)(a). In setting forth the test for applying the definition of "compensable injury" in the context of ORS 656.308, this court in *Drews* described the injury discussed in the first part of ORS 656.005(7)(a) as an "accidental *injury*." However, this court went on to make it clear that the "accidental injury" so described was *not* compensable, unless the limitations in ORS 656.005(7)(a)(A) or (B), if applicable, were satisfied. *Id.* at 8-9.

We turn to the question of what the definition of "compensable injury" means. The dissent relies on the fact that specific types of injuries are excluded under ORS 656.005(7)(b), quoted *supra* at note 2, to try to demonstrate that the context requires that ORS 656.005(7)(a)'s definition of "compensable injury" covers every work-related injury that ORS 656.005(7)(b) does not exclude. The dissent argues, in effect, that the definition of "compensable injury" stops after the words "or resulting in disability or death" in ORS 656.005(7)(a), and that the balance of the text merely establishes conditions that may lead to non-payment of compensation for what otherwise is a compensable injury. We disagree. To the extent that the dissent is suggesting that unless something is specifically codified as "not a compensable injury" for purposes of ORS 656.005(7)(b), it therefore is a compensable injury for purposes of the exclusivity provision, the context certainly does not demonstrate that this is the only permissible construction of the statutes.⁴ The entire text of the statute is the legislature's definition of "compensable injury." The definition includes the limitations in subparagraphs (A) and (B). That is, unless the major contributing cause standard is satisfied, consequential conditions (sub-paragraph (A)) and resultant conditions (subparagraph (B)) are not "compensable injuries." When the legislature, in ORS 656.005(7)(a)(A), declares that "[n]o injury or disease is <320 Or 518/519> compensable" as a consequential condition, absent compliance with the major contributing cause proof standard, it is *defining* a compensable injury, not merely announcing further conditions under which a compensable injury will be paid. We apply the entire text, not only one part, of subsection (7)(a) as the relevant definition.

The dissent says that, if the legislature intended the "major contributing cause" limitations to apply to "compensable injuries" as used in the exclusivity provision, it would have put those limitations in ORS 656.005(7)(b) rather than in ORS 656.005(7)(a)(A) and (B). The context does not necessarily lead to this conclusion. ORS 656.005(7)(b) is part of the context of ORS 656.005(7)(a). The exclusions in ORS 656.005(7)(b) do not demonstrate that ORS 656.005(7)(a)(A) and (B) are merely limitations on "a subclass of compensable injuries" for which workers will not receive benefits," as the dissent asserts. 320 Or at 528. The conditions described in subparagraphs (7)(a)(A) and (B) are compensable injuries if their major contributing cause is a compensable injury, whereas the conditions described in subsection (7)(b) are not compensable injuries despite the existence of a causal link to an injury described in (7)(a). That distinction explains why the legislature defined the conditions under which "consequential" or "resultant" conditions are compensable injuries in ORS 656.005(7)(a)(A) and (B), rather than in the context of the conditions categorically excluded from "compensable injury" under ORS 656.005(7)(b).

The foregoing discussion explains why, in our view, plaintiff's argument about the scope of the immunity provided in ORS 656.018 appears more likely to be correct than does the argument of defendant. That is not to say, however, that defendant's construction of the relevant statutes is not plausible also. We conclude that, although the text and context of ORS 656.018 tend to support the conclusion that the legislature did not intend the exclusivity provision of that statute to bar a civil action where an injury has been determined not to be compensable because it was not a "major contributing cause" of a condition, the text and context of the relevant statutes do not settle the issue. We therefore turn to the legislative history of ORS 656.018 and ORS 656.005(7)(a) <320 Or 519/520> to aid in discerning the intent of the legislature. *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 610.

The exclusivity provision of ORS 656.018 was amended essentially to its present form in 1977. See Or Laws 1977, ch 514, § 1. We have found no legislative history that indicates that the 1977 amendments were intended to alter the scope of the exclusivity provision in any way relevant to the issue at hand. Before 1977, the relevant provisions were in essentially the same form as when they were enacted in 1965, when a major overhaul of the Workers' Compensation Law was undertaken, moving from elective to compulsory workers' compensation coverage:

"Every employer who satisfies the duty required by sub-section (1) of section 5 of this 1965 Act is relieved of all other liability for compensable injuries to his subject workmen, the workmen's beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries, except as specifically provided otherwise in ORS 656.002 to 656.590." Or Laws 1965, ch 285, § 6(1).

⁴ Although both ORS 656.005(7)(a) and (b) are part of the context of ORS 656.018, ORS 656.005(a) is more helpful to a determination of what ORS 656.018 means, because it states what a "compensable injury" *is*, while ORS 656.005(7)(b) only states what a "compensable injury" *is not*, at least under the described conditions.

The 1965 Workers' Compensation Law also introduced for the first time a statutory definition of "compensable 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; an injury is accidental if the result is an accident, whether or not due to accidental means." Or Laws 1965, ch 285, § 1(21).

We have examined the legislative history of the 1965 enactments and the later amendments to the exclusivity provision and the definition of "compensable injury" before 1990, and have found nothing that sheds light on the issue at hand. However, in *Cope v. West American Ins. Co.*, 309 Or 232, 236, 785 P2d 1050 (1990), a case decided before the 1990 amendments to ORS 656.005(7)(a), this court indicated that the statutory definition of "compensable injury" found in ORS 656.005(7)(a) applied to that term as it is used in the exclusivity provision of ORS 656.018(1)(a). See *Stephens v. Bohlman*, 314 Or 344, 350 n 6, 838 P2d 600 (1992) (this court's interpretation of a statute becomes a part of the statute as if written into it at the time of its enactment).

320 Or 521> The question is whether the 1990 legislature intended that its amended definition of "compensable injury," found in the current version of ORS 656.005(7)(a), would apply to the exclusivity provisions of ORS 656.018. If the legislature intended the new definition of "compensable injury" to apply, then the exclusivity provision would apply when the "accidental injury" "arising out of and in the course of employment" was the "major contributing cause" of a resulting or consequential condition requiring medical services. ORS 656.005(7)(a)(A), (B).

We turn to the history of the 1990 amendments to the Workers' Compensation Law, in which the definition of "compensable injury" was amended to include the "major contributing cause" limitations.⁵ It is clear from the text and the legislative history of the 1990 amendments that those changes were intended to have the effect of reducing the number of workers who could recover for work-related injuries under the workers' compensation system. See Or Laws 1990, ch 2, § 3 (Spec. Sess.) (changing requirements regarding objective findings and compensable injuries); Exhibit E, Joint Interim Special Committee on Workers' Compensation, May 5, 1990 (fiscal analysis showing cost savings expected from reducing number of compensable injuries); Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 7, Side B (testimony from various witnesses regarding fewer compensable injuries).

The legislative history of the 1990 amendments to the definition of compensable injury in ORS 656.005(7)(a) reveals that the joint committee reviewing the amendments considered the potential impact of the change in compensability on the exclusivity provision of the Workers' Compensation Law:

CHARLES WILLIAMSON, OREGON TRIAL LAWYERS ASSOCIATION: "* * * I think you may be overlooking a situation here where a worker is having a coffee break or a cigarette break on the loading dock and he gets run over by a forklift or some other negligence. Any worker that is injured <320 Or App 521/522> through the fault of another, if it's not going to be compensable, he's going to have a lawsuit against the employer, and the employee that was negligent. And so you're going to be taking cases out of the workers' comp system and putting them into the court system. Not completely, but just when it's someone else's fault, you will take those cases out of the workers' comp system."

* * * * *

REP. EDMUNSON: "The -let's use for example the major cause test. If work was, if something that happened at work was a material factor in an injury condition, but not the major factor, it would not be a compensable claim under the major cause test. So it wouldn't be covered under workers' comp laws. But if that material contribution at work was some negligent

⁵ The parallel provisions of ORS 656.802 (occupational disease) were amended at the same time to state the "major contributing cause" standard for occupational diseases. Or Laws 1990, ch 2, § 43 (Spec. Sess.).

act, by a co-worker or the employer failing to clean up the oil on the factory floor, then *that negligence would be the grounds of a lawsuit against the employer for premises liability or negligent care and control of his work-force.* The Court of Appeals ruled real recently that even though something happens at work, an injury happens at work, if it's not covered under workers' comp law, then all other civil remedies are available because there is no exclusive protection under the act. So *every time we make a work-related condition not compensable, we are exposing the employer to Civil liability.*" Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 7, Side B. (Emphasis added.)

"* * * * *

REP. EDMUNSON: "How about the earlier assertion that if an on-the-job condition does not qualify as a compensable claim, the employer would then be subject to liability for civil action?"

JERRY KEENE, WORKERS' COMPENSATION DEFENSE ATTORNEYS: "I need to see that case because *my understanding of the law is to the contrary*, and in fact I've won a few cases to the contrary, so I would need to see what you're talking about. I haven't seen that case yet."

REP. EDMUNSON: "Well, my principal point, Jerry, is if an injury is not compensable under the workers' comp laws -- "

KEENE: "-- civil liability --"

REP. EDMUNSON: "-then, you would agree that there is no exclusive remedy under the comp laws -"

320 Or 523> KEENE: "-No, that's not true -"

REP. EDMUNSON: "-- and therefore liability is, would have to be litigated as any other type of injury."

KEENE: "*Exclusive remedy applies so long as it is work-related, or within, for example, we've had decisions where an occupational disease was proven not to be the major contributing cause but was still partially work-related, it fell outside civil liability because exclusive liability applied. And whether that's a good result or not, I'm not saying. But I don't agree with your assessment of that blanket statement of the law.*"

REP. EDMUNSON: "Well, I, Mr. Chair, Madame Chair, I just want to direct Mr. Keene to section 18 of the act [ORS 656.018], *which says the liability for any employer who satisfies the duty is exclusive and in place of all other liability arising out of compensable injuries to subject workers. Therefore, if the injury is not compensable but is yet to a subject worker, I would submit that section 18 does not protect that employer from liability.*"

KEENE: "In the cases I've been involved in, they interpreted that as *potentially compensable.*"

REP. EDMUNSON: "Well, if it was clearly not compensable, would your answer change?"

KEENE: "Once it was litigated and turned out not to be? No. Because that's what happened in my case."

SEN. SHOEMAKER: "Chairman, I want to return to the hypothetical that Representative Mannix posed to an earlier witness and I believe -"

KEENE: "They didn't appeal, by the way." Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B (emphasis added).

Not surprisingly, that legislative history indicates that Williamson, a witness on behalf of the claimant's bar, essentially argued what plaintiff is arguing in the present case, and that Keene, a witness on behalf of the insurance defense bar, essentially argued what defendant is arguing in the present case. However, the exchanges quoted above also indicate that Representative Edmundson, one of the legislative committee members, believed that just as the definition of "compensable injury" narrowed, so also the exclusivity provision narrowed, because the new definition would apply to the term "compensable injuries" as used in ORS 656.018.

320 Or 524> During the House floor debate, Representative Edmundson made similar statements:

"[Speaking of the major contributing cause limitation] That means that if an older worker for example has a heart attack and its not the major cause and they don't get coverage, they may die, and their heirs or their family could have a lawsuit against the employer that is now presently is not allowed under Oregon law. The federal courts have made it pretty clear that -even something that happens at work if it's not compensable under the workers' comp laws, the employee can sue the employer. And I don't think that business has really thought this one through. I predict, and as you all know I practice this law, I predict were going to have some lawsuits that are going to surprise some employers when they find out they don't have insurance coverage for them. So, that's the downside on that, that I don't think - that I know some insurance people are a little concerned about that too." House Floor Debate, May 7, 1990, Tape 2, Side A.

Moreover, during that floor debate, Representative Dwyer commented:

"Representative Edmundson said it may subject a small employer, or an employer, to tort action, and I'm inclined to agree that you can't conceivably have an exclusive remedy that is no remedy at all and claim refuge under it." *Id.*, Tape 3, Side A.

No other legislator voiced disagreement with Representative Edmundson's and Representative Dwyer's conclusions during floor debate, and neither the amended definition of "compensable injury" nor the exclusivity provision of ORS 656.018(1) were further amended to address the issue.

We conclude that this legislative history supports a conclusion that the legislature intended the definition of "compensable injury" as amended in 1990 to apply in the context of the exclusivity provision of ORS 656.018(1).

Oregon courts long have recognized that the workers' compensation system involves a trade-off, offering certain advantages, as well as disadvantages, to both employers and employees. *See, e.g., Hale v. Port of Portland*, 308 Or 508, 521-22, 783 P2d 506 (1989) ("The scheme penalized some members of both camps those plaintiffs <320 Or 524/525> who could prove actionable negligence of their employers, and so obtain damages beyond their medical expenses, and other employers who could defeat liability either because they had not been negligent or because they could show the worker was guilty of contributory negligence or assumption of risk."); *McGarrah v. SAIF*, 296 Or 145, 160, 675 P2d 159 (1983) ("Workers' compensation systems are founded on political compromise."). Undoubtedly, the 1990 legislature changed the nature of the trade-off when it narrowed the definition of "compensable injury" in ORS 656.005(7)(a) to reduce the number of injuries that would be compensated under the Workers' Compensation Law. The history available to us does not, however, justify a conclusion that the 1990 legislature intended that change to work solely in favor of employers, thus relieving employers of liability while keeping the workers' end of the bargain unchanged.⁶

⁶ Because we decide this case on statutory grounds, we need not consider plaintiff's arguments based on Article I, section 10, of the Oregon Constitution ("every man shall have remedy by due course of law for injury done in his person, property, or reputation").

In sum, we conclude that the 1990 legislature intended the present definition of "compensable injury" in ORS 656.005(7)(a) to apply to ORS 656.018, because that result is consistent with the text and context of those statutes, because the context does not otherwise require, ORS 656.003, and because the legislative history supports that conclusion. Thus, we conclude that the exclusivity provision of ORS 656.018 does not provide defendant with immunity from plaintiffs civil claims here, because plaintiff did not have a "compensable injury" within the meaning of ORS 656.005(7)(a) and ORS 656.018(1).⁷

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed. The case is remanded to the circuit court for further proceedings.

⁷ Defendant expresses concern that interpreting the exclusivity provision in a manner that does not preclude civil actions for noncompensable conditions could lead injured workers to bypass the workers' compensation system entirely in order to take their cases before juries and that, had the legislature sought to provide workers with such an election to proceed outside the Workers' Compensation Law, such a policy choice would be evident from the law itself. Nothing in our decision here supports a conclusion that workers may elect to bypass the workers' compensation system. In view of the procedural posture of this case, we do not decide whether a Board determination that plaintiffs claim is not a compensable injury is a prerequisite to this action in circuit court.

320 Or 526 > GRABER, J., dissenting.

I dissent. In my view, the majority misreads the applicable statutes and, in doing so, undermines some of the fundamental purposes of the Workers' Compensation Law.

This case involves an application of the exclusivity provision of the Workers' Compensation Law, ORS 656.018, which provides in part:

"(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in this chapter.

* * * * *

"(2) The rights given to a subject worker and the beneficiaries of the subject worker for compensable injuries under this chapter are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury."

On review, plaintiff argues that the exclusivity provision does not bar a civil action against his employer because, although plaintiffs symptoms arose in the course and scope of his employment, plaintiff does not have a "compensable injury" as defined in ORS 656.005(7)(a). The majority agrees with plaintiffs argument.

Plaintiff and the majority are wrong. Plaintiff has a "compensable injury" within the meaning of ORS 656.005(7)(a), even though he did not carry the burden of proving that he should receive benefits. Plaintiff and the majority blur the distinction between "compensable injuries" (the scope of the Workers' Compensation Law) and "compensation" (entitlement to benefits). That distinction has been in the statutory scheme from its inception and, until now, the exclusivity <320 Or 526/527> provision has been construed to cover all "compensable injuries," even those that do not result in the payment of "compensation."

This court has established a method of construing statutes, which applies to the provisions in question. Our overriding aim is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). First, we examine the text and context of the statute. *Id.* at 610-11. When reading the text of a statute, certain principles apply, including the principle that the

text means what this court's prior interpretation thereof states. *Stephens v. Bohlman*, 314 Or 344, 350 n 6, 838 P2d 600 (1992). The context of a statute includes its historical development. *Krieger v. Just*, 319 Or 328, 336, 876 P2d 754 (1994). If the meaning of a statute is unclear from the text and context, the court looks to legislative history and then, if the meaning still is unclear, to "general maxims of statutory construction," to determine the legislature's intent. *PGE*, 317 Or at 611-12.

At present, ORS 656.005(7)(a) defines "compensable injury." It provides, as relevant here:

"A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence, supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

"(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

ORS 656.005(7)(a) supplies a two-step analysis. The *first* step is to decide whether a worker's injury falls within the definition -- *i.e.*, whether the worker's injury is a "compensable <320 Or 527/528> injury." If the worker's injury is a "compensable injury," then the second step is to take into consideration the "limitations" in subparagraphs (A) and (B). Those subparagraphs describe a subclass of "compensable injuries" for which workers will not receive benefits. In effect, subparagraphs (A) and (B) say that, even if a worker has a "compensable injury," the worker must prove that the "compensable injury" should be compensated; the worker must establish that the compensable injury in fact caused the harm complained of. Either the worker has a compensable injury for which the worker can receive benefits, or the worker has a compensable injury for which the worker can receive no benefits. Either way, however, every injury that is "an accidental injury * * * arising out of and in the course of employment" is a "compensable injury," no matter how sub-paragraphs (A) and (B) affect the workers' ability to collect benefits.¹

The foregoing reading of ORS 656.005(7)(a) is based on the plain grammar, structure, and logic of the paragraph. That reading is even clearer when that paragraph is contrasted to ORS 656.005(7)(b). ORS 656.005(7)(b) provides:

"'Compensable injury' does not include:

"(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties;

"(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure; or

¹ The majority argues that this court recognized a more limited definition of "compensable injury" in *SAIF v. Drews*, 318 Or 1, 8, 860 P2d 254 (1993). 320 Or at 516 n 3. The majority is wrong, for three reasons. First, the majority takes the sentence that it quotes out of context. The majority omits the cautionary sentence that limited the court's discussion to the narrow question presented: "As we interpret ORS 656.308(1) and 656.005(7)(a) together, they work in this case as follows[.]" *Drews*, 318 Or at 8. Second, and relatedly, *Drews* did not decide the issue that we must decide today. In *Drews*, this court was not faced with the question that we consider here, of defining the entire range of "compensable injuries."

Third, in its discussion of *Drews*, as in the remainder of the opinion, the majority makes the mistake of freely interchanging the distinct concepts of "compensable injury," "compensable," "compensation," and "compensated."

"(C) Injury the major contributing cause of which is demonstrated to be by clear and convincing evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the <320 Or 528/529> employer permitted, encouraged or had actual knowledge of such consumption." (Emphasis added.)

That is, paragraph (b) contains a list of *exclusions from the definition of "compensable injury."* By contrast, in ORS 656.005(7)(a), subparagraphs (A) and (B) are worded as "limitations" on what kinds of "compensable injuries" are "compensable" (that is, entitling the worker to receive benefits). Subparagraphs (A) and (B) limit the "compensable injuries" that may be "compensated" to those compensable injuries that the worker can prove under a specified standard. They are not, however, *excluded* from the definition of "compensable injury." For the purposes of the Workers' Compensation Law, the legislature has defined what is a "compensable injury" in ORS 656.005(7)(a) and what is *not* a "compensable injury" in 656.005(7)(b). When the legislature uses different terms in different sections of the same statute, it is deemed to do so intentionally, and we give effect to the difference. *See* PGE, 317 Or at 611 (stating general principle). Here, the majority has failed to give effect to the distinction between exclusions from the definition of "compensable injury" (ORS 656.005(7)(b)) and limitations on benefits pay-able for a "compensable injury" (ORS 656.005(7)(a)(A) and (B)).

In short, ORS 656.005(7)(a) simply recognizes that some "compensable injuries" will not in fact be compensated. We next must examine ORS 656.018. The pertinent part of ORS 656.018 provides that "[t]he 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." (Emphasis added.) The phrase that we are called on to interpret is the emphasized one.

The wording of that phrase covers *all* "compensable injuries" by its plain terms; it is not limited to those "compensable injuries" for which benefits are paid. The context of ORS 656.018 likewise supports an expansive reading. The context includes the policy statement in the Workers' Compensation Law, codified at ORS 656.012. ORS 656.012 suggests that the exclusivity provision should apply to all injuries <320 Or 529/530> that arise in the course and scope of employment. The legislature expressed its decision to reduce litigation, ORS 656.012(2)(b), and to expedite resolution of claims, ORS 656.012(2)(c). Those legislative decisions resulted from the legislature's finding that court procedures concerning injuries arising in the course and scope of employment lead to unnecessarily "long and costly litigation" that is detrimental to the economic welfare of society. ORS 656.012(1)(b).

Another principle comes into play in this case. As noted above, when this court construes a statute, that construction becomes part of the statute construed. This court has construed the exclusivity provision of the Workers' Compensation Law, which has remained essentially intact since enactment in 1913, to cover all work-related events unless a specific statutory exception applies (such as the exception for willful and unprovoked aggression).

In *Martelli v. R.A. Chambers and Associates*, 310 Or 529, 533-35, 800 P2d 766 (1990), this court discussed the history of the Workers' Compensation Law and of the exclusivity provision:

"Oregon's Workers' Compensation Law first came into being as an innovation adopted legislatively in 1913. Its original form included direct antecedents of present statutory provisions * * *. Oregon Laws 1913, chapter 112, section 12, in part provided:

"'[T]he right to receive such sum or sums [as workers' compensation] shall be in lieu of all claims against his employer on account of such injury or death except as hereinafter specially provided.'

* * * * *

"In return for immunity granted to his employer, the worker injured in the course of employment, and in a way defined by that act, was guaranteed compensation, regardless whether a fault or neglect on the part of the employer caused the injury, * * *

* * * * *

"* * * [T]he compensation law was extensively revised in 1965 * * *. The immunity of an employer from any worker's claims, other than for workers' compensation, was continued in section 6 of the 1965 Act, as worded in the 1913 Act * * * and now phrased in modern terms, in ORS 656.018(1) * * *."

320 Or 531> In *Olds v. Olds*, 88 Or 209, 213-14, 171 P 1046 (1918), the court held that the exclusivity provision of the 1913 Workers' Compensation Law "confers a special privilege upon an employer, thereby releasing him from the common-law liability to respond in damages for a personal injury that has been caused by his negligence, unless he formally renounces the benefits thus bestowed." That rule was restated in *Reynolds et al v. Harbert et al*, 232 Or 586, 591, 375 P2d 245 (1962); "[i]t is our conclusion that the statutory scheme was intended to provide that a workman covered by Chapter 656 must accept the benefits thereof as his exclusive remedy except in the enumerated situations mentioned in the statute." (Emphasis added.)² See also *Bigby v. Pelican Bay Lbr. Co.*, 173 Or 682, 689, 147 P2d 199 (1944) ("When a workman has become subject to the act he can not recover from his employer for injuries sustained by him, unless the facts give rise to one of the exceptions specified in the act."); *Ellis v. Fallert et al*, 209 Or 406, 413-14, 407 P2d 283 (1957) ("The Oregon Workmen's Compensation Act offers compensation to workmen who are within its purview for negligent and for non-negligent injuries and provides that such compensation is 'in lieu of all claims against his employer' except as provided * * * [T]he remedy under the act is exclusive." (emphasis in original)); *Shoemaker v. Johnson*, 241 Or 511, 519, 407 P2d 257 (1965) ("the rights and remedies provided by the act are exclusive "). In some of those cases, such as *Bigby*, this court recognized explicitly that exclusivity barred the claim even though the plaintiff could obtain nothing under the workers' compensation scheme. *Bigby*, 173 Or at 685-92.

When the legislature "continued" the exclusivity provision by simply updating its wording in 1965, the legislature effectively re-enacted the 1913 statute, with knowledge of how that statute had been interpreted by this court. See *Billings v. State Ind. Acc. Com.*, 225 Or 52, 56, 357 P2d 276 (1960) (this court assumes that, when the legislature re-enacts a section of a statute, it does so with knowledge of prior rulings by this court construing that statute).³

320 Or 532> This court has continued to read the post-1965 exclusivity provision to apply to all work-related injuries. Those interpretations are part of ORS 656.018 in its post-1965 form. See *Stephens*, 314 Or at 350 n 6 (stating principle).

In *Leech v. Georgia-Pacific Corp.*, 259 Or 161, 485 P2d 1195 (1971), this court concluded that the plaintiff, a dependent child of a deceased employee, was barred by the exclusivity provision of the workers' compensation statutes from bringing a civil action. In reaching that conclusion, the court stated:

"Subsection (1) [of ORS 656.018], however, makes it clear that * * * it provides for the employer's immunity from actions by workmen, their beneficiaries, 'and anyone otherwise entitled to recover damages from the employer on account of such injuries, * * *'. This provision indicates * * * that the legislature intended the remedy provided by compensation to be exclusive and that complying employers are not to be subject to negligence actions by persons omitted from the compensation benefit schedules." 259 Or at 165-66 (emphasis added).

The court held that the rationale of *Bigby* survived the 1965 amendments to the workers' compensation statutes and that exclusivity continued to bar claims related to on-the-job events even for those plaintiffs who could obtain no workers' compensation benefits. *Id.* at 164-66.

In *Duk Hwan Chung v. Fred Meyer, Inc.*, 276 Or 809, 556 P2d 683 (1976), a worker argued that the exclusivity provision should not control, because the employer had acted with the deliberate intention of causing injury or death to the employee; therefore, one of the statutory exceptions to the exclusivity provision applied. This court concluded that there was no evidence to suggest that the employer had

² The statutory exceptions included willful and unprovoked aggression, for example. ORS 656.156 (1961).

³ Before 1965, the Workers' Compensation Law contained no separate definition of "compensable injury." Rather, from 1913 to 1965, the definition was contained within the applicable exclusivity provision. From 1913 until 1965, the exclusivity provision applied to any employee "who * * * sustains an accidental injury * * * arising out of and in the course of his employment." See, e.g., ORS 656.152 (1963) (so providing). That is the same phrase used in ORS 656.005(7)(a) to define a "compensable injury." The scope of "compensable injury" covered under the Workers' Compensation Law has always been the same; since 1913, it has applied to accidental injuries arising in the course and scope of employment.

acted with the deliberate intention to injure the employee or someone else, and it affirmed the trial court's grant of summary <320 Or 532/533> judgment in the employer's favor. 276 Or at 513-14. The court noted that "[t]he Workmen's Compensation Law provides the sole and exclusive remedy for injuries sustained by a workman in the course and scope of his employment when the employer is subject to and fully complying with the provisions of the Act, unless the facts give rise to one of the exceptions specified in the Act." *Id.* at 812. *See also Nicholson v. Blachly*, 305 Or 578, 581, 753 P2d 955 (1988) ("The exclusive remedy of injured employes against their employers for injuries suffered in the course and scope of employment is to receive workers' compensation benefits.").

This court has construed ORS 656.018 and its predecessors consistently to grant immunity with respect to all accidental injuries that arise in the course and scope of employment, *i.e.*, all "compensable injuries." At the same time, it always has been true that a worker can sustain a compensable injury (on-the-job event) but collect no compensation (benefits). Over the years, this court has recognized that fact in three categories of cases.

One category of such cases recognizes that a worker can sustain an on-the-job injury but collect no benefits due to an extrinsic reason, such as untimeliness of the claim. *Rhode v. State Industrial Acc. Com.*, 108 Or 426, 217 P 627 (1923), is the earliest example. In *Rhode*, this court held that a worker who suffered an accidental injury in the course and scope of employment, but who failed to adhere to the procedural requirements of the statutes, was not entitled to relief. The court stated:

"The case, like so many other accidents, presents pitiable features, but whosoever claims under the statute must bring himself within its terms. This the claimant has not done in this instance, and as a matter of law he is not entitled to relief in these proceedings." 108 Or at 441.

The court never has deviated from that holding and has restated it repeatedly. *See, e.g., Dragicovic v. State Industrial Acc. Com.*, 112 Or 569, 571, 230 P 354 (1924) (court will not "entertain" claim that is untimely filed); *Rosell v. State Ind. Acc. Com.*, 164 Or 173, 192, 95 P2d 726 (1940) (same); *Landauer v. State Ind. Acc. Com.*, 175 Or 418, 421, 154 P2d 189 (1944) (same); *Johnson v. Compensation Department*, 246 Or 449, 452, 425 P2d 496 (1967) (same); *Colwin v. <320 Or 533/534> Industrial Indemnity*, 301 Or 743, 748, 725 P2d 356 (1986) ("a claimant may not avoid the notice requirements if the [employer] has clear procedures for reporting accidents and injuries and the employe knows or should know of and is able to follow the procedures, but does not").

A second category of cases recognizes that a worker can sustain an on-the-job injury but collect no benefits due to an intrinsic reason, such as failure to sustain the applicable burden of proof. *Vale v. State Ind. Acc. Com.*, 160 Or 569, 86 P2d 956 (1939), is the earliest example of a case in this second category. In *Vale*, the plaintiff, survivor of a deceased worker, claimed that the worker's death was caused by an accident arising in the course and scope of the worker's employment. The plaintiff argued that the worker's death had resulted from contaminated food that the employer had provided to the worker. The court stated:

"In view of the vague character of the evidence which furnished the hypothesis for the medical testimony * * * we are constrained to hold that the plaintiff has failed to sustain the burden of proving that the decedent's death was caused by contaminated food furnished by his employers." 160 Or at 577.

Again, the court never has deviated from that holding and has restated it repeatedly. *See, e.g., McKay v. State Ind. Acc. Com.*, 161 Or 191, 200, 87 P2d 202 (1939) ("there is no evidence [that worker's being struck by lightning in the course and scope of employment resulted in] injury to the decedent's heart. It is a mere possibility lacking proof"); *Dimitroff v. State Ind. Acc. Com.*, 209 Or 316, 323, 306 P2d 398 (1957) ("We have repeatedly held that a claimant under the Act has the burden of proof to show that he is entitled to compensation."); *Grandell v. Roseburg Lbr. Co.*, 251 Or 88, 91, 444 P2d 944 (1968) (upholding denial of benefits to worker because "work activity was not a material contributing factor in producing his heart attack"); *Marston v. Compensation Department*, 252 Or 640, 644, 452 P2d 311 (1969) ("[s]ince there is a total lack of medical testimony that the bumping of claimant's head either caused or contributed to his condition, there is no evidence to support [an award of compensation]"); *Weller v. Union Carbide*, 288 Or 27, 30, 602 P2d 259 (1979) (worker failed to offer sufficient evidence to <320 Or 534/535> "establish * * * a worsening of the underlying disease"); *Harris v. SAIF*, 292 Or 683, 689, 642 P2d 1147 (1982) (in order to collect under the Workers' Compensation Law, claimant "has the burden of proving that he is so disabled").

A third category of cases recognizes that a worker can sustain an on-the-job injury but collect no benefits due to statutory limits on the nature of benefits payable. *Leech v. Georgia-Pacific Corp.* is an example. In that case, a person (a dependent child of a deceased worker) was omitted from the compensation benefit schedule with respect to an on-the-job injury of the deceased worker. As noted above, the dependent child was barred by the workers' compensation exclusivity provision from pursuing a civil action. 259 Or at 170. See also *Bigby v. Pelican Bay Lbr. Co.*, *supra*, 173 Or at 692 (beneficiary omitted from compensation schedule could obtain nothing under Workers' Compensation Law, but still was barred from bringing a civil action). More recently, in *Hathaway v. Health Future Enterprises*, 320 Or 383, 386-87, 884 P2d 549 (1994), and *Nicholson v. Salem Area Transit*, 320 Or 391, 395, 884 P2d 864 (1994), this court recognized that "palliative care" is not compensable even though a worker has suffered a compensable injury for which the palliative care is given.

The foregoing cases, which span the whole history of workers' compensation in Oregon, show that this court has recognized that workers' compensation is the exclusive remedy available to workers covered under the Workers' Compensation Law for accidental injuries that arise in the course and scope of their employment, while at the same time recognizing that not all compensable injuries result in an award of compensation. The majority focuses on the words "liability" and "other liability" in ORS 656.018(1)(a), asserting that they imply "that there must exist, as a predicate for that freedom [from civil suit on the part of the employer], some actual liability under the Workers' Compensation Law." 320 Or at 518. The majority errs in that analysis. The term "liability" does not necessarily mean responsibility to pay money; it may refer to liability to defend against an action or claim, whether or not the employer ultimately is obliged to pay. There are two reasons why the latter reading, rather than the majority's reading, is the applicable one. First, the <320 Or 535/536> context suggests it. ORS 656.018(2) contains a provision parallel to ORS 656.018(1)(a), which limits the worker to act under the workers' compensation system for compensable injuries; "the right * * * to bring suit against the employer," not an obligation to pay money, is the core concern. Second, this court's prior cases -which are part of the statute -uniformly have interpreted ORS 656.018 in a manner that is at odds with the majority's interpretation.

To use a metaphor: the land of workers' compensation benefits that actually are available has never abutted the land of permissible civil actions. Between those lands has flowed a river of "compensable injuries" for which no benefits are available and for which no civil action may be brought. That river is formed by the three streams described above (intrinsic reasons why a compensable injury results in no compensation, extrinsic reasons for that result, and statutory limits on the nature of benefits payable). Today the majority makes a radical departure from those established principles.

The majority bases that departure on the 1990 amendments to ORS 656.005(7)(a), when the legislature amended the definition of "compensable injury" to include the "major contributing cause" "limitations" contained in ORS 656.005(7)(a)(A) and (B). The majority concludes that the 1990 amendments narrowed the definition of "compensable injury" and "so also the exclusivity provision narrowed." 320 Or at 523. But the 1990 amendments did not narrow the exclusivity provision.

Before 1990, the Workers' Compensation Law applied to all accidental injuries "arising out of and in the course of employment." The current definition of "compensable injury" likewise encompasses all accidental injuries "arising out of and in the course of employment." Accordingly, what is covered by the concept of "compensable injury" has not changed. The only thing that has changed is how much causation a worker needs to show to receive compensation for certain compensable injuries. A worker must now show that the compensable injury is the "major contributing cause" of the consequential condition, disability, or need for treatment in certain circumstances. Before 1990, there was no such statutory requirement. Thus, the 1990 change was a <320 Or 536/537> change of degree, not a change of coverage of the Workers' Compensation Law.

To return to the earlier metaphor, the legislature can change the boundary line and create, for the first time, contiguity between the land of workers' compensation benefits that actually are available and the land of permissible civil actions. The legislature also can narrow or widen the river that now exists between those lands -the river of compensable injuries for which no benefits are available and for which no civil action may be brought (subject only to constitutional limitations, which, as noted below, are not at issue in this case). The question before us is which of those changes the 1990 amendment to ORS 656.005(7)(a) wrought. In my view, ORS 656.005(7)(a) plainly constitutes a slight widening of the river.

As the discussion above shows, the text and context of the Workers' Compensation Law (including this court's prior interpretations and the historical development of the statutes) make clear the definition of "compensable injury" contained in ORS 656.005(7)(a) and applied to ORS 656.018 and the legislative intent behind those provisions. Thus, the court's inquiry should stop here. *See PGE*, 317 Or at 611 (explaining methodology).

The majority finds ambiguity in the statute where there is none, by confusing "compensable injuries" with "compensation" and by ignoring the difference between ORS 656.005(7)(a) and (b). Because of the alleged ambiguity, the majority then proceeds to analyze the legislative history of the 1990 amendments to the definition of "compensable injury," ORS 656.005(7)(a). From that scant legislative history, the majority concludes that plaintiff's claim is not a "compensable injury" under the definition provided in ORS 656.005(7)(a) and, therefore, that the exclusivity provision does not apply. The majority thus concludes that the legislature made a geologic change that eliminated the river of compensable injuries for which no benefits are available and for which no civil action may be brought.

Assuming that the statutes are ambiguous and that an inquiry into legislative history is called for, the material on which the majority relies does not support its drastic result. <320 Or 537/538> First, the legislative history of the 1990 amendment to ORS 656.005(7)(a) is not clear. Conflicting testimony before the Joint Special Committee on Workers' Compensation and statements on the House floor concerning how federal courts have interpreted *other* workers' compensation statutes does not provide a clear indicator of legislative intent. Further, the statement on the House floor by Representative Dwyer, quoted by the majority - that he was "inclined to agree" that the major-contributing-cause test "*may* subject * * * an employer[] to tort action" - does not resolve this ambiguity in legislative intent, but rather heightens it. 320 Or at 524 (emphasis added). His is not a statement of certitude; it is a statement of possibility.

In addition, there was no amendment to ORS 656.018 before the legislature. Most of the discussion quoted by the majority related to witnesses' and legislators' understanding of ORS 656.018. 320 Or at 521-24. To the extent that legislators were commenting on their understanding of that long-existing provision, their comments have no bearing on what ORS 656.018 meant. *See DeFazio v. WPPSS*, 296 Or 550, 561, 679 P2d 1316 (1984) ("The views legislators have of existing law may shed light on a new enactment, but it is of no weight in interpreting a law enacted by their predecessors.").

The majority also discusses the legislative history of ORS 656.005(7)(a) without giving effect to the legislative history of the whole package of interrelated 1990 amendments to the Workers' Compensation Law. The broader purposes of the 1990 amendments to the Workers' Compensation Law are revealed by the legislative history of the 1990 special session during which the legislature revised that law extensively. The underlying theme of all the 1990 amendments was to make the system more cost-effective for employers and more efficient. *See* Exhibit B, Interim Special Committee on Workers' Compensation, May 3, 1990 (letter from the Governor's Workers' Compensation Labor Management Advisory Committee to Governor Neil Goldschmidt proposing changes to Workers' Compensation system, requested by Governor Goldschmidt, to "control the costs of Oregon's workers' compensation program"); Exhibit P, Interim Special Committee on Workers' Compensation, May 3, 1990 (summary fiscal analysis provided by Legislative <320 Or App 538/539> Fiscal Office concerning "anticipated premium reductions" associated with the proposed changes); Exhibit F, Interim Special Committee on Workers' Compensation, May 7, 1990 (analysis provided by SAIF Corporation discussing cost savings under proposed changes); Testimony of Matt Hersee, Administrator, Workers' Compensation Division, Department of Insurance and Finance, Interim Special Committee on Workers' Compensation, May 7, 1990, Tape 26, Side A (discussing anticipated savings that will result from proposed changes). As the discussion below will demonstrate more fully, the majority's interpretation of ORS 656.005(7)(a) is at odds with that theme.⁴

⁴ This case presents an opportunity to make a general observation about the use of legislative history. Much of the majority's discussion concerns statements of two witnesses before a committee and of two legislators. Much of the dissent's discussion concerns the manifest general intention of the legislature in enacting the 1990 amendments to the workers' compensation laws. In general, an examination of legislative history is most useful when it is able to uncover the manifest general legislative intent behind an enactment. By contrast, an examination of legislative history is most fraught with the potential for misconstruction, misattribution of the beliefs of a single legislator or witness to the body as a whole, or abuse in the form of "padding the record" when the views of only a small number of persons on a narrow question can be found.

To summarize, the 1990 legislative history itself is unclear. The majority errs by relying on it.

If the majority were correct in finding an ambiguity, then, the second step in statutory interpretation (legislative history) would not resolve such an ambiguity. The third level of analysis would be required, that is, the application of maxims of statutory construction. See *PGE*, 317 Or at 612 (describing methodology). The majority's result could not survive at that third level, because its reading of ORS 656.005(7)(a) violates the principle that a statute should not be construed to produce an unreasonable or absurd result. See *State v. Garcias*, 298 Or 152, 159, 690 P2d 497 (1984) (stating principle). As has already been mentioned, one of the chief objectives of the workers' compensation statutes is to reduce the litigation and social costs of having workers and employers fully litigate claims concerning workplace injuries. By adopting a workers' compensation system, the legislature hoped to reduce costs for all parties involved and find a comprehensive and efficient means of dealing with on-the-job injuries. See ORS 656.012(2)(d) (stating objectives of the <320 Or 539/540> Workers' Compensation Law); see also *Bigby*, 173 Or at 692 (stating purposes of pre-1965 version of Workers' Compensation Law). The position taken by the majority seriously undermines that objective by making the overall incentives of the workers' compensation system topsy-turvy and irrational.

After today, an injured worker will seek to pursue a worker's compensation claim as limply as possible, so as to achieve the goal of having the Workers' Compensation Board declare the claim noncompensable.⁵ Once noncompensability is determined, the worker can then bring a civil action against the employer and avoid the exclusivity provision altogether. By creating a system in which workers have an incentive to pursue litigation to acquire damages for work-related injuries, the majority jeopardizes the receipt of "prompt" medical treatment and the assurance of income benefits (contrary to the policies set out in ORS 656.012(2)(a), (c)) and increases litigation (contrary to the policy set out in ORS 656.012(b)). Indeed, the more serious the worker's condition, the greater the incentive to pursue a civil claim and the greater the trespass on the legislatively stated policies.

The implications of today's decision for employers and their insurers are equally peculiar. The employer, who now has the incentive to resist workers' compensation claims, will take up the position presently occupied by the injured worker, that is, attempting to have the claim declared compensable, so as to retain the protection of ORS 656.018. The workers' compensation insurance carrier, who now has the same incentive as the employer to resist claims, will be opposed to the employer's interest and will instead have the same goal as the worker, to have the claim declared noncompensable, so the insurer will not have to pay the claim unless the same carrier also happens to cover the employer for general liability insurance.

Self-insured employers will pay non-meritorious claims to eliminate the risk of civil actions, and insured employers will encourage their insurers to do the same. That <320 Or 540/541> practice, although costlier than present practices, would be a reasonable way to avoid even greater costs, and potential awards of damages, associated with litigation. The greater costs will be passed on to consumers, workers, and employers. The speedy, efficient, and costs effective resolution of claims concerning on-the-job injuries, desired by the legislature, will become more difficult.

In short, the majority's reading of ORS 656,005(7)(a) undercuts the *raison d'être* of the workers' compensation system. The workers' compensation system represents a legislatively mandated "bargain" between employers and workers. The system gives workers the opportunity to seek compensation for work-related injuries and diseases without the need to prove fault on the employer's part; in exchange, workers give up the right to sue the employer for work-related injuries and diseases. Workers benefit from the security of knowing that, if they prove their claims, they will be compensated quickly; employers benefit from limited liability and reduced litigation costs. That bargain is implicit in the policy statement accompanying the Workers' Compensation Law, ORS 656.012, and has been recognized by this court.

In *Hale v. Port of Portland*, 308 Or 508, 521-22, 783 P2d 506 (1989), this court described the bargain this way:

⁵ The majority blithely assumes, by way of a footnote, 320 Or at 525 n 7, that an injured worker could not "elect to bypass the workers' compensation system," but fails to explain why not. For the purpose of this dissent, however, I accept the assumption.

"[T]he Oregon legislature * * * eliminated the haphazard system of liability of employers to some employees for some injuries occurring under a limited number of circumstances, and replaced it with a system that made employers liable for the medical expenses of their injured workers without regard to fault. The scheme penalized some members of both camps -those plaintiffs who could prove actionable negligence of their employers, and so obtain damages beyond their medical expenses, and those employers who could defeat liability either because they had not been negligent or because they could show the worker was guilty of contributory negligence or assumption of the risk."

See also McGarrah v. SAIF, 296 Or 145, 160-61, 675 P2d 159 (1983) ("In exchange for * * * relief under this no-fault recovery system, employees are limited to a fixed schedule of recovery and must abandon any common law right of action against their employers.")

320 Or App 542> The overall bargain suggests that the employer is not civilly liable for on-the-job activities and conditions if the employer provides the required workers' compensation coverage and if those activities and conditions fall short of being willful and unprovoked aggression. *See* ORS 656,018(3) (exemption from liability does not apply when injury caused by willful and unprovoked aggression of person otherwise exempt). The majority's interpretation of the statutory definition of "compensable injury," however, guts the bargain. Every claimant will have the opportunity and the incentive to try to "opt out" of the workers' compensation system. The legislature did not intend that result.

Under a proper reading of ORS 656,005(7)(a), plaintiff has a compensable injury, because he has an "injury * * * arising out of and in the course of employment." The Board found that plaintiff has "transient irritation of the upper respiratory tract and paranasal sinuses *as a result of inhalation of substances found in his work place.*" (Emphasis added.) The Board then held that "[t]he medical evidence, however, does not support the conclusion that [plaintiff] has a compensable disease," because "[h]is symptomatic response to irritants is not a pathological process." In other words, although plaintiffs injury arose out of and in the course of his employment (was a compensable injury), the evidence adduced at the hearing did not entitle plaintiff to collect benefits.⁶

Whether or not plaintiff received benefits, defendant's asserted liability here "arise[es] out of compensable injuries" and, therefore, the workers' compensation system <**320 Or 542/543**> "is exclusive and in place of all other liability." ORS 656,018(1). Plaintiff thus is foreclosed, under ORS 656.018(2), from pursuing the present action. Accordingly, the decision of the Court of Appeals and the judgment of the circuit court should be affirmed.

For the foregoing reasons, I respectfully dissent.

Carson, C. J., joins in this opinion.

⁶ Plaintiff argues that such a result would be contrary to Article I, section 10, of the Oregon Constitution, which provides in part that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation." Plaintiff did not preserve that argument below; therefore, this court should not consider it. *See Leiser v. Sparkman*, 281 Or 119, 122, 573 P2d 1247 (1978) ("The parties to an appeal are restricted to the theory upon which [the case was tried] in the court below.").

I would note, however, that the workers' compensation scheme has withstood Article I, section 10, challenges since *Evanhoff v. State Industrial Acc. Com.*, 78 Or 503, 517-18, 154 P 106 (1915). Recently, in *Hale v. Port of Portland*, 308 Or 508, 523, 783 P2d 506 (1989), this court again stated that, so long as the party injured is not left without a remedy, Article I, section 10, is not violated. As discussed above, plaintiff is not left without a remedy. Plaintiff has a remedy, because he had an opportunity to prove that his condition was compensable; he has simply failed to prove his case.

Cite as 132 Or App 620 (1995)

February 8, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Craig L. Hiatt, Claimant.

Craig L. **HIATT**, *Petitioner*,
v.
HALTON COMPANY, *Respondent*.
(92-14383; CA A83240)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 16, 1994.

Donald E. Beer argued the cause for petitioner. With him on the brief was Popick & Merkel.

Kenneth L. Kleinsmith argued the cause for respondent. With him on the brief was Meyers, Radler, Replogle & Bohy.

Before Riggs, Presiding Judge, * and De Muniz and Leeson, Judges.

De MUNIZ, J.

Reversed and remanded for reconsideration.

* Riggs, P. J., *vice* Rossman, P. J., retired.

132 Or App 622> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in holding that employer could contest the compensability of claimant's "left hearing loss."

Claimant was injured at work when a burning hot metal slag popped into his left ear. Employer accepted a claim for left otitis media, left middle ear infection. On April 13, 1992, a determination order awarded claimant permanent partial disability compensation for six percent loss of hearing in the left ear. Employer did not request a hearing on the determination order, and it became final. On November 2, 1992, employer denied the compensability of the "left hearing loss," based on new medical evidence that showed that the hearing loss preexisted the on-the-job injury and was not work related.

The referee set aside the denial, concluding that employer was barred from denying the compensability of a disability that had been finally determined by a determination order. The Board reversed the referee, holding that, although it was the law of the case that claimant has "left hearing loss" as a result of the compensable injury, the denial of noise-induced hearing loss is not barred by principles of *res judicata*, because the medical evidence shows that claimant's noise-induced hearing loss bears no relationship to his employment, and therefore the hearing loss is treated as a separate claim that can be separately litigated.

We agree with claimant that the Board erred. At the time the determination order was issued, Dr. Dowsett, claimant's treating physician, was of the view that claimant's hearing loss was attributable to his injury. At that time, however, Dowsett had not seen claimant's pre-employment audiogram, performed before the injury, which showed noise-induced hearing loss in the left ear. Other doctors who examined claimant after the determination order was issued, and in the context of this proceeding, have concluded that claimant's hearing loss, if any, is not related to the burn injury. There is no medical evidence now in this record that indicates that claimant has any hearing loss that is not the result of noise. Nonetheless, the determination order made <132 Or App 622/623> an award for hearing loss and that order has become final. Employer could have sought a hearing on the 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, we conclude that claim preclusion bars it from later arguing that the condition for which the award was made is not part of the compensable claim. *Messmer v. Deluxe Cabinet Works*, 130 Or App 254, 881 P2d 180 (1994), *rev den* 320 Or 507 (1995).

Reversed and remanded for reconsideration.

Cite as 133 Or App 13, 889 P2d 1351 (1995).

February 15, 1995

Court of Appeals of Oregon.
Argued and Submitted Nov. 1, 1994.

**In the Matter of the Compensation of Marvin L. Thrasher, Sr., Claimant.
Marvin L. THRASHER, Sr., Petitioner,**

v.

**REYNOLDS METALS and Cigna Insurance Companies, Respondents.
WCB 92-02339; CA A79516.**

Susan Frank, Portland, argued the cause, for petitioner. On the brief were Kevin Keaney and Pozzi, Wilson & Atchison.

Montgomery W. Cobb, Portland, argued the cause and filed the brief, for respondents.
Before WARREN, P.J., and EDMONDS and LANDAU, JJ.

WARREN, Presiding Judge.

133 Or App 15> Claimant seeks review of an order of the Workers' Compensation Board denying him additional compensation for chondromalacia. We reverse.

Claimant injured his knee at work. A determination order awarded him nine percent scheduled permanent disability, based on reduced range of motion. Claimant requested reconsideration, arguing that he was entitled to further compensation because of impairment resulting from chondromalacia in the knee, and asking that the Director of the Department of Consumer and Business Services promulgate a temporary rule to address the chondromalacia. The order on reconsideration reduced his award to six percent. The Director did not promulgate a temporary rule.

Thereafter, the Director promulgated a temporary rule addressing chondromalacia. On appeal, the Board considered claimant's request for additional compensation for chondromalacia in light of the new temporary rule. It declined to award additional compensation for the chondromalacia because it held that the doctor's report was "not in conformance with the requirements of" the temporary rule, and therefore the doctor's report was not persuasive.

Employer says that this case is just like *Cooney v. Safeway Stores, Inc.*, 125 Or App 536, 865 P.2d 499 (1993). In that case, the claimant was denied additional compensation for chondromalacia. As in this case, there were no standards addressing chondromalacia when the order on reconsideration issued. On appeal of the reconsideration order, the Board found the medical report, which was written before the temporary rule was promulgated, "not persuasive," because it was "not in conformance with the requirements" of the temporary rule. Because the Board was required to apply the disability rating standards that were in effect on the date the order on reconsideration was issued, and there were no rules regarding chondromalacia at that time, we held that the Board should have remanded to the Director to adopt an appropriate rule. This case presents exactly the same situation and requires the same result.

Reversed and remanded with instructions to remand to Director of Department of Consumer and Business Services.

Cite as 133 Or App 16, 889 P2d 1305 (1995)

February 15, 1995

Court of Appeals of Oregon.
Argued and Submitted Dec. 7, 1993.

**In the Matter of the Compensation of Manuel Altamirano, Claimant.
Manuel ALTAMIRANO, Petitioner,**

v.

**WOODBURN NURSERY, INC., and EBI Companies, Respondents.
91-00697; CA A79706.**

Edward J. Harri, Salem, argued the cause, for petitioner. On the brief were Michael B. Dye and Stanley Fields.

Howard R. Nielsen, Portland, argued the cause and filed the brief, for respondents.
Before WARREN, P.J., and EDMONDS and LANDAU, JJ.

WARREN, Presiding Judge.

133 Or App 18 > Claimant seeks review of an order of the Workers' Compensation Board that affirmed employer's denial of his "current condition." Claimant also challenges the Board's denial of his request for interim compensation. We reverse.

The Board's findings are unchallenged. Claimant was employed as a nursery worker when he compensably injured his low back on February 22, 1990. Claimant was diagnosed with an acute lumbar strain, and employer accepted the claim. He returned to work in March, 1990, and his claim was closed on September 25, 1990.

Claimant continued to work until October 31, 1990, when his back pain increased and radiated down his leg. A CT scan showed a bulging disc at L5- S1. Claimant was released to sedentary work. In early December, 1990, claimant was no longer working. His physician believed that claimant was developing functional overlay.

On December 10, 1990, claimant sought treatment from Dr. Buttler, a chiropractor and naturopath. On the "Change of Attending Physician" form, Buttler noted that claimant's condition had worsened and that he was unable to work. In January, 1991, claimant was examined by Dr. Mitchell, who diagnosed chronic lumbar strain and suggested continued chiropractic treatment. Claimant was released to work in March, 1991. In May, he was examined for employer by an orthopedic surgeon and a chiropractor. He was diagnosed with lumbar strain, shallow left lumbar scoliosis, L5-S1 disc bulge and moderate to severe functional overlay.

On August 15, 1991, employer sent a letter denying reopening for aggravation, as well as the compensability of claimant's L5-S1 disc bulge, functional overlay, and claimant's then current condition. The Board set aside the denial of the aggravation claim and upheld the denials of the L5-S1 disc bulge and functional overlay, and the denial of claimant's then current condition. According to the Board, there was no indication at the time of denial that claimant required any medical services or that he was suffering any disability. The Board also held that claimant was not entitled to temporary disability benefits beginning on the date his claim for aggravation was made. It disagreed with claimant's assertion that <133 Or App 18/19> Buttler's December 10, 1990, letter taking claimant off work provided a basis for interim compensation, reasoning that the December 10 report was from a chiropractor, who was not authorized to be an attending physician who could authorize time loss. Claimant seeks review, claiming that employer improperly denied the current condition, and that he is entitled to interim compensation beginning on the date of Buttler's letter.

Claimant first assigns error to the Board's upholding the August 15, 1991, denial of his "then current condition." He argues that, because there was no claimed need for treatment at that time, the denial of his current condition constituted an invalid prospective denial. He asserts that the denial must

have been intended as a denial of the compensability of his condition as of December, 1990, the date of the aggravation claim, and that that claim was accepted by order of the Board. Employer responds that the denial was for claimant's condition as of August 15, 1991, the date the denial was issued, and that it was entitled to deny that condition, because an employer can deny a current condition, so long as it does not deny future medical treatment or benefits. See *Boise Cascade Corp. v. Hasslen*, 108 Or App 605, 816 P2d 1181 (1991); *Green Thumb, Inc. v. Basl*, 106 Or App 98, 806 P2d 186 (1991).

At the outset, we reject claimant's assertion that the denial related to his condition as of December, 1990. The denial letter sent by employer referred to his "then current condition." That letter was dated August 15, 1991. There is nothing in the letter that could be read to relate the denial to anything other than claimant's condition as of the date of the letter.

An employer may not deny future benefits or disability on an accepted claim. *Evanite Fiber Corp. v. Striplin*, 99 Or App 353, 781 P2d 1262 (1989). An employer may deny specific unpaid services or a current claimed need for treatment; it may deny a current claimed need for treatment, even if there are no remaining unpaid medical bills. *Boise Cascade Corp. v. Hasslen, supra*; *Green Thumb, Inc. v. Basl, supra*. In every instance, however, there must be a claim for medical treatment or disability for the employer to deny. A "claim," for purposes of acceptance and denial, is "a written request for <133 Or App 19/20> 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). In this case, employer purported to deny claimant's unspecified "current condition." The Board found that "[t]here is no evidence in this record that claimant's 'current condition' on August 15, 1991 required medical service or resulted in disability." Based on that finding, there was no claim. In the absence of a claim, there cannot be a denial that has any legal effect. Because there was no claim that claimant's unspecified current condition required medical treatment or resulted in disability, employer's attempted denial was ineffective. The Board erred in upholding the denial.¹

Claimant next assigns error to the Board's denial of interim compensation. He asserts that the Board erred as a matter of law when it held that Buttler, the physician who took claimant off work, did not qualify as an attending physician who could authorize time loss, because he is a chiropractor. Claimant argues that ORS 656.005(12)(b) authorizes Buttler to be his attending physician for 30 days after the date of his first visit on the aggravation claim. That statute provides:

" 'Attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury and who is:

" * * * * *

"(B) For a period of 30 days from the date of first visit on the claim or for 12 visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon." ORS 656.005(12)(b). (Emphasis supplied.)

Employer responds that the term "claim" in the statute is ambiguous and is subject to agency interpretation. It asserts that OAR 436-10-005(1), which interprets "claim" in ORS 656.005(12)(b) to mean only the initial claim, is a permissible <133 Or App 20/21> agency interpretation of the statute, and precludes claimant's entitlement to interim compensation.

- A claimant is entitled to receive interim compensation for disability from the date the claim is filed until the claim is accepted or denied. ORS 656.262(2); *Bono v. SAIF*, 298 Or 405, 692 P2d 606 (1984); *Jones v. Emanuel Hospital*, 280 Or 147, 570 P2d 70 (1977). Only an attending physician may authorize payment of temporary compensation. ORS 656.245(3)(b)(B).

¹ This case differs from *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, 771 P2d 295, rev den, 308 Or 184, 776 P2d 1291 (1989), in which we held that a partial denial of a specific condition was valid. Unlike in *Warrilow*, in this case the denial is neither specific to a particular condition, nor does it relate to a condition that arguably could have been encompassed in a claim that was made.

By rule, the Department of Consumer and Business Services has limited the period during which a chiropractor can be an attending physician to 30 days after the first visit on the *initial* claim for compensation:

" 'Attending Physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness and who is:

* * * * *

"(c) For a period of 30 days from the date of first chiropractic visit *on the initial claim* or for 12 chiropractic visits during that 30 day period, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon * * *." OAR 436-10-005(1). (Emphasis supplied.)

"Initial claim" is defined to mean

"the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician." OAR 436-10-005(20).

Relying on those administrative rules, the Board held that, because claimant sought interim compensation for his aggravation claim rather than for an initial claim, claimant's release from work, provided by Buttler, a chiropractor, could not support his claim for interim compensation. Under OAR 436-10-005(1), Buttler did not qualify as an attending physician who could authorize time loss.

The word "claim" in ORS 656.005(12)(b) is an inexact statutory term, because the legislature expressed its meaning completely, but the meaning is subject to agency interpretation. See *England v. Thunderbird*, 315 Or 633, 638, 848 P2d 100 (1993); *Springfield Education Assn. v. <133 Or App 21/22> School Dist.*, 290 Or 217, 621 P2d 547 (1980). That does not mean, as employer seems to argue, that the interpretation is reviewable only for reasonableness. As the Supreme Court explained:

"An inexact term gives the agency interpretive but not legislative responsibility. See *Springfield Education Assn. v. School Dist.*, *supra*, 290 Or at 233 [621 P2d 547] * * *. 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 [621 P2d 547]." *England v. Thunderbird*, *supra*, 315 Or at 638, 848 P2d 100.

Accordingly, we review to determine whether the Department's interpretation of the term "claim" to mean "initial claim" is correct, see *SAIF v. Allen*, 320 Or 192, 209-10, 881 P2d 773 (1994); *England v. Thunderbird*, *supra*, 315 Or at 638, 848 P2d 100, and conclude that it is not.

We begin with the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). We apply the statutory definitions to terms in the workers' compensation statutes, "[e]xcept where the context otherwise requires." ORS 656.003.

"[U]nder 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." *Astleford v. SAIF*, 319 Or 225, 233, 874 P2d 1329 (1994).

Accordingly, we first look to the statutory definition to determine whether its use would be inappropriate, because it would conflict with the statute's structure or purpose. "Claim" is defined in ORS 656.005(6) as

"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."

That definition encompasses not only claims for compensation for particular conditions, e.g., initial claims and aggravation claims, but also any claim for medical treatment, <133 Or App 22/23> vocational assistance, and any other element of compensation. See ORS 656.005(8). That definition, if applied to the word claim in ORS 656.005(12)(b), would result in a new 30-day period each time a claimant received medical treatment, during which a chiropractor could act as an attending physician. Reading the statute in that way would make the 30-day time limitation wholly illusory. Because using the statutory definition of claim would conflict with the limitation that ORS 656.005(12)(b) imposes, we agree with the parties that the legislature did not intend that definition to apply to the use of the word claim in ORS 656.005(12)(b).

In the absence of a statutory definition, we ordinarily give words of common usage their plain, natural and ordinary meaning. *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611, 859 P2d 1143. The word "claim" has a common meaning in the context of workers' compensation statutes: It is commonly used to refer to initial requests for compensation for a compensable injury or disease, and to requests to reopen a previously closed claim for additional compensation for the worsening of a compensable condition.

There is nothing in the text or the context of ORS 656.005(12)(b) to indicate that the legislature intended "claim" to mean anything other than what it is commonly understood to mean. Accordingly, we conclude that the legislature intended to use the term in that way. See *Cook v. Workers' Compensation Department*, 306 Or 134, 143, 758 P2d 854 (1988). The Department's rule, OAR 436-10-005(1)(c), places a limitation on the statutory term by defining it to include only a part of its ordinary meaning. An agency may not, by its rules, limit the terms of a statute. *Cook v. Workers' Compensation Department, supra*, 306 Or at 138, 758 P2d 854. Therefore, the Board erred in applying OAR 436-10-005(1)(c) to deny claimant's request for interim compensation.

Reversed and remanded for reconsideration.

Cite as 133 Or App 30, 889 P2d 1352 (1995)

February 15, 1995

Court of Appeals of Oregon.
Argued and Submitted Nov. 1, 1994.

In the Matter of the Compensation of Marvin L. Thrasher, Sr., Claimant.
REYNOLDS METALS and Cigna Insurance Companies, Petitioners,

v.

Marvin THRASHER, Respondent.
WCB 92-07640; CA A80926.

Montgomery W. Cobb, Portland, argued the cause and filed the brief, for petitioners.

Susan Frank, Portland, argued the cause, for respondent. On the brief were Kevin Keaney and Pozzi Wilson & Atchison.

Before WARREN, P.J., and EDMONDS and LANDAU, JJ.

133 Or App 32 > WARREN, Presiding Judge.

Employer seeks review of a Workers' Compensation Board order that set aside its denial of claimant's chondromalacia condition. We reverse.

Claimant was working for employer when bricks fell and hit his left knee, causing a disabling injury. When claimant's symptoms persisted, his orthopedist performed an arthroscopy of the knee, which revealed extensive chondromalacia. When claimant's condition became medically stationary, he was awarded permanent partial disability based on reduced range of motion, not chondromalacia. Claimant sought reconsideration of the determination order, seeking additional compensation for

impairment due to the chondromalacia. At that time, there were no standards addressing chondromalacia. The order on reconsideration reduced claimant's award for reduced range of motion and did not make an award for the chondromalacia. Claimant sought a hearing, continuing to seek compensation for impairment due to chondromalacia. On the day the referee's order issued, denying additional compensation, employer denied the compensability of the chondromalacia. Claimant requested a hearing on the denial. The referee set the denial aside, holding that employer was barred by claim preclusion from denying the chondromalacia, because employer did not contest compensability at the hearing challenging the order on reconsideration regarding extent of disability. On appeal, the Board affirmed. It determined that, even if employer is not barred by claim preclusion from contesting the compensability of the chondromalacia, claimant had established that his current condition is compensable.

On review, employer does not assert that claimant's current condition is not compensable, but argues that the specific condition of chondromalacia is not compensable. It argues that there is no evidence to support what it characterizes as a Board finding that the chondromalacia is compensable. Claimant responds that, because employer did not challenge the compensability of chondromalacia in the dispute regarding the extent of disability, it is barred by claim preclusion from asserting that chondromalacia is not compensable.

133 Or App 33> Employer is not barred by claim preclusion from arguing that the chondromalacia is not compensable, even if it did not assert the noncompensability of the condition in the proceeding regarding extent of disability. We recently explained:

"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 [795 P.2d 531]; *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 [795 P.2d 531]; *Hammon Stage Line v. Stinson*, 123 Or App 418, 422, 859 P2d 1180 (1993)." *Messmer v. Deluxe Cabinet Works*, 130 Or App. 254, 257, 881 P2d 180 (1994), *rev den*, 320 Or 507, 888 P2d 568 (1995).

Claim preclusion applies only when the prior determination has become final. *Drews v. EBI Companies*, *supra*, 310 Or at 140, 795 P2d 531; *see Hammon Stage Line v. Stinson*, *supra*. Employer is correct that there has been no final determination of the extent of claimant's disability. The Board's order declining to award compensation for chondromalacia is on review to this court. *See Thrasher v. Reynolds Metals*, 133 Or App 13, 889 P2d 1351 (1995). Because there has not been a final determination in that case, claim preclusion does not apply in this case.

Employer next argues that the Board erred in finding that claimant established the compensability of chondromalacia. It asserts that, instead of considering whether the chondromalacia is compensable, it erroneously considered the compensability of claimant's "current condition," that is, the condition that resulted from the combination of the knee injury and the preexisting chondromalacia. Claimant does not respond to that argument.

We agree with employer. Although the Board accurately stated in its order that the issue was employer's partial denial of chondromalacia, it then decided the compensability of the current resulting condition, concluding that the "current disability and need for treatment" are compensable. The <133 Or App 33/34> Board failed to address the issue posed to it: the compensability of the underlying chondromalacia condition. Because the Board did not address that issue, we remand for it to determine whether claimant's chondromalacia condition is compensable.

Reversed and remanded for reconsideration.

Cite as 133 Or App 159, 890 P2d 1004 (1995)

February 22, 1995

Court of Appeals of Oregon.
Argued and Submitted Sept. 9, 1994.

Virginia KILMINSTER, Curtis Irwin, Sr., and Curtis Irwin, Sr., as
Personal Representative of the Estate of Curtis Irwin, Jr. (the decedent),
Appellants,

v.

DAY MANAGEMENT CORPORATION, an Oregon corporation, dba Clackamas
Communications, and Gordon Day, Respondents,

and

KSGO/KGON, Inc., a Washington corporation; Motorola, Inc., a Delaware
corporation; and Skilling Ward Magnusson Barkshire, Inc., a Washington
corporation, Defendants.
9301-00574; CA A82220.

Tom Steenson, Portland, argued the cause for appellants. With him on the brief were Michael Schumann, Terrance M. McCauley and Steenson & Schumann.

Howard Rubin, Portland, argued the cause for respondents. With him on the brief was Amburgey, Segel & Rubin, P.C.

Before RIGGS, P.J., *] and De MUNIZ and LEESON, JJ.

* Riggs, P.J., *vice* Rossman, P.J., retired.

133 Or App 162 > De MUNIZ, Judge.

Plaintiffs are the parents and personal representative of decedent, who was killed when he fell more than 400 feet while working inside the KGON tower. Defendant Day Management Corporation (DMC) was decedent's employer, and defendant Day is the president of DMC.¹ Plaintiffs brought this action alleging, *inter alia*, a claim of negligence against DMC, a claim under ORS 656.156(2) that DMC deliberately intended to produce decedent's injury or death, and a claim against DMC and Day for violating Oregon's Racketeering Influenced and Corrupt Organization Act (ORICO). ORS 166.715 *et seq.*

Defendants filed motions to dismiss for failure to state claims. ORCP 21 A(8). The trial court granted the motions and entered judgment under ORCP 67 B. On review of claims dismissed under ORCP 21 A(8), we accept as true the allegations pleaded in the complaint. *Nicholson v. Blachly*, 305 Or 578, 580, 753 P2d 955 (1988). We affirm.

Plaintiffs assign error to the dismissal of their claim for negligence. The trial court held that ORS 656.018 is the exclusive remedy for decedent's death. Plaintiffs argue that ORS 656.018 takes away the parents' claim under ORS 30.020(1) for the wrongful death of their son and replaces it with a burial payment of \$3,000. They contend that that result deprives them of their constitutional right to an adequate remedy under Article I, section 10.

The dissent concludes that, under *Neher v. Chartier*, 319 Or 417, 879 P.2d 156 (1994), plaintiffs are correct. In *Neher*, the decedent was killed when she was struck by a Tri-Met bus while she was engaged in an activity covered by the Workers' Compensation Law. Her estate sought damages against Tri-Met and the bus driver. Those defendants claimed immunity under ORS 30.265(3)(a) of the Oregon Tort Claims Act, which granted immunity to the public body and its employees if the person injured or killed was covered by the Workers' Compensation Law. The Supreme Court held that ORS 30.265(3)(a) violated Article I, section 10, because it left the plaintiff without a remedy against the public body and its <133 Or App 162/163> employees to recover for the benefit of the decedent's surviving parents under ORS 30.010.

¹ Our references to defendants are to DMC and Day, the only defendants involved in this appeal.

We note at the outset that the Supreme Court, in *Neher*, stated that

"ORS 30.020 recognizes the existence of a right of recovery for surviving parents for damages to compensate them 'for pecuniary loss of the society, companionship and services of the decedent.' ORS 30.020(2)(d)." 319 Or at 428, 879 P2d 156.

The Supreme Court made that statement without mention or discussion of the derivative nature of the parent's right to bring a claim under the wrongful death statutes. Under ORS 30.010(2), a parent may recover damages only as provided in ORS 30.020. ORS 30.020(1) provides, in part:

"When the death of a person is caused by the wrongful act or omission of another, the personal representative of the decedent, for the benefit of the * * * surviving parents * * * may maintain an action against the wrongdoer, *if the decedent might have maintained an action, had the decedent lived*, against the wrongdoer for an injury done by the same act or omission." (Emphasis supplied.)

As the dissent correctly notes, the argument can be made that, in *Neher*, the decedent would have been barred from bringing an action. However, from the Supreme Court's omission of any effect of the derivative right, we conclude that it is not germane to the discussion of the rights and remedies under Article I, section 10.

However irrelevant the language of ORS 30.020 might be, we cannot agree with the dissent that the statutory source of the immunity and the defendant's status as the employer are also irrelevant. The dissent concludes that the analysis of rights and remedies in *Neher* controls the analysis here. However, in *Neher*, the court considered the wrongful death statute in a claim brought under the Tort Claims Act. Here, plaintiffs' claim implicates the workers' compensation system directly. The dissent's conclusion would seriously erode--if not destroy--the exclusivity of remedy on which the workers' compensation system depends, *see Shoemaker v. Johnson*, 241 Or 511, 518, 407 P2d 257 (1965), but *see Errand v. Cascade Steel Rolling Mills, Inc.*, 320 Or 509, 888 P2d 544 (1995), and is not commanded by the opinion in *Neher*.

133 Or App 164 > Under the Tort Claims Act, plaintiffs have the right to bring an action for the torts of a public body and its employees. ORS 30.265(1). For purposes of the Act, a tort is defined as "the breach of a legal duty that is imposed by law * * * for which the law provides a civil right of action for damages * * *." ORS 30.260(8). In *Neher*, thus, the consequence of ORS 30.265(3)(a) was to bar the plaintiff's cognizable legal claim.

Here, in contrast, there is no comparable cognizable right of action. With the exception of intentional injury, there is no such thing as tort liability of an employer for a covered worker's injury or death from a comparable injury. The employer's duty to maintain coverage is its exclusive liability to its workers. *Roberts v. Gray's Crane & Rigging*, 73 Or App 29, 32, 697 P2d 985, *rev den* 299 Or 443, 702 P2d 1112 (1985). ORS 656.018(1)(a) provides, in part:

"The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and *anyone otherwise entitled to recover damages from the employer on account of such injuries* * * *." (Emphasis supplied.)

In *Leech v. Georgia-Pacific Corp.*, 259 Or 161, 485 P2d 1195 (1971), the plaintiff was the mentally incapacitated adult child of a worker who was killed in an industrial accident. At that time, the workers' compensation statutes did not provide for benefits on behalf of a child in the plaintiff's situation and she sought to bring a negligence action for her father's death. The Supreme Court rejected the plaintiff's contention that the statutes violated Article I, section 10, of the Oregon Constitution and equal protection. It held that the language of ORS 656.018, which then, as now, included immunity for the employer from actions from "anyone otherwise entitled to recover damages from the employer on account of such injuries," indicated

"that the legislature intended the remedy provided by compensation to be exclusive and that complying employers are not to be subject to negligence actions by persons omitted from the compensation benefit schedules." 259 Or at 166, 485 P2d 1195.

In *Neher*, the Supreme Court's holding was that ORS 30.265(3)(a) violated Article I, section 10, by abolishing <133 Or App 164/165> the parent's remedy, pursuant to the wrongful death statutes, under the circumstances of that case: The statute gave immunity from liability not only to the municipality, but also to the municipality's negligent employees. 319 Or at 428, 879 P2d 156. That holding does not abrogate the exclusivity of the workers' compensation system. Plaintiffs here had no cause of action for negligence against defendants, and the trial court did not err in dismissing plaintiffs' claim.

Plaintiffs also assign error to the trial court's dismissal of their claim against DMC under ORS 656.156(2), which provides:

"If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker, the widow, widower, child or dependent of the worker may take under this chapter, and also have cause for action against the employer, as if [the workers' compensation] statutes had not been passed, for damages over the amount payable under those statutes."

We do not decide whether the estate here may bring a claim, even though ORS 656.156(2) does not provide a cause of action for the worker's estate. Plaintiffs must allege facts showing that they are entitled to bring the statutory cause of action, *see Riddle v. Eugene Lodge No. 357*, 95 Or App 206, 215, 768 P2d 917 (1989), and they have not done so here. Plaintiffs have not pleaded that decedent's "employer had a deliberate intention to injure him or someone else and that he was in fact injured as a result of that deliberate intention." *Duk Hwan Chung v. Fred Meyer, Inc.*, 276 Or 809, 813, 556 P2d 683 (1976).

" '[D]eliberate intention' implies that the employer must have determined to injure the employee. It is not sufficient to show that there was mere carelessness, recklessness, or negligence, however gross it may be. Reckless disregard of the consequences * * * does not charge an intent to injure plaintiff." *Heikkila v. Ewen Transfer Co.*, 135 Or 631, 635, 297 P 373 (1931).

DMC argues that the essence of plaintiff's allegations² is that DMC knowingly maintained an unsafe workplace and knew or should have known that eventually <133 Or App 165/166> someone would be injured or killed thereby. It contends that such allegations do not rise to the level of an allegation that it deliberately sought to produce an injury or death.

Plaintiffs rely on *Lusk v. Monaco Motor Homes, Inc.*, 97 Or App 182, 775 P2d 891 (1989). *Lusk* was an appeal from a summary judgment. The plaintiff's injury was certain: The defendant knew that the plaintiff was suffering from an injury caused by paint, knew that the plaintiff would continue to suffer so long as he worked without a required respirator and, after deliberation, consciously decided not to provide the respirator. We concluded that the jury could infer a deliberate intent to injure.

Plaintiffs argue that the dangerous, unsafe and life-threatening climbing conditions in the tower, to which decedent was deliberately subjected by DMC, were no less threatening than the conditions in *Lusk*. However, it is the nature of the injury, not the conditions, that demonstrate intent. As explained by Larson:

² Plaintiffs alleged, *inter alia*, that decedent's death "resulted from the deliberate intention of Defendant DMC to produce such injury and death." They alleged that DMC made a deliberate decision to commit multiple violations of Oregon's safety laws regarding fall protection requirements, and that it knew full well of the grave life-threatening danger such violations posed for decedent. They alleged that DMC knew what it was doing and made a conscious decision not to comply with fall protection requirements, even after being cited by the Department of Insurance and Finance, Occupational Safety & Health Division, for such violations, and that it deliberately ignored decedent's complaints about the unsafe working conditions. They alleged that DMC knew that decedent and other employees had slipped and fallen from the tower, that someone was going to fall again and that a fall from over 400 feet was virtually certain to result in death. They alleged that DMC ordered decedent to climb, threatened him with the loss of his job if he did not, and that DMC deliberately withheld the required safety equipment, supervision and training necessary and required by Oregon law to protect decedent from injury and probable death.

"Even if the alleged conduct goes beyond aggravated negligence, and includes such elements as knowingly permitting a hazardous work condition to exist, knowingly ordering claimant to perform an extremely dangerous job, wilfully failing to furnish a safe place to work, or even wilfully and unlawfully violating a safety statute, * * * this still falls short of the kind of actual intention to injure that robs the injury of accidental character.

" * * * * *

"If these [case] decisions seem rather strict, one must remind oneself that *what is being tested here is not the degree of gravity or depravity of the employer's conduct, but rather <133 Or App 166/167> the narrow issue of intentional versus accidental quality of the precise event producing injury.*" 2A Larson, *Workmen's Compensation Law* section 68.13 (1994). (Footnotes omitted; emphasis supplied.)

Here the issue is before us on plaintiff's pleadings. Plaintiffs' allegations show crass indifference to workers' safety; they do not, however, show that DMC intentionally created the accident-causing event. Plaintiffs' allegations do not meet the stringent test for "deliberate intent" to cause injury or death under ORS 656.156. The trial court did not err in dismissing plaintiffs' claim.

Plaintiffs assign error to the trial court's dismissal of their ORICO claims. The racketeering activity is alleged to be acts of safety violations.³ Plaintiffs alleged claims against DMC and Day under ORS 166.720(1) and (2) and against Day under ORS 166.720(3).⁴

³ The racketeering activity was "criminal activity" under ORS 166.715(6), because the alleged workplace safety violations constituted the misdemeanor of "reckless endangerment" under ORS 163.195.

⁴ ORS 166.720 provides, as relevant:

"(1) It is unlawful for any person who has knowingly received any proceeds derived, directly or indirectly, from a pattern of racketeering activity * * * to use or invest, whether directly or indirectly, any part of such proceeds, or the proceeds derived from the investment or use thereof, in the acquisition of any title to, or any right, interest or equity in, real property or in the establishment or operation of any enterprise.

"(2) It is unlawful for any person, through a pattern of racketeering activity * * * to acquire or maintain, directly or indirectly, any interest in or control of any real property or enterprise.

"(3) It is unlawful for any person employed by, or associated with, any enterprise to conduct or participate, directly or indirectly, in such enterprise through a pattern of racketeering activity * * *.

Relevant definitions are contained in ORS 166.715:

"(2) 'Enterprise' includes any individual, sole proprietorship, partnership, corporation, business trust or other profit or nonprofit legal entity, and includes any union, association or group of individuals associated in fact although not a legal entity, and both illicit and licit enterprises and governmental and nongovernmental entities.

" * * * * *

"(4) 'Pattern of racketeering activity' means engaging in at least two incidents of racketeering activity that have had the same or similar intents, results, accomplices, victims or methods of commission or otherwise are interrelated by distinguishing characteristics, including a nexus to the same enterprise, and are not isolated incidents, provided at least one of such incidents occurred after November 1, 1981, and that the last of such incidents occurred within five years after a prior incident of racketeering conduct.

"(5) 'Person' means any individual or entity capable of holding a legal or beneficial interest in real or personal property.

"(6) 'Racketeering activity' means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce or intimidate another person to commit:

"(a) Any conduct which constitutes a crime, as defined in ORS 161.515, under any of the following provisions of the Oregon Revised Statutes:

" * * * * *

"(G) ORS 163.160 to 163.205, relating to assault and related offenses[.]"

133 Or App 168> Under ORS 166.725(7)(a), "[a]ny person who is injured by reason of any violation of the provisions of ORS 166.720(1) to (4) * * * " has a cause of action for damages. ORS 166.720(1) prohibits the investment of income derived from a pattern of racketeering activity in an enterprise. ORS 166.720(2) prohibits acquiring an interest in an otherwise legitimate enterprise through a pattern of racketeering activity. Plaintiffs allege that decedent suffered injury and death because of safety violations. They did not allege that they were injured by defendants' use or investment of income derived from racketeering or that they were injured by defendants' acquisition of an enterprise. The trial court agreed with defendants' argument that failure to make those allegations was a failure to allege the requisite injury under subsections (1) and (2).

Plaintiffs argue that that holding was error, because all that they need to allege is an injury resulting from the predicate acts. Plaintiffs acknowledge that, in *Beckett v. Computer Career Institute, Inc.*, 120 Or App 143, 852 P2d 840 (1993), we held that, in order to state a claim under ORS 166.720(1), a plaintiff must plead facts that show that he or she was injured by the use or investment of racketeering income. In arriving at our holding, we noted that ORICO is patterned after the federal RICO statutes, and we adopted the rationale set out in *Brittingham v. Mobil Corp.*, 943 F2d 297, 305 (3d Cir.1991), under the analogous federal provision:

" 'If this remote connection [of the mere reinvestment of racketeering income into the defendant's business were sufficient to support an 18 USC s 1962(a) claim], the use-or-investment injury requirement would be almost completely eviscerated when the alleged pattern of racketeering is committed on behalf of a corporation. * * * Over the long term, corporations generally reinvest their profits, regardless of the source. Consequently, almost every racketeering act by a <133 Or App 168\169> corporation will have some connection to the proceeds of a previous act. Section 1962(c) is the proper avenue to redress injuries caused by the racketeering acts themselves. If plaintiffs' reinvestment injury concept were accepted, almost every pattern of racketeering activity by a corporation would be actionable under section 1962(a), and the distinction between section 1962(a) and section 1962(c) would become meaningless.' " 120 Or App at 147, 852 P2d 840. (Emphasis supplied.)

Plaintiffs urge us to reconsider our holding in *Beckett*. We decline to do so. We also conclude that our reasoning there applies to a claim under ORS 166.720(2). ORS 166.720(3) is the avenue to redress injuries caused by the predicate acts themselves. ORS 166.720(2) prohibits a different activity. In order to state a claim under ORS 166.720(2), more must be shown than the acquisition or control of an interest in an enterprise; the plaintiff must allege facts showing that the injury resulted from that acquisition. See *Danielsen v. Burnside-Ott Aviation Training Center*, 941 F2d 1220, 1231 (DC Cir 1991) (plaintiffs who alleged injury as a result of defendants' underpayment of legally required minimum wages and fringe benefits failed to state a claim under 18 USC section 1962(b) because they did not allege injury resulting from the acquisition of an enterprise). The trial court did not err in dismissing plaintiffs' claims under ORS 166.720(1) and (2).

The court also did not err in dismissing the claim against Day under ORS 166.270(3), which prohibits any "person" from conducting the affairs of an "enterprise" through a "pattern of racketeering activity." Plaintiffs claim that Day is the ORICO "person" who participated in the ORICO DMC "enterprise" through a pattern of racketeering activity. The trial court agreed with defendants that "person" must be distinct from "enterprise," and that Day, as the president and agent of DMC, is not distinct. Plaintiffs argue that Day is "merely the corporate DMC Enterprise's president and thus separate from the DMC Enterprise itself." Defendants contend that the issue is not whether a corporate president can be a defendant under subsection (3), but whether Day can be, when he is not separate from the enterprise.

Federal cases considering the analogous section under 18 USC section 1962(c) have held that the enterprise must be <133 Or App 169/170> different from the person whose racketeering the act was designed to prohibit. See, e.g., *Brittingham v. Mobile Corp.*, *supra*; *Rae v. Union Bank*, 725 F2d 478 (9th Cir 1984); *U.S. v. Computer Sciences Corp.*, 689 F2d 1181 (4th Cir 1982), *cert den* 459 US 1105, 103 S Ct 729, 74 LEd2d 953 (1983). The court explained the purpose of the subsection in *Brittingham v. Mobil Corp.*, *supra*, 943 F2d at 300:

"The issue here is not whether defendants have participated in a 'pattern of racketeering activity,' but whether the alleged 'enterprise' is sufficiently distinct from the defendants.

"A section 1962(c) violation requires a finding that the defendant 'person' conducted or participated in the affairs of an 'enterprise' through a pattern of racketeering activity. In *B.F. Hirsch v. Enright Refining Co., Inc.*, 751 F2d 628, 633-34 (3rd Cir 1984), we held that the 'person' charged with violation of s 1962(c) must be distinct from the 'enterprise.' In addition to noting that the plain language of the statute provides that the person must be 'employed by or associated with'--and therefore separate from--the enterprise, we stated that:

"One of the Congressional purposes in enacting RICO was to prevent the takeover of legitimate businesses by criminals and corrupt organizations. It is in keeping with that Congressional scheme to orient section 1962(c) toward punishing the infiltrating criminals rather than the legitimate corporation which might be an innocent victim of the racketeering activity in some circumstances.

"*Id.* at 633-34 (citations omitted).

"We reaffirmed this holding in *Petro-Tech, Inc. v. Western Co. of North America*, 824 F2d 1349 (3rd Cir 1987), where we noted that 'section 1962(c) was intended to govern only those instances in which an "innocent" or "passive" corporation is victimized by the RICO "persons" and either drained of its own money or used as a passive tool to extract money from third parties.' *Id.* at 1359. In *Petro-Tech*, we extended the *Enright* rule, holding that a corporate 'enterprise' cannot be held vicariously liable for the section 1962(c) violations of its employees, either for aiding and abetting, or under a theory of respondeat superior. We noted that a contrary holding would circumvent the holding in *Enright* by making the 'victim' enterprise liable. We recognized that the enterprise may often benefit from the RICO violations, but <133 Or App 170/171> noted that a plaintiff may recover only from the actual violators. *Id.* at n. 11."

Plaintiffs do not contend that ORS 166.720(3) was intended to reach prohibited activity that is different from that discussed in *Brittingham v. Mobile Corp., supra*, and we agree with the reasoning there. To allege a claim under subsection (3), plaintiffs must show the existence of two entities: person and enterprise. Here, plaintiffs have alleged one entity. They allege that DMC is an enterprise and that Day is the corporate president of DMC. The alleged racketeering activity was conducted by DMC and Day. However, corporations act only through their officers and agents, 943 F2d at 301, and plaintiffs' allegations do not maintain the distinction between Day and the enterprise that "ensures that RICO sanctions are directed at the persons who conduct the racketeering activity, rather than the enterprise through which the activity is conducted." 943 F.2d at 301. The trial court did not err in dismissing plaintiffs' claim under ORS 166.720(3).

Because of our holding, we do not address plaintiffs' final assignment of error.

Affirmed.

LEESON, Judge, concurring in part; dissenting in part.

I agree with the majority's conclusion that plaintiffs have not stated a claim under the Oregon Racketeer Influenced and Corrupt Organization Act. ORS 166.715 *et seq.* I also agree that plaintiffs have not pleaded a claim for damages under ORS 656.156(2), because their allegations do not meet the test for "deliberate intent."

I part ways with the majority on its analysis of the negligence claim. In my view, *Neher v. Chartier*, 319 Or 417, 879 P2d 156 (1994), is directly applicable and requires the conclusion that ORS 656.018 violates Article I, section 10, of the Oregon Constitution insofar as it eliminates any remedy that

nondependent parents of an injured worker might have for the negligent acts of the employer.¹ There are only two <133 Or App 171/172> distinctions between this case and *Neher*, and I do not think that either of them is relevant for purposes of our analysis of the challenge under Article I, section 10. In this case, defendant is the deceased worker's employer. In *Neher*, the defendant was a third party that had allegedly caused the deceased worker's injury. In this case, the statutory source of the immunity is ORS 656.018. Defendant, its officers, employees and directors are immune from tort liability for negligence, because defendant is a complying employer who has satisfied its obligation to provide workers' compensation coverage. In *Neher*, the defendant Tri-Met and its officers, employees and agents, were immune from liability for a third-party claim by the deceased worker's estate, because Tri-Met was a public body within the meaning of ORS 30.265(3) and the injury was covered by workers' compensation law. The Supreme Court's opinion in *Neher* leads me to conclude that neither the statutory source of the immunity nor the defendant's status as the employer or as a third-party public entity is relevant to the question of whether there has been a violation of Article I, section 10.

In *Neher*, the court said that the focus of the analysis under Article I, section 10, is whether the effect of the immunity is to leave the tort plaintiff without any substantial remedy against the responsible party. In that case, as here, the named plaintiff was the personal representative of the deceased worker's estate. There, as here, the action was brought under ORS 30.020(1), the wrongful death statute. The court said that, because the estate was entitled under the Workers' Compensation Law to recover for the cost of burial, ORS 656.204(1), the *estate* of the worker was not left without a remedy. The same is true here. However, the court also said that, in a wrongful death action, the estate is not the only real party in interest. Relying on ORS 30.020(2)(d), which provides that damages that "justly, fairly and reasonably compensate the decedent's * * * parents" may be awarded in a wrongful death action, the court held that such actions are also brought on behalf of surviving parents. The court concluded that the immunity provided by ORS 30.265(3)(a) left <133 Or App 172/173> the decedent's parents, "who otherwise would be entitled to recover under ORS 30.010(2)(d)," wholly without a remedy.

In *Neher*, had the decedent survived her injury, she could not have sued Tri-Met, because of its statutory immunity. Nonetheless, the court held in *Neher* that the worker's parents could recover damages for her wrongful death, because to apply the immunity of ORS 30.265(3)(a) to that circumstance would have left the parents wholly without a remedy, in violation of Article I, section 10. Similarly, in this case, the decedent could not have sued his employer, because of the immunity provided by ORS 656.018. To apply the immunity of that statute to bar the deceased worker's nondependent parents from bringing an action for his wrongful death would leave them wholly without remedy for their injury. I would hold that, to the extent that it prohibits a wrongful death action against a negligent employer by the estate of the deceased worker, ORS 656.018 violates Article I, section 10, of the Oregon Constitution, because it leaves the nondependent parents of a deceased worker wholly without a remedy.²

The majority appears to be moved by a concern that to permit this negligence action will "seriously erode--if not destroy--the exclusivity of remedy on which the workers' compensation system depends." 133 Or App at 163, 890 P2d at 1006. Such is not the case. Under my reading of *Neher*, the only person who would be entitled to bring an action is one who would have been able to bring an action but for the immunity provision and who is not otherwise provided a remedy. Accordingly, I dissent.

¹ The majority's contention that *Leech v. Georgia-Pacific Corp.*, 259 Or 161, 485 P2d 1195 (1971), is relevant to the analysis in this case is misplaced. 133 Or App at 164, 890 P2d at 1006. In *Leech*, the court disposed of the plaintiff's Article I, section 10, argument in a footnote, observing that that constitutional contention "was not pressed on oral argument, and we think it requires no comment here." 259 Or at 167 n. 3, 485 P2d 1195. Even if *Leech* once aided the majority's analysis, *Neher* is now the controlling authority and we are obliged to follow it.

² I do not understand the significance of the majority's distinction between a right to bring a third-party action and the right to sue the employer directly. In both cases, clearly there is no legal bar to *bringing* the action, but in both, the statutory immunity could be raised as a defense.

Cite as 133 Or App 179, 889 P2d 1310 (1995)

February 22, 1995

Court of Appeals of Oregon.
Argued and Submitted Sept. 16, 1994.

In the Matter of the Compensation of James M. King, Claimant.
James M. KING, Petitioner,

v.

BUILDING SUPPLY DISCOUNT and SAIF Corporation, Respondents.
92-12157; CA A82403.

Michael A. Gilbertson, Portland, argued the cause and filed the brief for petitioner. 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 RICHARDSON, C.J.,* and De MUNIZ and LEESON, JJ.
* Richardson, C.J., *vice* Rossman, P.J., retired.

133 Or App 181 > De MUNIZ, J.

Claimant seeks review of an order of the Workers' Compensation Board determining that he has failed to establish the compensability of his coronary artery disease.

Claimant has had two compensable heart attacks. When he had his first heart attack in 1977, doctors also diagnosed coronary artery disease. Claimant had coronary bypass surgery, which apparently was not treated as a part of the compensable claim. In holding that the 1977 heart attack was compensable, the referee noted in a 1978 order that claimant's underlying coronary artery disease "is of course not in issue." When claimant had a second heart attack in 1988, he filed a claim for the heart attack. SAIF denied the claim on June 8, 1988, stating:

"Information in your file indicates that your current condition and need for treatment is unrelated to your myocardial infarction of March 19, 1977, and that this incident of March 19, 1977 did not materially contribute to your current disability or need for treatment. We further find that the incident of March 19, 1977, did not materially worsen your pre-existing, underlying coronary artery disease. *Therefore, without waiving further questions of compensability we must issue this partial denial for your recent condition and need for medical treatment, as well as your pre-existing coronary artery disease.*" (Emphasis supplied.)

After a hearing, in December, 1988, a referee found that the 1977 heart attack and subsequent coronary bypass surgery were a material contributing cause of the 1988 heart attack. The referee set aside the denial "in its entirety" and remanded the case to SAIF for processing. SAIF did not appeal the order to the Board.

Beginning in 1990, while the claim was still open, claimant received treatment for angina pectoris and coronary insufficiency. In August, 1991, claimant's treating doctor declared claimant to be medically stationary. In September, 1991, the claim was closed with an award of temporary disability. Employer apparently continued to pay for claimant's treatment for angina pectoris and coronary artery disease until September, 1992, when it issued a denial, stating that the major contributing cause of the need for treatment is the natural progression of claimant's coronary artery disease.

133 Or App 182 > Claimant sought a hearing. The referee held that the legal effect of the December, 1988, unappealed referee order was to preclude further litigation on the compensability of the coronary artery disease. The Board reversed. It found, and no party contests, that the only claim made or litigated by claimant at the time of the first order had been for the heart attack. Claimant did not dispute employer's denial of the coronary artery disease. The Board reasoned, therefore, that the

only claim before the referee had been for the heart attack. Read in the context of the matter being litigated at the time, therefore, the Board concluded that the one sentence statement in the referee's order reversing the denial "in its entirety" could only have been intended to overturn the denial of the heart attack, not the denial of the coronary artery disease, which had not been litigated.

The Board reasoned that, in order for a matter to be subject to claim preclusion, the action to be barred must be on the "same cause of action" as the first matter. Concluding that the claim for the coronary artery condition was not on the same cause of action as had been the claim for the heart attack, the Board held that the later claim was not barred.

We conclude otherwise. Although no specific claim had been made for the coronary artery disease, the condition arguably could have been encompassed within the original claim. Compare *Altamirano v. Woodburn Nursery*, 133 Or App 16, 889 P2d 1305 (1995). SAIF's June 8, 1988, denial specifically includes that condition. Accordingly, apart from the effect of the referee's order overturning the denial, if claimant had later sought compensation for that condition, a denial of that claim would have been upheld on the ground that, there having been no request for hearing on the June 8, 1988, denial of the condition, it had become final. Claimant's opportunity to seek compensation for the condition would have been lost with his failure to appeal the denial. Thus, although no specific claim had been made by claimant for the coronary artery disease, employer's denial specifically including that condition framed the issues that were subject to litigation. See *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, 771 P2d 295, *rev den*, 308 Or 184, 776 P2d 1291 (1989). It must be assumed that SAIF itself was aware of its denial of the coronary artery disease. The referee's December, 1988, order setting aside <133 Or App 182/183> that denial, even if wrong, had the effect of ordering the acceptance of the coronary artery disease. The order was not appealed and became final by operation of law.

Under the doctrine of claim preclusion, when there has been an opportunity to litigate a question along the road to a final determination, and a final judgment is entered that disposes of the matter, then further litigation of the matter is barred. *Drews v. EBI-Companies*, 310 Or 134, 140, 795 P2d 531 (1990). We agree with claimant that further litigation of the compensability of the coronary artery condition is barred by claim preclusion.

Reversed and remanded.

Cite as 133 Or App 203, 890 P2d 429 (1995)

February 22, 1995

Court of Appeals of Oregon.
Argued and Submitted Oct. 15, 1993.

In the Matter of the Compensation of Erwin L. Farmen, Claimant.
WELLIVER WELDING WORKS and Liberty Northwest Insurance Corporation,
Petitioners,

v.

Erwin L. FARMEN, Respondent.
No. 92-01495, 92-01494; CA A79302.

Kevin L. Mannix argued the cause and filed the brief, for petitioners.

Arthur Klosterman argued the cause, for respondent. With him on the brief was Whitehead & Klosterman.

Before WARREN, P.J., and EDMONDS and LANDAU, JJ.

133 Or App 205 > LANDAU, Judge.

Employer seeks review of an order of the Workers' Compensation Board that directed employer to provide vocational assistance. We affirm.

The facts are not in dispute. In 1986, claimant worked as a welder for approximately \$425 per week. That same year, he compensably injured his back. Employer accepted his claim and closed it, with no award of permanent disability. Claimant was not entitled to vocational assistance at that time. Claimant returned to work as a welder with another employer.

Sometime around 1988, claimant quit his work as a welder, and became employed as an apartment manager at a "minimal wage." While working at the new job, his prior back injury worsened. Employer accepted his aggravation claim, and in 1991, he was awarded 34 percent unscheduled permanent disability. His aggravated back condition left him able to perform only sedentary to light work. He returned to work as an apartment manager, on a part-time basis.

Claimant filed a claim for vocational assistance. Employer denied the claim. Claimant sought administrative review, and the Director of the Department of Insurance and Finance¹ upheld the denial. In his order, the director explained that only those unable to return to "suitable employment" are eligible for vocational assistance. According to the director, OAR 436-120-005(6)(a) defines "suitable employment" as employment at a wage within 20 percent of what claimant received for his or her "regular employment," which is, in turn, defined as the claimant's employment "at the time of the injury or the claim for aggravation, whichever gave rise to the eligibility for vocational assistance * * *." The director concluded that, because claimant was capable of employment at a wage within 20 percent of his minimal wage for apartment management, which was his employment at the time of his claim for aggravation, he was not eligible for vocational assistance.

133 Or App 206 > Claimant requested a hearing, arguing that he is eligible for vocational assistance because he is currently incapable of employment at a wage within 20 percent of his wage of four years earlier, when he was injured as a higher-paid welder. The referee agreed and set aside the director's order, concluding that the rule on which the director's decision was based, OAR 436-120-005(6)(b), is invalid. The referee explained that the rule conflicts with ORS 656.340(5), which provides that the objective of vocational assistance is to return the worker to employment at a wage as close as possible to the worker's wage "at the time of injury." The referee construed that statutory reference to mean the time of the *original* injury, not the time of aggravation. The Board affirmed on the same basis.

¹ The department has since been renamed the Department of Consumer and Business Services. ORS 705.105.

On review, employer contends that the Board erred in concluding that OAR 436-120-005(6)(b) is invalid. Employer argues that, because it is the claim for aggravation that gave rise to claimant's request for vocational assistance, his employment at that time must be the basis for determining his eligibility. Claimant argues that the Board correctly determined that OAR 436-120-005(6)(b) impermissibly departs from the plain language of the statute.

We review the Board's conclusion for errors of law. ORS 656.298(6); ORS 183.482(7) and (8); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 202, 205, 752 P2d 312 (1988).

A worker becomes eligible for vocational assistance

"if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment." ORS 656.340(6)(a).

"Suitable employment," in turn, is defined, in part, as:

"Employment 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)(iii).

Thus, assuming compliance with other relevant statutory requirements, if a worker's injury renders him or her incapable of employment at a wage within 20 percent of the wage for the worker's "regular employment," the worker is eligible for <133 Or App 206/207> vocational assistance. Unfortunately, the statute does not define "regular employment."

The director promulgated OAR 436-120-005(6)(b) to define the term "regular employment" as:

"employment of the kind the worker held at the time of the injury or the claim for aggravation, whichever gave rise to the eligibility for vocational assistance; or, the worker's customary employment."

The issue in this case is whether the Board correctly determined that the director's rule defining "regular employment" is invalid.

In *Springfield Education Assn. v. School Dist.*, 290 Or 217, 223, 621 P2d 547 (1980), the Supreme Court said that the analysis of the validity of an agency rule that construes a statute depends on which of three categories of statutory terms is involved:

"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."

In this case, the term "regular employment" is an inexact term. Accordingly, our role is to determine whether the agency erroneously interpreted a provision of law. 290 Or at 234; ORS 183.982(8)(a); see also *SAIF v. Allen*, 320 Or 192, 209, 881 P2d 773 (1994); *England v. Thunderbird*, 315 Or 633, 638, 848 P2d 100 (1993).

We begin with the text and context of the statute, which includes other provisions of the same statute as well as other related statutes. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). We also consider, at this first level of analysis, rules of construction that bear directly on the interpretation of the text and context. 317 Or at 611. As we have noted, the legislature did not define "regular employment." However, from the context and from various rules of construction, it becomes apparent <133 Or App 207/208> that the director's definition of the term does not comport with what the legislature intended.

The term "regular employment" is used in the statute to define "suitable employment *with the employer at the time of the injury* * * *." ORS 656.340(6)(a). (Emphasis supplied.) Similarly, ORS 656.340(5) provides that the purpose of vocational assistance is to return the worker to employment at a wage as close as possible to the worker's wage "at the time of injury." In both cases, the statute does not say "at the time of injury or the claim for aggravation," as does the director's rule.

It seems unlikely that the legislature would have chosen "at the time of injury" to refer to the time of a claim for aggravation. Employer refers to no place in the statutes at which the legislature ever has referred to a claim for a worsened compensable condition as an "injury." To the contrary, the statutory provisions concerning claims for aggravation draw a distinction between a "worsened condition" that gives rise to the aggravation claim and the original "injury." See ORS 656.273. Under the aggravation statute, in fact, there need only be a worsening of the original compensable condition, the material contributing cause of which is the original injury. ORS 656.273(1); see *Jocelyn v. Wampler Werth Farms*, 132 Or App 165, 173-74, 888 P2d 55 (1994).

Accordingly, to construe "at the time of injury" to include the time of a claim for aggravation imbues the term "injury" with a meaning that is contrary to common sense. We are generally constrained to assume that the legislature intended the words of a statute to be given their common, ordinary meaning unless there is a clear indication that some other meaning was intended. *Griffin v. Tri-Met*, 318 Or 500, 508, 870 P2d 808 (1994); *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611, 859 P2d 1143.

Employer argues that language in ORS 656.340(4) supports the director's definition. That section provides that a worker who has been determined to be ineligible for vocational assistance "may not be found eligible thereafter unless * * * the worker's condition worsens substantially." According to employer, because that language recognizes that a worker's claim for vocational assistance may arise out of a <133 Or App 208/209> worsening of a compensable injury, the director's rule makes sense in defining "regular employment" as the employment at the time of the worsening of the condition.

Employer misses the point, which is what the legislature meant by defining eligibility by reference to the worker's employment "at the time of injury." That a compensable worsening may give rise to a claim for vocational assistance does not resolve what the legislature intended by determining eligibility by reference to a worker's wages "at the time of injury." Indeed, to accept employer's argument would leave us with the problem of defining the term "injury" to include "compensable worsening," which, as we have suggested, is inconsistent with the manner in which that term is commonly understood and used elsewhere in the statutes.

We conclude that the text and the context strongly suggest that the legislature intended "regular employment" to refer to a worker's employment at the time of the injury, not at the time of a subsequent claim for aggravation. Nevertheless, we cannot say that the matter is completely free from doubt. See *To v. State Farm Mutual Ins.*, 319 Or 93, 101, 873 P2d 1072 (1994). Accordingly, we proceed to an examination of the legislative history. *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 611-12, 859 P2d 1143.

The parties have cited no legislative history that reveal a discussion of the matter directly at issue, and we are aware of none. However, there are several passing references to eligibility in terms of a percentage of the worker's wage "at the time of injury." The focus of those discussions was the legislature's attempt to provide vocational assistance to workers who can find minimum wage work but had previously been and, but for the compensable condition, could still be earning more than that. Tape Recording, Senate Labor Committee, June 9, 1987, Tape 206, Side A at 70. Those references support our initial conclusions about the statute; indeed, they seem quite close to the facts of this case, in which claimant is apparently capable of earning a minimum wage, but not the wage he was earning before his back injury.

There also is a colloquy between the chair of the Senate Labor Committee, which considered the amendments that became ORS 656.340, and one of the committee members:

133 Or App 210> "[Senator Otto:] 80 percent at the time of injury or 80 percent at the time of settlement of the claim?

"[Chairman Hill:] This would be the regular employment at the time of injury.

"[Senator Otto:] At the time of injury?

"[Chairman Hill:] Yes--that's the definition of the regular employment.

"[Senator Otto:] I'm thinking of pay raises or pay reductions.

"[Chairman Hill:] Currently being paid for the regular employment. * * * If the worker takes a light-duty job and goes back to the employer and takes a light-duty job making \$5 per hour and their regular job was \$10, when determination is made about available and suitable employment and eligibility for vocational assistance and it would be looking at the wage to the job that they had left when they were injured. So it would be the millworker job, not the light-duty job." Tape Recording, Senate Labor Committee, June 9, 1987, Tape 206, Side A at 129.

The discussion is not precisely on point. But, once again, it bears out our conclusion that the legislature placed emphasis on the "time of injury," and not some later event, as the reference point for defining the worker's "regular employment." Still, because we cannot fairly say that the legislative history clearly disposes of the matter, we proceed to an application of other general maxims of statutory construction to aid us in resolving any remaining uncertainties. *PGE v. Bureau of Labor and Industries, supra*, 317 Or at 612, 859 P2d 1143.

One such maxim is that we attempt to construe the language of the statute in a manner consistent with its purposes. *Bartz v. State of Oregon*, 314 Or 353, 358, 839 P2d 217 (1992). The Supreme Court has said that a purpose of workers' compensation benefits is to compensate workers

"who are active in the labor market, for wages lost *because of inability (or reduced capacity) to work as a result of a compensable injury.*" *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296, 702 P2d 403 (1985). (Emphasis supplied.)

A worker's inability or reduced capacity to work may result from a worsening of a compensable injury, *i.e.*, an aggravation. However, that aggravation does not exist in a vacuum. It is defined by statute as a compensable worsening of an <133 Or App 210/211> original injury. ORS 656.273. Without the injury, there is no worsened condition that renders the worker unable to work. Accordingly, if a purpose of the statutes is to provide benefits to workers who are incapable of working "as a result of a compensable injury," then it is more likely that the legislature intended a worker's eligibility for vocational assistance to be predicated on the wage at the worker's "regular employment" at the time of the injury, not at the time of a later claim for a worsening of the condition caused by that injury.

We conclude that, taking into consideration the text and context of the statute, the history of the legislation and relevant rules of construction, it is evident that the legislature intended "regular employment" within the meaning of ORS 656.340(6) to mean the worker's employment at the time of the injury, not at the time of a claim for aggravation. Accordingly, the Board was correct in holding that the director's rule conflicts with the statute and is invalid.

Affirmed.

Cite as 133 Or App 297, 891 P2d 697 (1995)

March 8, 1995

Court of Appeals of Oregon.
Argued and Submitted Feb. 7, 1994.

**In the Matter of the Compensation of Kevin P. Silveira, Claimant.
Kevin P. SILVEIRA, Petitioner,**

v.

**LARCH ENTERPRISES and SAIF Corporation, Respondents.
No. WCB 91-05623; CA A80657.**

Edward J. Harri, Salem, argued the cause, for petitioner. With him on the brief were J. Robert Moon, Jr. and Coughlin, Leuenberger & Moon, P.C., Baker City.

David L. Runner, Asst. Atty. Gen., argued the cause, for respondents. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.

Before DEITS, P.J., and RICHARDSON, C.J., and RIGGS, Judge.
Silveira v. Larch Enterprises

133 Or App 299 > RIGGS, Judge.

Claimant seeks review of an order of the Workers' Compensation Board (Board) affirming employer's denial of his claim. He argues that the Board erred in its treatment of his out-of-state employment with employer. We reverse and remand for reconsideration.

Claimant began experiencing back pain in 1988 while working for employer Larch Enterprises (Larch) in California. At that time, Larch was not an Oregon employer. Claimant sought treatment from a chiropractor but he never missed work. Larch told claimant to seek coverage under his health insurance and discouraged him from filing a claim for workers' compensation benefits in California. In October, 1990, Larch moved its operations to Oregon and became an Oregon employer. In late December, claimant began experiencing severe back pain, but continued to work. In early February 1991, Larch fired claimant.

Claimant went to see Dr. Driver about his back condition, and x-rays revealed a degenerative disc disease. Driver stated in his report that

"[claimant's] work activities beginning in 1988 were the cause of his back condition. The degeneration is due to continuous work, not necessarily one specific injury."

Claimant filed a workers' compensation claim in Oregon for "lower back pain." SAIF, Larch's Oregon workers' compensation insurer, denied the claim, and claimant requested a hearing. The Board determined that Larch was not a subject employer when its operations were in California and that claimant was not a worker subject to Oregon law while employed in California. Therefore, the Board concluded, "any injuries suffered during claimant's employment in California are not compensable" and claimant must prove that his employment in Oregon was the major contributing cause of his disease.¹

133 Or App 300 > Claimant assigns error to the Board's treatment of his out-of-state employment. He argues that the last injurious exposure rule relieves him of the burden of proving that any specific employment or exposure caused his disease.

¹ On June 27, 1994, during the pendency of this review, SAIF accepted a "symptomatic exacerbation of a degenerative disc disease in the lower back." SAIF has filed a motion to dismiss, contending that that acceptance renders moot claimant's petition; the acceptance covers all the compensation requested by claimant to this point. However, we are asked to review the Board's determination that claimant has not shown a compensable "degenerative back condition." The claim is broad enough to encompass that condition. SAIF's acceptance of the symptomatic exacerbation does not render moot the question of whether the underlying degenerative back condition is compensable.

In order to establish an occupational disease, claimant must show that his condition arose "out of and in the course of employment" and was "caused by substances or activities to which [he was] not ordinarily subjected or exposed other than during a period of regular actual employment * * *." ORS 656.802(1). He must show that the major contributing cause of his disease was work related. *Runft v. SAIF*, 303 Or 493, 498, 739 P2d 12 (1987). When a claimant asserts that work conditions at a single employer are the cause of the disease, the claimant's task is relatively straightforward: "the claimant must show that working conditions at that employment were the major contributing cause of the disease." 303 Or at 498-99, 739 P2d 12. However, when there are two or more employers or insurers, the task becomes more difficult. As the Supreme Court recognized, "by their very nature[,] chronic conditions * * * usually cannot be traced to a single incident or injury." *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 341, 605 P2d 1175 (1980).

To relieve claimants of "the often impossible burden of showing that workplace conditions at a specific time and place caused" an occupational disease, the courts adopted the last injurious exposure rule. 288 Or at 344, 605 P2d 1175. This "rule of proof" aspect of the last injurious exposure rule²

"operates generally for the benefits of claimants. It relieves <133 Or App 300/301> claimants of the burden of proving the degree to which, if any, exposure to disease causing substances at a particular employer actually caused the disease. The claimant is required to prove only that the disease was caused by employment-related exposure; the claimant is not required to prove that exposure at a particular employer's workplace caused the disease. Whether employment at any one workplace was the actual cause of the disease is irrelevant under the rule." *Runft v. SAIF, supra*, 303 Or at 500, 739 P2d 12. (Citations omitted.)

The rule operates in the context of claims implicating multiple employments or multiple insurers for the same employer. *FMC Corp. v. Liberty Mutual Ins. Co.*, 73 Or App 223, 698 P2d 551, *rev den* 299 Or 203, 700 P2d 252 (1985); *Meyer v. SAIF*, 71 Or App 371, 373 n. 1, 692 P2d 656 (1984), *rev den* 299 Or 203, 700 P2d 251 (1985).

Here, claimant's out-of-state employment, if relevant at all for purposes of determining compensability, would be treated as a separate occupational exposure from his Oregon exposure, because employer had a different workers' compensation insurer during that time. The question is whether claimant's out-of-state employment can be considered to prove that his condition was caused by his employment.

In *Bennett v. Liberty Northwest Ins. Corp.*, 128 Or App 71, 875 P2d 1176 (1994), the claimant suffered from tinnitus and hearing loss. He had worked at two different employers, both of which had conditions that could have caused his disease. The claimant entered into a disputed claim settlement with the first employer. In litigation involving only the second employer, he attempted to use the last injurious exposure rule to establish the compensability of his disease. The Board concluded that, because the claimant had settled with the first employer, he had elected to prove actual causation against the second employer. We reversed the Board and held that, in determining whether a disease is work related, the rule of proof aspect of the last injurious exposure rule allows consideration of all employments, even those that could not ultimately be held responsible for the claim. 128 Or App at 78, 875 P2d 1176; *see also Kepford v. Weyerhaeuser Co.*, 77 Or App 363, 713 P2d 625, *rev den* 300 Or 722, 717 P2d 630 (1986).

² The last injurious exposure rule also operates to assign responsibility:

"As a rule of assignment of responsibility, the last injurious exposure rule assigns full responsibility to the last employer at which the claimant could have been exposed to the disease-causing substance. This is true no matter how brief or insignificant the possible exposure at the last such employer." *Runft v. SAIF, supra*, 303 Or at 500, 739 P2d 12.

The 1990 amendments to the Workers' Compensation Law did away with some aspects of the last injurious exposure rule. *See SAIF v. Drews*, 318 Or 1, 6-9, 860 P2d 254 (1993); *Liberty Northwest Ins. Corp. v. Senters*, 119 Or App 314, 850 P2d 403 (1993). But the amendments had no effect on the last injurious exposure rule's role in initially assigning responsibility for an occupational disease. *SAIF v. Yokum*, 132 Or App 18, 887 P2d 380 (1994).

133 Or App 302> Citing *Progress Quarries v. Vaandering*, 80 Or App 160, 722 P2d 19 (1986), SAIF argues that all out-of-state employments must be disregarded for purposes of determining whether the last injurious exposure rule is even applicable. For example, it argues that if, as here, a claimant has only two employments, one of which was out-of-state, then the out-of-state employment must be disregarded. Therefore, according to SAIF, because only one potentially responsible employer remains, the last injurious exposure rule is inapplicable and the claimant must show actual causation by the Oregon employer. We disagree.

In *Progress Quarries*, all of the parties agreed that the claimant's disease, which could have been caused by any or all of the employers, was compensable; the issue was the assignment of responsibility. One Oregon employer sought to establish that a subsequent out-of-state employer was responsible for the claim, because conditions at that out-of-state workplace were of the kind that could have caused the disease. We held that, under the last injurious exposure rule, when it has been shown that the Oregon employment is injurious and a potential cause of the claimant's occupational disease, the claimant is entitled to compensation in Oregon. We held that an Oregon employer cannot proffer as a defense a subsequent potentially causal employment not covered by the Oregon Workers' Compensation Act. 80 Or.App. at 164-66, 722 P.2d 19.

The issue is different here, but the objective is the same: compensation for a work-related condition, a potential cause of which is an Oregon employment. The consideration of claimant's out-of-state employment for the purpose of determining whether his condition is work related does not necessarily bear on which employer might ultimately be held responsible for the claim. Although permitting a claimant to rely on out-of-state employment to establish a work relationship might increase the chances that a claim will be found to be work related, it does not alter the requirement set out in *Progress Quarries* and the cases it cites, that, for the Oregon employer to be held responsible, the Oregon employment must be injurious and a potential cause of the disease. We hold that for purposes of establishing that an occupational <133 Or App 302/303> disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws.

SAIF argues that to adopt such a rule would make Oregon "the workers' compensation dumping ground for the United States," permitting a claimant with even the briefest period of employment in Oregon to receive compensation in Oregon for a condition that was caused elsewhere. SAIF suggests that, to avoid those consequences, we should require a claimant to establish that recovery is precluded in the other jurisdictions where there was potentially causative employment. We have done that in cases involving an initial compensable injury in Oregon and a subsequent out-of-state increased disability of the same part of the body. See *Wootton v. Stadeli Pump & Construction*, 108 Or App 548, 816 P2d 689 (1991); *Olson v. E.B.I. Co.*, 78 Or App 261, 715 P2d 1348 (1986); *Miville v. SAIF*, 76 Or App 603, 710 P2d 159 (1985). However, we rejected that same requirement in the occupational disease context in *Progress Quarries v. Vaandering, supra*, 80 Or App at 166, 722 P2d 19, where we said that cases involving successive injuries

"do not involve the problems of proof and responsibility which produced the disease-oriented last injurious exposure rule, under which issues are whether there is compensability in the first instance and which of the successive employers or carriers is responsible."

Accordingly, we held that, in occupational disease cases, the claimant is not required to file a claim with other potentially causative out-of-state employers in order to receive compensation in Oregon. 80 Or App at 166, 722 P2d 19.³ The same reasoning applies here.

Because of our disposition of claimant's first assignment of error, we need not reach claimant's second.

Reversed and remanded for reconsideration.

³ SAIF also argues that this rule would create situations in which a worker could obtain a double recovery and that there is a policy in the Oregon workers' compensation system against double recoveries. While we acknowledge that double recovery is a potential problem, the alternative is to leave an Oregon worker with an admittedly work-related disease without compensation. We believe that the policy to make certain that Oregon workers are compensated for their injuries, see ORS 656.012, outweighs the concern about double recovery.

DEITS, Presiding Judge, dissenting.

The question presented here is whether the last injurious exposure rule applies in circumstances where one of two work exposures that contributed to claimant's current condition occurred while claimant was working out of state for a non-Oregon employer. The majority reverses the Board and holds that the rule applies in these circumstances. I believe that the Board result was right and, accordingly, I dissent.

The Board concluded that under ORS 656.023, during the time of claimant's work in California, employer was not a "subject employer" and that, consequently, claimant was not a "subject worker." Because of that, it concluded that Oregon's workers' compensation law was not applicable and that any injuries suffered during claimant's employment in California are not compensable under Oregon law. Accordingly, the Board concluded that claimant must prove, under ORS 656.802, that his Oregon employment was the major contributing cause of his present condition or its worsening.

The majority does not appear to believe, as did the Board, that the statutes resolve this question. Rather, the majority turns immediately to our case law and concludes that because we have multiple employments here, we must apply the last injurious exposure rule to decide this matter. I agree with the majority that the statutes do not resolve this question. It appears from the text and context of the workers' compensation law that the legislature has not directly considered this issue. However, I do not agree with the majority that our case law has resolved this issue. The majority first relies on our decision in *Bennett v. Liberty Northwest Ins. Corp.*, 128 Or App 71, 875 P2d 1176 (1994). That case, however, is inapposite, because all of the employers involved were Oregon employers.

The majority also relies strongly on our decision in *Progress Quarries v. Vaandering*, 80 Or App 160, 722 P2d 19 (1986). As the majority correctly recites, in *Progress Quarries*, the claimant filed a claim for hearing loss and tinnitus against several Oregon employers. All of the employers that were parties to the case agreed that the claimant's injuries were compensable. However, responsibility was contested. The claimant's last employment before the "date of disability," for purposes of the last injurious exposure rule, was with an out-of-state employer. One of the Oregon employers argued that the out-of-state employer was responsible under the last injurious exposure rule. We rejected that argument and concluded that the out-of-state employment should *not* be considered in assigning responsibility under the last injurious exposure rule.

Although recognizing that *Progress Quarries* involved a different issue,¹ the majority reads our decision in that case as supporting its conclusion that out-of-state employment may be considered in deciding on the applicability of the last injurious exposure rule. In my view, our decision in *Progress Quarries* does not support that conclusion. In fact, the rationale of our decision in *Progress Quarries* supports the opposite conclusion--that out-of-state employment may not be considered in determining if compensability should be determined based on the last injurious exposure rule.

In our decision in *Progress Quarries v. Vaandering*, *supra*, we noted the rationale supporting the application of the last injurious exposure rule, as explained by the Supreme Court in *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982). In *Bracke*, the court explained that the purpose of the last injurious exposure rule is to relieve a claimant from having to prove causation in cases of successive incremental injuries or disease and in cases where employment at more than one successive employer could have caused a disease. The reason that it is important to relieve a claimant of this burden is that it is often difficult in such cases for a claimant to prove that the injury or disease was caused by a particular employer. The court in *Bracke* recognized that, under the rule, liability may end up being imposed on an employer that was not primarily responsible for a claimant's injury. However, the court reasoned that the use of the rule is not unfair to employers, because liability is spread proportionately among them. As the Supreme Court explained:

¹ The majority is correct that the issue in *Progress Quarries* was somewhat different from the one presented here, because the employer in that case was trying to use the last injurious exposure rule defensively to place responsibility on a subsequent out-of-state employer. Here, the question is whether exposure during a prior out-of-state employment should be considered in determining if compensability should be determined based on the last injurious exposure rule.

"By arbitrarily assigning liability to the last employment which could have caused the disease, the rule satisfies claimant's burden of proof of actual causation. The reason for the rule lies not in their achievement of individualized justice, but rather in their utility in spreading liability fairly among employers by the law of averages and in reducing litigation." *Bracke v. Baza'r*, *supra*, 293 Or at 248, 646 P2d 1330.

After our discussion of *Bracke* in *Progress Quarries*, *supra*, we concluded that the rationale supporting the use of the rule does not exist when an out-of-state employment is considered:

"As the Supreme Court noted in *Bracke v. Baza'r*, 293 Or. 239, 646 P.2d 1330 (1982), the rule, which is for claimants' benefit, can operate fairly for employers if applied consistently. *The basic overall fairness can be achieved only if application of the rule remains under control of the Oregon workers' compensation system. If out-of-state employment is considered, the systematic application of the rule breaks down.* By reason of the analysis required under the last injurious exposure rule, only if the Oregon employment environment is injurious and a potential cause of the disease can the claimant be entitled to compensation under the rule of proof aspect of the doctrine. An individual employer escapes liability because Oregon has no apportionment provision and because of a policy to award compensation for occupational disability despite a lack of precision in the proof." 80 Or App at 166, 722 P2d 19. (Emphasis supplied.)

A similar analysis applies here. The last injurious exposure rule makes sense and achieves overall fairness so long as we are dealing with employers over which the Oregon workers' compensation system has control. However, if we allow out-of-state employment to be considered in the application of the rule, the rule breaks down, because we have no control over if and when an out-of-state employer will be responsible for workers under similar circumstances. When an out-of-state employer is involved, there is no guarantee of any consistency in the application of the rule. Further, unlike if we were dealing with two Oregon employers, a holding that the Oregon employer here is responsible does not preclude claimant from seeking recovery for the same injury from the out-of-state employer and, accordingly, receiving a double recovery. The last injurious exposure rule simply does not work when out-of-state employment is involved.

Although our statements in *Progress Quarries* were made in the context of the application of the responsibility aspect of the last injurious exposure rule, rather than as here, in the context of the rule as a rule of proof, that difference should not matter. The rationale underlying the last injurious exposure rule as a rule of proof and as a rule of liability assignment are the same; i.e., a claimant is relieved from a difficult burden of proof. The trade-off for employers is that liability will be spread evenly among employers by the law of averages. Our comments in *Progress Quarries* that the last injurious exposure rule does not work well when out-of-state employers are involved, because the trade-off for employers is not there, is equally true whether we are considering the rule as a rule of proof or a rule of assigning liability. In both instances, we have no control as to if, and to what extent, an out-of-state employer will be found responsible and, consequently, no control over whether liability will be spread evenly among employers.

My understanding of the application of the last injurious exposure rule does not necessarily mean that an injured claimant will not recover. If a claimant can show that the Oregon employment was the major contributing cause of a claimant's condition, a claimant may recover in Oregon. Further, as mentioned above, nothing prevents a claimant from seeking recovery against an out-of-state employer. In this case, for instance, although claimant's employer discouraged him from seeking workers' compensation in California, claimant could have filed a claim in California and perhaps still can. Obviously, if an injured claimant is left without any recourse, that may be a very undesirable result. However, it is equally unfair to Oregon employers to be held responsible for an injury that was caused by employment in another state. Applying the last injurious exposure rule to initial claims for compensation involving out-of-state employment would allow workers with serious work-related injuries caused by employment in other states to come to Oregon and, by simply showing that the Oregon employment could have contributed to the condition, hold the Oregon employer responsible. That is

not a result that the last injurious exposure rule was ever designed or intended to achieve. If the rule is to be so extended, that is a policy decision that the legislature ought to make.²

I believe that the Board correctly decided that the last injurious exposure rule does not apply here, because we have only one Oregon employment to consider. Accordingly, in my view, the Board properly required claimant to establish under ORS 656.802 that claimant's Oregon work exposure was the major contributing cause of his disease. I would also hold that there is substantial evidence to support the Board's conclusion that claimant did not prove that his Oregon employment was the major contributing cause of his occupational disease. For all of the above reasons, I respectfully dissent.

² The dissent to the Board's opinion suggests an alternative resolution to this problem:

"The alternate potential resolution is to adopt a rule similar to *Miville* [*v. SAIF*, 76 Or App 603, 710 P2d 159 (1985)] to apply to prior potentially causal out-of-state employment exposures. Under such a rule, claimant would be required to file his claim with any prior out-of-state employer who could have contributed to the condition prior to litigating the claim in Oregon. If benefits are provided under the out-of-state claim, then, and only then, would claimant be required to show an actual contribution to a worsened condition as required by preexisting conditions under *Weller v. Union Carbide*, 288 Or 27 [602 P2d 259] (1979). If the claim for benefits in the out-of-state exposures was not allowed[,] claimant's demonstration that his condition was caused by his employment would be sufficient to assign liability to the last potentially causal Oregon employer on the risk."

That may well be a sensible solution to this problem, but it is a choice that the legislature ought to make.

Cite as 133 Or App 324, 891 P2d 1326 (1995) March 8, 1995

Court of Appeals of Oregon.
Argued and Submitted Dec. 21, 1994.

In the Matter of the Petition of
BROADWAY DELUXE CAB COMPANY, aka Broadway Enterprises, Inc., dba Broadway Cab
Cooperative, and dba Broadway Cooperative, Inc., Petitioner,

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and **SAIF**
Corporation, Respondents.
90-06-04; CA A71182.

William F. Hoelscher, Tigard, argued the cause for petitioner. With him on the briefs was Hoelscher & Associates.

David L. Runner, Asst. Atty. Gen., argued the cause for respondent SAIF Corp. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.

Peter A. Ozanne, Portland, waived appearance for respondent Nat. Council on Compensation Ins.

Before WARREN, P.J., and RICHARDSON, C.J., and EDMONDS, J.

133 Or App 326 > EDMONDS, Judge.

Broadway Deluxe Cab Company (Broadway) petitions for review of a Department of Insurance and Finance (DIF) order directing it to pay premiums to SAIF, its workers' compensation carrier, for its "shift-lease" taxicab drivers.¹ We review for errors of law, ORS 183.482(8)(a), and affirm.

DIF found these facts. Broadway owns and operates a taxicab business. The City of Portland issues vehicle permits to Broadway, which in turn sells the right to use the permits to taxicab owners. Customarily, each Broadway cab operates 24 hours a day for seven days a week. A driver's normal work shift is 12 hours per day. An owner of a cab may choose to operate his or her cab under Broadway's permit each day for a 12-hour shift and to lease the cab to another driver for the remaining 12-hour shift. The other driver is known as a "shift-lease driver."

If an owner-operator desires to lease the cab, the owner-operator asks Broadway to list the cab for lease. Broadway maintains a list of drivers who have met its shift-lease driver qualifications. It assigns an available cab to a shift-lease driver on a "first-come, first-serve" basis. Under Broadway's practice, shift-lease drivers could be assigned a different cab on each shift that they work. Each shift-lease driver pays a flat fee to the owner-operator for the use of the vehicle. Broadway collects this amount on behalf of the owner-operators at the time of the shift.

SAIF audited Broadway for the period of January 1, 1989, through December 31, 1989, and concluded that Broadway's shift-lease drivers were subject to the Workers' Compensation Law and that Broadway owed premiums for their workers' compensation coverage. Broadway disputed SAIF's determination and sought a hearing before DIF. At the hearing, Broadway argued that the shift-lease drivers were "nonsubject workers" under ORS 656.027(14)(c), and, therefore, no premiums were owed. DIF determined that, because Broadway's shift-lease drivers did not "maintain or furnish" <133 Or App 326/327 > the cabs that they used, they did not fall within the definition of a "nonsubject worker."

¹ DIF has been renamed The Department of Consumer and Business Services. We will refer to it as DIF throughout this opinion, because that was its name at the time it issued the order in this case.

On review, Broadway makes several assignments of error. The first assignment is that DIF erred in ruling that the shift-lease drivers were "subject workers" under the Workers' Compensation Act, because Broadway was not a "subject employer." Second, Broadway argues that DIF's ruling that the drivers were subject workers was error, because they are exempt as "nonsubject workers" under ORS 656.027(14)(c).

In *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 630- 31, 872 P2d 1 (1994), the Supreme Court said:

"Thus we conclude that the statutes [ORS 656.027(14)(c) and ORS 656.005(28)] work together in the following manner. A determination first is made as to whether one is a 'worker' before a determination is made as to whether that 'worker' is a 'nonsubject worker' pursuant to one of the exemptions of ORS 656.027. The initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test. One who is not a 'worker' under that test is not subject to the workers' compensation coverage, and the inquiry ends. The 'nonsubject worker' provisions of ORS 656.027 never come into play. If the initial determination made under ORS 656.005(28) is that one is a worker because one is subject to direction and control under the judicially created 'right to control' test, then one goes on to determine under ORS 656.027 whether the worker is 'nonsubject' under one of the exceptions of that statute." (Emphasis in original.)

With that format in mind, we turn to Broadway's first argument that the shift-lease drivers are not subject workers and Broadway is not a "subject employer," because Broadway had no right of control over the drivers. SAIF points out that Broadway did not make that argument to DIF. Generally, we will not address an argument made for the first time on judicial review. Broadway counters that the issue is controlled by our decision in *Broadway Deluxe Cab v. National Council on Comp. Ins.*, 113 Or App 482, 833 P2d 1303 (1992), and the Supreme Court's holding in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, *supra*. The Broadway case involved a similar issue of whether Broadway was responsible <133 Or App 327/328> to pay workers' compensation premiums for its shift-lease drivers for a different audit period than the one involved in this case. In that case, Broadway argued that its shift-lease drivers were independent contractors. We said that, by arguing that the drivers were independent contractors, Broadway necessarily argued that it was not a "subject employer." We applied the right to control test and held for Broadway. Regardless of our holding in that case, we will not review an issue in this case unless it was raised before DIF. Although the facts in each audit period may be similar or identical, nonetheless, the law requires that DIF be given an opportunity to adjudicate a specific issue before this court will review it. Accordingly, petitioner's first assignment of error fails for lack of preservation.

In support of its second assignment of error, Broadway contends that even if it is deemed a "subject employer," the shift-lease drivers are "nonsubject workers." It says that, because the shift-lease drivers have a "lease-hold interest" in equipment that they "furnish, maintain and operate" as taxicabs, they are nonsubject workers under ORS 656.027(14)(c). That statute provides, in part:

"All workers are subject to this chapter, except those nonsubject workers described in the following subsections:

" * * * * *

"(14) A person who has an ownership or leasehold interest in equipment and who furnishes, maintains and operates the equipment as used in this subsection. 'equipment' means

" * * * * *

"(c) A motor vehicle operated as a taxicab as defined in ORS 767.025."

Thus, the statute requires Broadway's shift-lease drivers to not only have a lease-hold interest in the equipment but to "furnish" and "maintain" the equipment as well as to operate it.

DIF found, in part:

"[T]he shift-lease drivers did not 'maintain' the cabs to which they were assigned. Cab maintenance was the owner-operator's responsibility. The shift-lease drivers' responsibility ended with the return of the cab to [Broadway] in <133 Or App 328/329> good working order, with a full fuel tank. The shift-lease driver was not responsible for the cab's normal wear and tear. Further, although the contract allowed an owner-operator to sue a shift-lease driver for cab damage beyond the value of the \$250.00 promissory note, in practice the shift-lease driver had no obligation beyond forfeiture of the note. This was true even if the shift-lease driver destroyed the cab entirely. This being the case, the shift-lease driver cannot be said to maintain the cab."

Broadway does not argue that those findings are not supported by substantial evidence; rather, it contends that DIF has erroneously interpreted the meaning of the word "maintains" in ORS 656.027(14), because

"[d]uring the shifts in which they *lease* a taxicab, shift-lease drivers *maintain* said taxicab at any service station or garage of their choice; they pay for such maintenance out-of-pocket from passenger fares they have collected; their sole compensation comes from any excess in collected fees less weekly or daily lease payments and maintenance costs; and neither the owner-operators nor Broadway receive any portion, percentage or otherwise of the shift-lease drivers' collected passenger fares and gratuities, except for the preset shift-lease fee, which pays the owner-operator for the lease of the vehicle and permit and major maintenance to the vehicle, and Broadway for dispatching and other business services." (Emphasis in original.)

The word "maintains" in ORS 656.027(14) is an inexact term because, although the legislature has expressed its meaning completely, the agency has interpretive responsibility as it applies the legislature's meaning to various factual contexts in its rules or orders. See *Springfield Education Assn. v. School Dist.*, 290 Or 217, 233, 621 P2d 547 (1980). On review of the agency's interpretation, our role is to determine whether the agency erroneously interpreted a provision of law in its attempt to discern and apply the legislature's intent. *England v. Thunderbird*, 315 Or 633, 848 P2d 100 (1993). If legislative intent is clear from the text and context of the words in the statute, we end our inquiry. If the intent is unclear, we move to the second level of analysis and examine the legislative history underlying the statute. Finally, if the intent of the legislature is still not clear, we resort to general maximums of statutory construction. See <133 Or App 329/330> *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993).

We conclude that the use of the word "maintain" in the text and context of ORS 656.027(14) does not preclude all doubt about what meaning the legislature intended. In essence, the issue is one of degree. Broadway argues that the common meaning of "maintain" encompasses minor repairs, such as gas, oil and other incidental repairs. SAIF argues that "to maintain" equipment is to be responsible for keeping the equipment in good working order, including responsibility for major as well as minor repairs. Because either interpretation is reasonable on the face of the statute and in its context, we turn to the legislative history underlying the statute for assistance.

The reference to taxicabs in paragraph (c) of ORS 657.027(14) was added in 1985. Or Laws 1985, ch 431, s 1. The purpose of the 1985 amendment was discussed at a House Labor Committee meeting on June 5, 1985:

"[Representative Hill:] Representative Campbell, you mentioned employees. It's my understanding that cab companies have owner-operators and bona fide employees, yet I think I heard you say that they would be put together under this language.

"[Representative Campbell:] No, the intention of this is that the owner, the people who have an investment in it would be excluded. Those who are employees, and I think I mentioned the fact and it's, I think it's clear in the language, *employees, whether they be dispatchers or cab drivers, would continue to be included.* This would not exclude them. It's not the intent.

" * * * * *

"[House Labor Committee Counsel:] The only question I would have is whether or not--and I'm playing devil's advocate; please don't--

"[Chairman Shiprack:] It's early in the day, so we can accept that.

"[House Labor Committee Counsel:] Okay. People are always concerned about end runs around statutory language. *Is there a possibility that Broadway Cab Company or some other cab company would require an employee--a back-up driver or whatever they call them--to have some kind of leasehold interest in a cab? Does that happen?*

133 Or App 331 > "[Mr. Gillespie:] There's another bill that was--

"[Chairman Shiprack:] Identify yourself.

"[Mr. Gillespie:] I'm sorry. Sam Gillespie, representing Radio and Broadway Cab. There was another bill, House Bill 2876, which deals with state-wide authority for regulation. The City of Portland is regulating the cab industry--that--by being regulated and with state-wide authority--it requires that that could not happen. There's no phony partnerships or any of that back door stuff that can take place and the Portland [*sic*], through their licensing of the owners--they would lose their license and be prevented from doing business and they maintain that very well--I mean, they police it very well. *That could not happen.*

"[Chairman Shiprack:] Does the devil's advocate have any more questions?

"[House Labor Committee Counsel:] Well I would just state for the record that I think the 'and' here is important and to state that it is the intent of the bill--they have to 'furnish, maintain and operate' the equipment as well as have an 'ownership or leasehold interest' in it." (Emphasis supplied.)

This history indicates that the legislature amended ORS 656.027(14) to exempt only those individuals who have a substantial interest in the equipment, an interest that requires them to be responsible for maintenance to the same extent as individuals who are owners of the vehicles or who have a financial investment in them. The evidence is uncontroverted that any major repairs occasioned by a shift-lease driver's accident or negligence results only in the driver's forfeiture of a \$250 promissory note. Repairs in excess of \$250 remain the owner-operator's responsibility. The shift-lease driver is not responsible for the vehicle's ordinary wear and tear resulting from the driver's use during a 12-hour shift. The driver's obligation is to return the vehicle at the end of the shift with a full gas tank. In the light of that evidence, DIF's interpretation of the meaning of the word "maintains" is in keeping with the legislature's intention. It did not err in ruling that the shift-lease drivers do not "maintain" the cabs as the statute requires. Because the shift-lease drivers must meet all of the statutory elements of ORS 656.027(14), they cannot qualify as "nonsubject workers."

133 Or App 332 > Broadway's other arguments and third assignment of error do not require discussion.

Affirmed.

Cite as 133 Or App 428, 891 P2d 706 (1995)

March 9, 1995

Court of Appeals of Oregon.
Argued and Submitted Sept. 28, 1994.

**In the Matter of the Compensation of Every Mendenhall, Claimant.
REYNOLDS METALS and Cigna Insurance Companies, Petitioners,**

v.

**Every MENDENHALL, Respondent.
91-10150; 89-24635; 91-05946; CA A80507.**

Montgomery W. Cobb, Portland, argued the cause and filed the briefs for petitioners.
Victoria A. Harriman, Portland, argued the cause and filed the brief for respondent.

Before DEITS, P.J., and RIGGS and HASELTON, JJ.

133 Or App 430 > HASELTON, Judge.

Employer Reynolds Metals seeks review of a Workers' Compensation Board order setting aside its partial denial of claimant's lower back conditions. We reverse and remand.

Claimant worked at employer's aluminum plant in a position that involved frequent pulling and lifting of heavy objects. On December 30, 1990, claimant developed severe lower back pain while carrying two heat shields. His physician took him off work for several months; eventually he was released for light work. Claimant filed a workers' compensation claim, which described the site of his injury as his "lower back" and the nature of his injury as a "possible ruptured disc."

On May 6, 1991, employer sent claimant a letter advising him that it was accepting his claim for "low back strain" but denying responsibility for various lumbar spine conditions that a medical examination had revealed. Claimant's condition had never been diagnosed as "low back strain." On June 7, 1991, employer issued an amended partial denial:

"This denial letter amends the denial of May 6, 1991. Pursuant to Notice of Acceptance dated May 6, 1991, we have accepted your low back strain of December 30, 1990. However, there is no medical evidence that the injury of December 30, 1990 or your work at Reynolds Metals is the major contributing cause of any other condition which exists in your lumbar spine.

"We are therefore denying all pre-existing conditions in your lumbar spine including but not limited to stenosis at L3-4, foraminal stenosis at L4-5, bulging disk at L3-4, ruptured disks in the lumbar spine, degenerative disease in the lumbar spine, disk protrusion at L3-4, bulging disk at L5-S1, right antalgia and limp, and all symptoms caused by these conditions."

Claimant requested a hearing. There, he argued that employer's partial denial was invalid. The referee agreed, and set aside the denial except for the denial of the bulging disk at L5-S1 and right antalgia. Although the referee never explained his reason for affirming the denial with respect to <133 Or App 430/431> those two conditions, there is evidence in the record that could support that disposition.¹

¹ Although, in his progress notes, claimant's physician, Dr. Berkeley, described claimant as suffering from right antalgia and a possible bulging disk at L5-S1, he never stated in those notes, or anywhere else in the record, that those conditions were caused by claimant's on-the-job injury. Berkeley's letter opinion discusses only two specific conditions-- degenerative changes in claimant's lumbar spine at L3-4 and L4-5. The letter states:

"It is my opinion that [claimant] had chronic degenerative changes in the lumbar spine at L3-4 and L4-5, unrelated to his injury of December 30, 1990. These degenerative changes are longstanding, are chronic, but did not

The Workers' Compensation Board generally affirmed most aspects of the referee's order, but reversed the portion of the order upholding employer's denial of the L5-S1 condition and right antalgia:

"[Claimant's] injury was accepted by the insurer as a 'low back strain.' This injury manifested itself as pain in the right lumbar region radiating to the right buttock and leg and severe right antalgia and limp. It resulted in disability and the need for treatment. Dr. Berkeley, claimant's treating neurosurgeon, diagnosed preexisting degenerative changes in his lumbar spine at L3-4 and L4-5 which were asymptomatic until the injury was superimposed on the preexisting condition. Claimant was never diagnosed with a low back strain.

* * * * *

"The medical record supports Dr. Berkeley's opinion that claimant's preexisting low back condition was asymptomatic until the injury. Dr. Berkeley also opined that the injury was the major contributing cause of claimant's disability and need for treatment. There is no contrary opinion. Accordingly we conclude that claimant's current symptomatic low back condition, which resulted from the combination of his injury and preexisting disease is compensable. ORS 656.005(7)(a)(B).

133 Or App 432> "Consequently, given the language in the denial that denies 'all symptoms caused by these conditions,' we must set aside the denials in their entirety.

"Claimant is entitled to an assessed attorney fee for prevailing on the issue of the compensability of the right antalgia and L5-S1 conditions. ORS 656.386(1)." (Emphasis supplied.)

Employer asked the Board to reconsider, arguing that there is no evidence that claimant's injury or employment caused claimant's L5-S1 condition and right antalgia. On reconsideration, the Board adhered to its order, but offered a different explanation:

"The insurer construes our order finding claimant's current combined condition to be compensable to make claimant's antalgia and L5-S1 conditions compensable. However, we determined only that claimant's current condition and request for treatment was related to his occupational injury. *No claim was presented solely for claimant's pre-existing conditions. In the absence of a specific claim for treatment limited to noncompensable preexisting conditions, the insurer's denial of those conditions was premature.*" (Emphasis supplied.)

Employer now seeks review of the Board's order on the ground that the order fails to clearly state whether claimant's right antalgia and L5-S1 condition must be accepted.

Employer concedes that its partial denial was overbroad, because it includes conditions that are compensable, i.e., those symptoms that were caused by the combination of claimant's preexisting conditions at L3-4 and L4-5 and claimant's December 30, 1990 injury. However, employer contends that

cause any symptoms to the patient until the aforementioned work injury occurred. It is my opinion, therefore, that the effects of the work injury superimposed on a pre-existing condition gave rise to the patient's clinical symptoms and pain which required medical evaluation and treatment. The activities that he undertook at work did not in any way cause the degenerative changes which predated this accident, but they only acted superimposed on this pre-existing condition in giving rise to his clinical symptoms necessitating medical evaluation."

Although Berkeley's notes *could* be viewed as categorizing claimant's right antalgia as a symptomatic condition related to his L3-4 or L4-5 conditions, the referee apparently did not read them in that way.

the Board erred in setting aside its denial of claimant's L5-S1 condition and right antalgia, when: (1) there is no medical evidence that those conditions were related to claimant's on-the-job injury; and (2) the Board's apparent reason for its holding, that employer's entire denial was procedurally defective, does not justify reversal with respect to those two conditions. Employer argues that, because the Board's order creates confusion as to whether claimant's L5- S1 condition and right antalgia must be accepted, we should remand for clarification. Claimant argues that a remand is unnecessary, because the order <133 Or App 432/433> clearly and appropriately requires employer to accept the L5-S1 condition and right antalgia.²

We agree with employer that the reason stated by the Board in its original order and the differing rationale in its order on reconsideration are inadequate to explain its reversal of the referee's order with respect to claimant's L5-S1 condition and right antalgia. Accordingly, we reverse and remand.

The Board's original order stated that the partial denial and amended partial denial, which pertained specifically to the L5-S1 and right antalgia conditions, must be set aside "*in their entirety*" (emphasis supplied) because they deny "all symptoms caused by [the listed] conditions." That statement suggests that the Board believed it must set aside the entire denial because part of it was incorrect. That belief was erroneous; setting aside a denial is not necessarily an all or nothing proposition. So long as the evidence supports its decision, the Board may set aside the denial of some conditions and affirm the denial of others.

The Board's different rationale on reconsideration--that, in the absence of a specific claim for treatment limited to noncompensable conditions, it is premature to deny those conditions--was also erroneous. We addressed that reasoning in *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, 38, 771 P2d 295, *rev den* 308 Or 184, 776 P2d 1291 (1989). There, the claimant's employer accepted "any treatment related to the effects of" a shoulder and neck injury the claimant had suffered at work, but denied responsibility for "mild degenerative changes with mild osteophytic spurring" that appeared on the claimant's x-rays. The referee set aside that denial, reasoning that "it was premature, because there was no evidence that claimant was contending that the degenerative condition was compensable, either by obtaining treatment or requesting payment of medical bills." 96 Or App at 36, 771 P2d 295. The Board affirmed, but on a <133 Or App 433/434> different ground. On the employer's petition for judicial review, the claimant reiterated the referee's reasoning. We rejected that reasoning as unsound:

"We agree with employer that such a rule could put the employer in a precarious position. For example, in *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988), the claim was for 'sore back.' The employer accepted it, and the medical evidence later showed that the sore back was the result of a noncompensable degenerative condition. The employer then attempted to deny the degenerative condition, but the Supreme Court held that the employer's acceptance of the sore back claim encompassed all conditions that caused the sore back, including the noncompensable degenerative condition.

"Here, employer's early denial of the degenerative cervical condition is intended to protect it from later finding itself in the position in which Georgia-Pacific found itself in *Piwowar*. To refuse to allow the partial denial would require the employer either to accept the claim and risk the result in *Piwowar*, or neither to accept nor deny the claim until all of the possible medical evidence concerning the cause of the condition is available, at which time the employer may be subject to a penalty for a late acceptance or denial.

* * * * *

² Claimant also contends that employer "waived" the scope of acceptance issue because it failed to raise it before the Board. However, in the workers' compensation context, a party's silence with respect to some issue cannot be viewed as a waiver unless the record shows an intent to waive a known right. *Dreus v. EBI Companies*, 310 Or 134, 150-51, 795 P2d 531 (1990); *V.W. Johnson & Sons v. Johnson*, 103 Or App 355, 358, 797 P2d 396 (1990), *rev den* 311 Or 60, 803 P2d 732 (1991). Because we find nothing in the record to support such an intentional waiver, we reject claimant's argument.

"The partial denial does not, on the other hand, prevent claimant from later showing that the degenerative condition has been worsened or accelerated as a result of the injury. We know of no reason why an employer should not be permitted to deny the compensability of a condition that it reasonably interprets to be encompassed in a claim and which it believes to be noncompensable." 96 Or App at 36-38, 753 P2d 948.

Here, as in *Weyerhaeuser Co. v. Warrilow*, *supra*, claimant submitted a claim for a condition that is described in only the most general terms: It is located in claimant's "lower back" and involves a "possible ruptured disc." Employer reasonably interpreted that claim to encompass claimant's right antalgia and bulging disk at L5-S1, and apparently believed that those conditions were noncompensable. Consequently, under the principle expressed in *Warrilow*, the Board erred in setting aside the employer's partial denial of the right antalgia and L5-S1 condition as "premature." *Accord King v. Building Supply Discount*, 133 Or App 179, 889 P2d 1310 (1995).

133 Or App 435 > Employer also assigns error to the Board's award of attorney fees to claimant for prevailing on the issue of the compensability of claimant's right antalgia and L5-S1 conditions. In view of our remand, we vacate the award of attorney fees.

Reversed and remanded for reconsideration.

Cite as 133 Or App 596, 891 P2d 1385 (1995)

March 22, 1995

Court of Appeals of Oregon.
Submitted on Remand Jan. 20, 1995.

**In the Matter of the Compensation of Deborah K. Atchley, Claimant.
SAIF CORPORATION and Centennial Medical, Petitioners,**

v.

**Deborah K. ATCHLEY, Respondent.
91-05626; CA A76029.**

Theodore R. Kulongoski, Atty. Gen., Virginia L. Linder, Sol. Gen., and David L. Runner, Asst. Atty. Gen., filed the supplemental brief for petitioners.

James L. Edmunson and Malagon, Moore, Johnson & Jensen, Eugene, filed the supplemental brief for respondent.

Before RIGGS, P.J., and RICHARDSON, C.J., and LEESON, J.

133 Or App 597 > PER CURIAM.

This case is on remand from the Supreme Court for reconsideration. *SAIF Corporation v. Atchley*, 320 Or 405, 884 P2d 867 (1994). The Board's order awarded claimant attorney fees for SAIF's late payment of claimant's medical services claim. SAIF concedes that in the light of *SAIF Corporation v. Allen*, 320 Or 192, 881 P2d 773 (1994), claimant is entitled to attorney fees under ORS 656.386(1), because its late payment of claimant's medical services claim constituted a *de facto* denial and the record does not establish that the denial was limited to the amount of compensation due.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Judith L. Duncan, Claimant.

Judith L. DUNCAN,
Petitioner - Cross-Respondent,

v.

LIBERTY NORTHWEST
INSURANCE CORPORATION
and Nike International,
Respondents - Cross-Petitioners.

(WCB 91-10737; CA A80842)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 20, 1994.

Robert Wollheim argued the cause for petitioner - cross-respondent. With him on the briefs was Welch, Bruun, Green & Wollheim.

Craig A. Staples argued the cause for respondents - cross-petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.

Before Richardson, Chief Judge, and Landau* and Leeson, Judges.

RICHARDSON, C. J.

Affirmed on petition and on cross-petition.

* Landau, J., *vice* Rossman, P. J., retired.

RICHARDSON, C. J.

Claimant seeks review of an order of the Workers' Compensation Board that modified her award of permanent partial disability benefits. Employer cross-petitions for review of the same order. We affirm.

On November 3, 1989, claimant fell at work and injured her left knee, left wrist and right wrist. Employer accepted a claim for her left knee and left wrist injuries. Seven months later, while neither accepting nor denying compensability of claimant's right wrist injury, employer authorized right carpal tunnel release surgery, which was performed. On February 12, 1991, a determination order was issued; it found claimant medically stationary as of September 17, 1990, and awarded her 11 percent permanent partial disability (PPD)

for her right wrist and four percent PPD for her left wrist.¹ She was also awarded temporary partial disability (TPD) for November 6, 1989, through May 14, 1990.²

On June 27, 1991, claimant filed a timely request for reconsideration of the determination order, ORS 656.268(5), alleging that she was entitled to increased PPD for her right wrist and enforcement of the TPD award. Employer did not request reconsideration of the determination order. The order on reconsideration increased to 33 percent claimant's PPD for her right wrist and affirmed the remainder of the determination order.

On August 12, 1991, claimant timely requested a hearing. On November 5, 1991, two days before the hearing, employer filed a cross-request for a hearing, seeking reduction of the PPD rating of the right wrist injury to zero on the ground that it was not a compensable injury. At the November 7, 1991, hearing, claimant moved to dismiss employer's cross-request as untimely.³ The referee granted the motion

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for dismissal, affirmed the reconsideration order and awarded claimant penalties and attorney fees for employer's unreasonable failure to pay the temporary benefits awarded by the determination order.

Employer requested review by the Workers' Compensation Board (Board).⁴ The Board reversed the portion of the referee's order that dismissed employer's cross-request for a hearing. The Board reasoned that claimant's timely request for a hearing placed the determination and reconsideration orders properly before the referee, and the referee could have considered employer's request for reduction of those awards. However, the Board concluded that, because employer had failed to request reconsideration of the determination order, the disability benefits awarded by the determination order served as a floor. Although the Board agreed with employer that the right wrist injury was not compensable, the Board reduced the PPD benefits from 33 percent to the 11 percent PPD rating awarded by the determination order. The remainder of the referee's order, including the award of penalties and attorney fees, was affirmed.

¹ The PPD award for her left wrist is not at issue on review.

² Claimant was also awarded TPD for August 21, 1990, through September 17, 1990, and temporary total disability (TTD) for the period of May 15, 1990, through August 20, 1990; however, only the TPD awarded for the period of November 6, 1989, through May 14, 1990, is at issue on review.

³ At the hearing, claimant withdrew her request for increased PPD and temporary disability benefits, leaving the following issues to be determined: payment rate of PPD, assessment of penalties and attorney fees, and enforcement of temporary disability benefits.

⁴ In its request, employer raised the following issues:

- (1) Whether the Board had jurisdiction to consider claimant's entitlement to the temporary and permanent disability benefits awarded by the determination order;
- (2) Whether the employer was obligated to pay the temporary disability benefits awarded;
- (3) Whether the imposition of penalties and attorney fees for unreasonable failure to pay were properly assessed;
- (4) Whether claimant was entitled to a PPD award for her right wrist; and
- (5) Whether claimant's PPD benefits are payable at a rate of \$145 or \$305 per degree.

Claimant's only assignment in this court is that the Board erred in holding that it had jurisdiction to consider employer's request that claimant's PPD be reduced. Claimant argues that employer's failure to timely request a hearing under ORS 656.268(6)(b) deprives the referee and the Board of jurisdiction to reduce her PPD award. Employer argues that the Board had jurisdiction over and could address employer's contentions regarding the determination and reconsideration orders because a timely request for a hearing was filed by claimant. That is correct. *Pacific Motor Trucking Co. v. Yeager*, 64 Or App 28, 666 P2d 1366 (1983). Employer

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was not required to cross-request a hearing to raise issues about the PPD award. However, the issues that employer could properly raise at the hearing are limited by our resolution of employer's first assignment of error.

Employer's first assignment on its cross-petition is that the Board erred in concluding that the disability benefits awarded by the determination order served as a floor and thus, employer was barred from seeking a reduction to zero of that award at the hearing because employer had failed to request reconsideration under ORS 656.268(5).⁵ Employer argues that the language of ORS 656.268(5) requires only that the reconsideration process be first invoked before the Board can acquire jurisdiction to conduct a hearing, not that it limits a party's ability to raise issues at a hearing once jurisdiction is established. Claimant contends that employer's failure to request reconsideration bars employer from challenging for the first time at the hearing the disability benefits awarded by the determination order.

The issue that must be resolved is what effect the failure to request reconsideration of a determination order has on a party's right to subsequently raise issues. ORS 656.268(6)(b) provides, in part:

"If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283."

ORS 656.283 provides that any party or the director may at any time request a hearing, subject to ORS 656.319.⁶ ORS 656.295 provides for Board review of referee orders and ORS 656.298 provides for judicial review of Board orders.

Considering the text of ORS 656.268(5) in that context, the language creates a reconsideration process that

⁵ ORS 656.268(5) provides, in part:

"If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order."

⁶ ORS 656.319 provides time periods within which a hearing must be requested. For example, ORS 656.319(4) provides:

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

serves as an additional level of review in the workers' compensation system. A review of the legislative history of ORS 656.268(5) provides further instruction in this regard. Cecil Tibbetts, a member of the Governor's Workers' Compensation Labor/Management Advisory Committee, explained:

"And our purpose here is to cut down the number of appeals, the number of hearings that have to take place. So what we're now instituting is that a worker who is unsatisfied with a determination order will have an obligation to request reconsideration of that order." Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side B at 394 (emphasis supplied).⁷

It is evident that the purpose of the reconsideration process created by ORS 656.268(5) was to provide a less formalized level of review of a determination order, at the department level, in an attempt to reduce the number of hearings and appeals.

If we were to adopt the analysis of ORS 656.268(5) urged by employer, the intent of the legislation would be diluted. If a party does not raise the objection on reconsideration, there is no opportunity to address and possibly correct the problem at this early stage of the process. If that party seeks to litigate an issue for the first time at the hearing, the reconsideration process has become a nullity and the process would then essentially begin anew at the more formalized hearing level. Employer sees ORS 656.268(5) as a jurisdictional statute. It argues that that statute only establishes reconsiderations as a prerequisite to the Board acquiring jurisdiction. The hearings division and the Board have jurisdiction pursuant to ORS 656.283(1). ORS 656.268(5) relates not to jurisdiction to conduct a hearing, but in part to preservation of issues that may be raised at the hearing.

Claimant asserts, and we agree, that employer is barred from challenging the determination order award at a hearing because it did not seek reconsideration. A party may

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seek review of the order on reconsideration, but when a party objects at a hearing to a part of the reconsideration order that merely affirms the determination order, the party's true objections are to the determination order and ORS 656.268(5) forecloses the objection if no request for reconsideration was made. Thus, the determination order becomes the instrument that defines the maximum or minimum awards when a party fails to raise its objections through a request for reconsideration. However, if the reconsideration order changes the determination order, the propriety of that change can be raised by either party at a hearing. In this case,

⁷ See Statements of Representative Shiprack: "We are also going to require workers who disagree with the initial disability of evaluation decision to seek a reconsideration. * * * This will dramatically cut back the time that is spent in the hearings process." Tape Recording, Special Session, House floor debate, May 7, 1990, Tape 2, Side A at 5. See also *Jackson v. Tuality Community Hospital*, 132 Or App 182, 186, 888 P2d 35 (1994) (citing Representative Shiprack and concluding that the purpose of reconsideration process was to cut down on the number of appeals).

the determination order served as a floor, and employer could not seek reduction of the temporary or permanent disability benefits below that level because it did not request reconsideration on those issues.

Employer argued before the Board that it had never accepted claimant's right wrist injury and, therefore, claimant's award of PPD should be zero. The Board agreed that the injury was not compensable, but applied the determination order as a floor when it reduced the PPD award. Employer does not argue on review that the PPD for the right wrist should be reduced because the extent of disability was not proven, but instead argues that the entire right wrist injury is not compensable. However, employer failed to challenge the compensability of claimant's injury by a request for reconsideration⁸; thus, it is precluded from arguing at a hearing, and on review, that the injury is not compensable.

Employer's second assignment of error challenges the Board's determination that employer was obligated to pay claimant temporary disability benefits at her full time loss rate from November 6, 1989, through May 14, 1990. Again, because employer failed to seek reconsideration of the TPD benefits awarded, we will not consider employer's arguments on review.

Employer's third assignment of error challenges the Board's affirmation of the referee's imposition of penalties for employer's nonpayment of TPD benefits. Employer
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argues that it properly relied on OAR 436-60-030(2)⁹ and recent Board decisions¹⁰ in refusing to pay the compensation awarded. It argues that imposition of the penalty was not supported by substantial evidence because, even though it failed to object to the award of TPD benefits in the determination order, the award was clearly wrong and refusing to pay it was not unreasonable. Claimant responds that if employer objected to the award of TPD benefits, it should have requested reconsideration of the determination order rather than raising the objection for the first time at the hearing. Claimant concludes that employer's actions in failing to object and then failing to pay were unreasonable, and the penalty was properly assessed.

⁸ Nor did employer, after determining that the claim was not compensable, properly issue a notice of claim denial pursuant to ORS 656.262(6).

⁹ OAR 436-60-030(2) provides:

"Temporary disability payments are not due if post-injury wages equal or are greater than the wages earned at the time of injury. However, a worker released to and doing modified work at full wage from the onset is entitled to temporary total disability under the circumstances described in subsection (4)(b) of this rule."

¹⁰ See, e.g., *Robert L. Parrish*, 45 Van Natta 1035 (1993); *Mindi M. Miller*, 44 Van Natta 2144 (1992); *Jason L. Bail*, 42 Van Natta 553 (1990), *aff'd Bail v. EBI Services*, 106 Or App 180, 807 P2d 347, *rev den* 311 Or 482 (1991).

On review, the only period of TPD benefits to which employer objects are November 6, 1989, through May 14, 1990. It has never challenged the award of TPD benefits for the period August 21, 1990, through September 17, 1990, and it is for part of this period that employer claims the penalty was wrongly assessed. However, because employer failed to object to *any* of the TPD benefits by requesting reconsideration, we do not consider employer's arguments on review.

Affirmed on petition and on cross-petition.

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April 12, 1995

No. 161

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Kevin D. Cox, Claimant.

SAIF CORPORATION
and Action Mill Work, Inc.,
Petitioners,

v.

Kevin D. COX,
Respondent.

(93-12345; CA A85496)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 10, 1995.

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.

Anita C. Smith argued the cause for respondent. With her on the brief was Estell and Bewley.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

HASELTON, J.

Reversed and remanded for reconsideration.

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HASELTON, J.

Employer petitions for review of an order of the Workers' Compensation Board, which determined that, under the so-called "dual capacity doctrine," claimant was a subject worker entitled to compensation. We remand for the Board to determine whether claimant was a bona fide corporate officer and director with a substantial ownership interest in employer, at the time he was injured. ORS 656.027(9).

The Board adopted these findings by the referee:

"Claimant, 31 years of age at hearing, has worked for approximately 7 years at the premises where he was working on July 22, 1994 when he sustained a severe left hand injury. Originally, the employer was named Action Lumber, but in 1989 or 1990 the business entity was changed into a corporation bearing the name of Action Millwork Inc. Until that time claimant had worked at an hourly rate and had no authority in the employing entity. Following that time, claimant became a 'stockholder,' as did all employees, each of whom received a dividend by Action Lumber and then sustained a deduction of \$200 from that dividend as payment for the individuals' stock certificates. Claimant also became an 'officer' of the new corporation. Seven employees of Action Lumber were listed as vice presidents and directors of Action Millwork Inc. Claimant attended four or five corporate board meetings, which originally were held once per month, but soon entirely ceased. The last such meeting was approximately two years ago. Claimant took no active part during the meeting, but, rather, merely sat there. Claimant has never received any distribution of corporate earnings. Claimant has no authority in management of the business — he simply takes orders from Rod Lucas, who is president of the corporation. Mr. Lucas has the authority to hire and fire, including the authority to fire claimant. * * * Non-officer employees continued to be covered by SAIF. Claimant understood that, as a corporate officer, he would not be covered by SAIF Corporation for any on-the-job injuries, but understood that he would be covered by another workers' compensation carrier. After the corporate change, he continued to work under the belief that he was still covered by workers' compensation insurance.

"Over the course of SAIF's dealings with the corporation, one or more corporate officers have expressly elected coverage, but claimant has never elected personal coverage, nor has that option ever been presented to him. At no time has

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the premium assessed by SAIF against the employer reflected claimant's earnings as an employee.

"As a corporate 'shareholder' and 'officer,' claimant's job did not change at all, and he continued to operate the planer. His hourly rate of pay did not change.

"On July 22, 1993, claimant suffered a severe injury to his left hand while changing blades on the planer. He has not yet been released to return to work. Meanwhile, he has received no worker's compensation coverage but has received some compensation through a disability insurance program he personally obtained and paid for." (Footnote omitted.)

Employer's insurer, SAIF Corporation, denied coverage for claimant's hand injury, asserting that claimant, as a corporate officer and director, was a nonsubject worker under ORS 656.027(9), and that he was not covered by an election of coverage under ORS 656.039(1).¹ ORS 656.027(9) provides, in part:

¹ ORS 656.039(1) provides, in part:

"An employer of one or more persons defined as nonsubject workers or not defined as subject workers may elect to make them subject workers. If the employer is or becomes a carrier-insured employer, the election shall be made by filing written notice thereof with the insurer with a copy to the director."

"All workers are subject to this chapter except those nonsubject workers described in the following subsections:

"* * * * *

"(9) Corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation * * * [.]"

Claimant disputed the denial of coverage on two grounds. First, ORS 656.027(9) was inapposite because claimant was not a bona fide corporate officer and director with a substantial ownership interest in the employer. Second, even if ORS 656.027(9) were otherwise applicable, claimant would still be entitled to compensation under the dual capacity doctrine. In *Erzen v. SAIF*, 40 Or App 771, 775, 596 P2d 1004, *rev den* 287 Or 507 (1979), this court summarized that doctrine:

"[U]nder the dual capacity doctrine, in the absence of contrary statute, if an officer of a corporation at the time of his injury is performing labor as an ordinary workman the Workers' Compensation Act does not preclude the allowance

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of compensation. It is the nature and character of the work performed, rather than the title of the individual that is controlling."

In this case, neither the referee nor the Board addressed whether claimant was a bona fide corporate officer and director of employer. Instead, both relied on the Board's precedent *Kenneth G. Mize*, 49 Van Natta 477 (1993), *dismissed* 129 Or App 636, 879 P2d 907 (1994), in concluding that, under the dual capacity doctrine, claimant was a subject worker because he was performing the labor of an ordinary worker, and not a corporate officer, at the time he was injured. In *Mize*, the Board held that a 1990 amendment to ORS 656.027(9) had revived the dual capacity doctrine, which had been endorsed in *Erzen*, and which had been subsequently abrogated by a 1981 statutory amendment.²

² When *Erzen* was decided in 1979, the then-pertinent statute, ORS 656.027(7) (*since amended* by Or Laws 1981, ch 535, § 3; Or Laws 1983, ch 579, § 3; Or Laws 1989, ch 762, § 4) provided:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(7) Sole proprietors, partners and officers of corporations."

At that time, the Board had promulgated an "administrative interpretation" of the term "officers of corporations," which concluded that the statutory exception applied only to officers injured during the performance of their official duties as corporate officers. 40 Or App at 776. This court sustained that "dual capacity" interpretation as "not inconsistent with the legislative intent." 40 Or App at 777. Two years later, in 1981, the legislature repudiated the Board's interpretation and *Erzen* by enacting ORS 656.027(8), which excepted:

"A corporate officer who is also a director of the corporation and has a substantial ownership in the corporation, *regardless of the nature of the work performed by such officer.*" Or Laws 1981, ch 535, § 3 (emphasis supplied).

In 1990, the legislature enacted the present ORS 656.027(9), Or Laws 1990, ch 2, § 4, which substantially revised ORS 656.027(8), adding new language and deleting the emphasized language inserted in 1981. In *Mize*, the Board pointed to the deletion of the emphasized language as evincing legislative intent to return to the pre-1981 dual capacity status quo.

On review, employer argues that the Board erred in relying on *Mize* because that case was wrongly decided. In particular, employer argues that the Board in *Mize* both misread *Erzen* and erroneously analyzed the text, context, and legislative history of the 1990 enactment of ORS 656.027(9). See *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993).

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We do not reach the merits of the parties' arguments regarding the dual capacity doctrine because the Board failed to determine a predicate issue: Was claimant a bona fide corporate officer and director with a substantial ownership interest in employer?³ If he was not, any discussion of the dual capacity doctrine, including its applicability to ORS 656.027(9), would be gratuitous.

Under ORS 656.027(9), only bona fide corporate officers and directors are excepted from subject worker status. See *Carson v. State Indus. Acc. Comm.*, 152 Or 455, 459-60, 54 P2d 109 (1936) (construing Or Laws 1933, ch 116, § 3); *Erzen*, 40 Or App at 777-78 (construing ORS 656.027(7) (1979)). "Sham" officers and directors are not: "[I]t was never intended that an employee, being an officer of a corporation in name only and having no voice in determining the policy of the company, should be precluded from receiving benefits under the Act." *Carson*, 152 Or at 459-60. Thus, regardless of the applicability of the dual capacity doctrine, employer cannot prevail, even under its own analysis, unless claimant was a bona fide, rather than a sham, officer and director. Until that predicate is established, any consideration of the dual capacity doctrine is unwarranted. See *Erzen*, 40 Or App at 777-78 (dual capacity doctrine applies only to bona fide officers and directors).

We conclude, accordingly, that review of the Board's dual capacity analysis would be premature until the Board determines whether claimant was, in fact, a bona fide corporate officer and director, with a substantial ownership interest in employer.

Reversed and remanded for reconsideration.

³ The parties agree that the Board did not decide that issue.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Connie M. Johnson, Claimant.

WRIGHT SCHUCHART HARBOR
and St. Paul Fire and Marine
Insurance Company,
Petitioners,

v.

Connie M. JOHNSON,
Respondent.

(WCB 92-06467; CA A83744)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 13, 1994.

Craig Creel argued the cause and filed the brief for petitioners.

James L. Edmunson argued the cause and filed the brief for respondent.

Before Deits, Presiding Judge, and Riggs and Haselton, Judges.

HASELTON, J.

Reversed and remanded for reconsideration of waiver issue.

HASELTON, J.

Employer petitions for review of an order of the Workers' Compensation Board that sets aside employer's denial of compensability to the extent that it denied the compensability of surgery to repair claimant's knee condition. Employer contends that the Board improperly considered the medical services issue because claimant had previously waived any medical services claim. We reverse and remand for reconsideration.

Claimant originally injured her left knee in a nonwork-related incident in 1977. In April 1990, she compensably reinjured her left knee. Her treating physician diagnosed a torn posterior horn of the medial meniscus and performed arthroscopic surgery to repair that problem and to remove an anterior cruciate ligament tag. In January 1991, the claim closed, and claimant was awarded a 20 percent scheduled permanent disability.

A year later, claimant began to experience more pain, swelling, and instability in her knee, and her doctor recommended either further conservative care or additional anterior cruciate ligament surgery. Claimant requested authorization for surgery. Employer's insurer required claimant to

attend an independent medical examination. The examining physician opined that the 1977 nonwork-related knee injury, rather than claimant's April 1990 on-the-job injury, was the major contributing cause of her current need for surgery. Based on that opinion, employer's insurer denied claimant's request for authorization.

Claimant sought a hearing before a workers' compensation referee by submitting a standard "Request for Hearing" form. On that form, she checked the boxes corresponding to seven of the 17 listed reasons for requesting a hearing, including the boxes for "aggravation" and "medical services."

At the beginning of the hearing, the following colloquy occurred among the referee, claimant's attorney (Alvey), and employer's attorney (Creel):

"REFEREE: * * * Concerning the issues in this case, I understand that the sole issue in this proceeding is the compensability of an alleged aggravation. Is that correct, Mr. Alvey?"

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"MR. ALVEY: That's correct.

"REFEREE: And Mr. Creel, is that your understanding?"

"MR. CREEL: That is my understanding.

"REFEREE: Okay. And there's no cross-issues by the insurer?"

"MR. CREEL: There are none.

"MR. ALVEY: Should claimant prevail, we would, of course, ask for a carrier-paid fee also.

"REFEREE: All right. I consider that part and parcel of an aggravation and not as a separate issue, but I appreciate you indicating that on the record."

Thereafter, neither claimant's nor employer's counsel made any reference to the compensability of medical services, specifically including any assertion that, regardless of whether claimant proved an aggravation, she was entitled under ORS 656.245 to the additional knee surgery as medical services that were materially related to her 1990 compensable injury. The parties' evidentiary and legal submissions focused solely on the aggravation issue and, specifically, on whether, given claimant's preexisting 1977 knee condition, the compensable April 1990 injury was the major contributing cause of her worsened condition. The referee upheld the insurer's denial on the ground that claimant had not proved the requisite causal connection between her compensable knee injury and her worsened condition.

The Workers' Compensation Board affirmed and adopted that order, but stated:

"By agreeing with the Referee's conclusion that claimant has failed to prove a compensable aggravation claim, we do not mean to suggest that claimant cannot assert a valid medical services claim under ORS 656.245. See *Beck v. James River Corporation*, [124 Or App 484, 863 P2d 526 (1993), *rev den* 318 Or 478 (1994)]."

Claimant moved for abatement and reconsideration of that order, arguing that she had proved a valid medical services claim under ORS 656.245, and asked that the Board enter an order stating that her need for surgery was compensable under the analysis of *Beck*. Employer opposed that motion, arguing that, because aggravation was the sole issue litigated
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at hearing, the Board should decline to address whether claimant had proved an entitlement to medical services on any other basis.

In its order on reconsideration, the Board rejected employer's waiver contention:

"We acknowledge that claimant's attorney agreed with the Referee's statement at hearing that the sole issue in the proceeding concerned aggravation. Without an express declaration, however, that claimant no longer wished to pursue the medical services issue, we find that she did not waive that question."

Proceeding to the merits, the Board decided that claimant had proved a compensable medical services claim "because claimant's 1990 injury bears a causative relationship to [claimant's] need for surgery."

Employer first assigns error to the Board's determination that claimant had not waived her right, under ORS 656.245, to seek compensation for medical services relating to her 1990 injury. Employer argues that claimant's counsel's response to the referee bears only one reasonable construction: Claimant had narrowed her claim exclusively to aggravation and was abandoning all other issues she had previously raised in her request for hearing, including medical services other than those based on aggravation. Thus, employer reasons, counsel's statements expressed and effected a waiver and precluded claimant from later raising the medical services issue, including before the Board. Claimant responds that her counsel was "at most silent" with respect to the medical services issue, that mere silence cannot be construed as a waiver, and that the Board had complete authority to consider the issue because the record was fully developed with respect to that issue.

In advancing their arguments, both parties indiscriminately equate the legal principles pertaining to *waiver* with those pertaining to an adjudicative body's authority to decide issues *not raised* in the antecedent proceedings. Although the two may overlap in particular cases, they exist for decidedly different reasons and should not be treated as freely interchangeable. Waiver is primarily a principle that addresses litigants' rights *inter se*; it seeks to give effect to a party's intentional and voluntary commitment to forgo some right. *Waterway Terminal v. P.S. Lord*, 242 Or 1, 26, 406 P2d 556 (1965). Conversely, limitations on an appellate body's ability to address previously unasserted claims or arguments, which are generally couched in terms of "preservation," arise primarily from jurisprudential concerns, *i.e.*, "to promote an efficient administration of justice and the saving of judicial time" and fairness in the process. *Shields v. Campbell*, 277 Or 71, 78, 559 P2d 1275 (1977).

Because of those differences in purpose, a party's waiver of a claim precludes that party from later asserting that claim, regardless of whether, as a prudential matter, the adjudicative body could otherwise have addressed the claim in the first instance. Just as a waiver binds a litigant at trial or at hearing, it continues to be binding on appeal or administrative review. *Accord State v. Maestas*, 113 Or App 744, 746, 833 P2d 1348 (1992)(even if court had discretion to reach unpreserved error because it was apparent on the face of the record, court would not review that error because defendant's failure to preserve was a tactical decision). Thus, regardless of the Board's discretion to reach and decide issues not raised in the first instance before a referee,¹ if claimant did, in fact, waive the medical services claim before the referee, she was barred from asserting that claim on reconsideration, and the Board erred in determining that claim.²

We turn, then, to the Board's determination that claimant did not waive her right to assert a medical services claim based on the 1990 injury. Waiver is "the intentional relinquishment of a known right." *Drews v. EBI Companies*, 310 Or 134, 150, 795 P2d 531 (1990); *Cravens v. SAIF*, 121 Or App 443, 447, 855 P2d 1129 (1993). Waiver must be plainly and unequivocally manifested, either "in terms or by such

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conduct as clearly indicates an intention to renounce a known privilege or power." *Great American Ins. v. General Ins.*, 257 Or 62, 72, 475 P2d 415 (1970). See also *Brown v. Portland School Dist. #1*, 291 Or 77, 84, 628 P2d 1183 (1981) ("To make out a case of waiver of a legal right there must be a clear, unequivocal, and decisive act of the party showing such a purpose[.]").

In general, the question of whether a waiver has occurred is resolved by examining the particular circumstances of each case. *State v. Meyrick*, 313 Or 125, 132, 831 P2d 666 (1992). Here, however, the Board did not engage in such an inquiry. Although it did acknowledge claimant's counsel's statements before the referee, the Board did not consider whether, as a factual matter, those remarks actually evinced and expressed an intent to relinquish a known right. Instead, the Board simply stated that in the absence of "an express declaration * * * that claimant no longer wished to pursue the medical services issue," it would not find a waiver. That "bright line" requirement of an explicit disclaimer, which was not related to the parties' particular circumstances, embodies a legal conclusion, and we review it for legal error. ORS 183.482(8)(a).

¹ Employer's brief to this court asserted that, even if claimant did not waive the medical services issue, the Board erred in reaching "a completely new issue * * * which was * * * never touched upon at hearing on reconsideration." However, at oral argument, employer's counsel withdrew that argument: "I don't think it is germane to the issues before us, nor do I think that recent case law is in support of the contention * * *." Accordingly, we need not address the contours and breadth of the Board's discretion to address issues raised for the first time on reconsideration. See generally *Rice v. Columbia Steel Casting*, 129 Or App 82, 877 P2d 672 (1994).

² No party contends that, in the absence of some assertion by claimant, the Board could *sua sponte* adjudicate an entitlement to medical services.

In general, waiver may be either explicit or implicit, that is, implied from a party's conduct. See *Powell v. Goff*, 126 Or App 194, 198, 868 P2d 26 (1994). Consequently, an explicit disclaimer is ordinarily not a prerequisite for an enforceable waiver. But see *State v. Grenvik*, 291 Or 99, 102, 628 P2d 1195 (1981) (waiver will not be presumed from a silent record). The issue thus reduces to whether the Board erred in deviating from that general, but not absolute, principle by requiring an explicit disclaimer in this case. We conclude that it did.

Our holding turns on the fundamental relationship between medical services and aggravation under the workers' compensation statutes. Under ORS 656.245, a claimant may seek medical services either for an initial compensable condition or for a compensable worsening of such a condition.³

Cite as 133 Or App 680 (1995)

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Moreover, under ORS 656.273, a claim for aggravation may, but need not, encompass a request for medical services.⁴ Thus, in the most elementary terms, some, but not all, requests for medical services are based on aggravation claims, and some, but not all, aggravation claims involve requests for medical services. The two are not congruent.

Here, claimant clearly asserted an entitlement to medical services based on an alleged aggravation. Thus, counsel's agreement that the sole issue at hearing was "aggravation" did not preclude an entitlement to medical services on that basis; the former subsumed the latter. However, claimant failed to prove the predicate aggravation, and does not seek review of that determination.

Conversely, claimant's counsel's agreement that the sole issue was aggravation could, depending on the circumstances, be viewed as impliedly limiting claimant from recovering medical services on any basis other than aggravation. We discern no reason why such an implied waiver — if waiver it was — should be deemed ineffective as a matter of law because it did not refer explicitly to a request for medical services based on the 1990 injury. Nor did the Board identify any special consideration of workers' compensation policy or practice compelling such an absolute requirement.

³ 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."

⁴ ORS 656.273(1) provides, in part:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for a worsened condition resulting from the original injury."

Stripped of its erroneous legal premise that claimant was required to explicitly disavow any entitlement to medical services based on the 1990 injury, the Board's order lacks "an ordered set of findings of fact and is devoid of any explanation of why facts supported by evidence lead to its conclusion" that claimant did not waive her right to assert that, regardless of the disposition of her aggravation claim, the proposed knee surgery was nonetheless compensable. *Armstrong v. Astenhill Co.*, 90 Or App 200, 207, 752 P2d 312 (1988). Ultimately,

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the meaning and effect of claimant's counsel's statements—*i.e.*, whether claimant actually intended to waive a known right to assert a claim for medical services—must be ascertained from the totality of the circumstances. We remand to the Board for such a determination.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gisela M. Stephens, Claimant.

DIANE'S FOODS
and Liberty Northwest
Insurance Corporation,
Petitioners,

v.

Gisela M. STEPHENS,
Respondent.

(WCB 92-10499; CA A81346)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 20, 1994.

Jerry K. Brown argued the cause for petitioners. On the brief were Charles L. Lisle and Cummins, Brown, Goodman, Fish & Peterson, P.C.

Randy Elmer argued the cause for respondent. With him on the brief was Law Offices of Michael B. Dye.

Before Richardson, Chief Judge, and Landau* and Leeson, Judges.

PER CURIAM

Affirmed.

* Landau, J., *vice* Rossman, P. J., retired.

PER CURIAM

In this workers' compensation case, employer seeks review of an order of the Board reversing the referee's order that reduced claimant's permanent partial disability (PPD) to zero. The Board reinstated the determination order award of 29 percent PPD because employer had failed to request reconsideration of that award under ORS 656.268(5).

Employer's only argument is that ORS 656.268 is a jurisdictional statute under which reconsideration is a prerequisite to the Board's acquiring jurisdiction to conduct a hearing. It argues that it does not matter which party initially requests reconsideration of the determination order and that it may properly raise any objections to the determination order award of PPD at the hearing. We rejected this same argument in *Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605, ___ P2d ___ (1995), in which we held that failure of a party to request reconsideration of a determination order will bar that party's subsequent challenge to the determination order award at a hearing.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Victoria Clark, Claimant.

FIRST INTERSTATE BANK
OF OREGON,
Petitioner,

v.

Victoria CLARK,
Respondent.

(WCB 92-16330; CA A82400)

In Banc*

Judicial Review from Workers' Compensation Board.

Argued and submitted August 9, 1994; resubmitted in banc
January 10, 1995.

Deborah L. Sather argued the cause for petitioner. With her
on the brief was Stoel Rives Boley Jones & Grey.

G. Duff Bloom argued the cause for respondent. With him on
the brief was Coons, Cole and Cary, P.C.

DEITS, J.

Affirmed.

* Warren, J., not participating.

DEITS, J.

Employer seeks review of an order of the Workers' Compensation Board holding that claimant's workers' compensation claim is compensable. We affirm.

The Board adopted the referee's findings.¹ Claimant is a part-time bank teller. Her duties primarily involve serving customers at the teller window and assisting customers with new accounts, incoming wires and interstate drafts. She is expected to market accounts and to encourage customer involvement in employer's Community Reinvestment Act program. As part of her duties, she also is encouraged to participate in two community service projects each year. Before her injury, claimant had received a performance review in which one of her supervisors expressed concern about claimant's ability to meet and maintain sales goals. Employer had recently increased its focus on sales activities in an attempt to improve the branch's unsatisfactory sales record. Regular sales meetings were held, and a weekly sales award system was implemented. Claimant's

¹ As will be discussed, employer challenges the Board's conclusions of fact that claimant "was not on a personal mission" and that "the employer clearly obtained the greater benefit in the form of potential business from the rodeo group." Other than that, employer does not challenge the Board's findings of fact.

immediate supervisor, Smith, conducted the sales meetings. In March or April 1992, Smith announced that each employee would be required to perform two community service functions annually. He also informed the employees that compliance would be considered at the time of their employee performance reviews.

On the evening of August 13, 1992, claimant attended an organizational meeting of the Emerald Empire Roundup, a group that was attempting to bring a rodeo to the area. The meeting was not on the bank premises, nor was claimant required to attend the meeting. She went to the meeting to attempt to solicit from the rodeo group a new account for employer and to provide the group with information about the Community Reinvestment Act funds. She also considered her attendance as fulfilling part of her community service goal for the year. After the meeting ended, claimant spoke with the comptroller of the group, who agreed to visit employer the following week to open an account. On her way to her car after the meeting, claimant tripped and fell, fracturing her wrist. She

Cite as 133 Or App 712 (1995)

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filed a workers' compensation claim, which employer denied on the ground that her injury did not arise out of and was not in the course of her employment. Both the referee and the Board held that the claim was compensable.

Employer first assigns error to the Board's findings that "employer clearly obtained the greater benefit [from claimant's attendance at the meeting, compared to any benefit enjoyed by claimant] in the form of potential business from the rodeo group," and that "claimant was not on a personal mission," arguing that they are not supported by substantial evidence. We disagree. Both of those findings are supported by substantial evidence. Claimant testified, and the referee and the Board believed her, that she went to the meeting to solicit business for the bank and to meet her community service obligation. She, in fact, later received a small award for her solicitation efforts. Although the rodeo comptroller did not open an account with employer, he did contact the bank to discuss that possibility. That constitutes substantial evidence to support the Board's finding that employer obtained a benefit in the form of potential business from claimant's activity.

The evidence also supports the Board's finding that claimant was not on a personal mission. Employer's fundamental disagreement with this finding is its view that, because it did not *require* claimant to attend the rodeo meeting or ever sanction the meeting as a community service activity, claimant's attendance was not job-related. However, the Board disbelieved employer's witnesses on this question. It explained:

"[Regarding employer's management witnesses,] I believe that they focused upon what should have occurred from a management perspective rather than actual practice known to the tellers at the windows, or their perception of management directives. The persuasiveness of the upper management witnesses was diminished by a sense of advocacy and redundancy which suggested repetition of a corporate position which appeared almost rehearsed."

The evidence that the Board did believe showed that employees were encouraged to increase their sales and community service activities, and that failure to meet employer's sales and community service requirements would affect employees' performance reviews. Employer also argues that claimant was on a personal mission, because she was seeking to protect her

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job. However, the fact that an activity is directed at keeping one's job does not, in itself, make the activity a personal mission. We conclude that the Board's findings were supported by substantial evidence.

Employer next argues that the Board erred as a matter of law in concluding that claimant's injury was compensable. Employer contends that the Board did not consider the "arising out of" element of the unitary work-connection test and that it improperly analyzed the "in the course of" element of the test. ORS 656.005(7)(a).

At the outset, we should discuss the parties' contentions regarding the impact of the Supreme Court's decision in *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 867 P2d 1373 (1994), on the test for work-connection. Claimant argues that *Norpac Foods* was "not intended to help interpret any situations beyond those dealing with the 'parking lot exception' to the 'coming and going rule.'" Employer essentially asserts that the *Norpac Foods* decision, while not substantially changing the unitary work-connection test that has been articulated in previous decisions, now provides the legal framework to be applied in determining the work-connection of an inquiry.

We agree with employer regarding the impact of *Norpac Foods*. Before that decision, both this court and the Board applied the seven-factor "Mellis test" to determine whether an injury was sufficiently work-connected to justify compensability. *Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, 703 P2d 255, rev den 300 Or 249 (1985).² In *Norpac Foods*, the Supreme Court re-examined the work-connection standard of

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ORS 656.005(7)(a) and clarified the proper framework for our analysis. The court emphasized that the unitary work-connection test includes two statutory elements, both of which must be evaluated. One prong of the inquiry is whether the

² The seven factors identified in *Mellis* are:

- "a. Whether the activity was for the benefit of the employer * * *;
- "b. Whether the activity was contemplated by the employer and employee either at the time of hiring or later * * *;
- "c. Whether the activity was an ordinary risk of, and incidental to, the employment * * *;
- "d. Whether the employee was paid for the activity * * *;
- "e. Whether the activity was on the employer's premises * * *;
- "f. Whether the activity was directed by or acquiesced [*sic*] in by the employer * * *;
- "g. Whether the employee was on a personal mission of his own * * *. *Jordan v. Western Electric*, 1 Or App 441, 443-44, 463 P2d 598 (1970); see also *Halfman v. SAIF*, 49 Or 23, 618 P2d 1294 (1980)." 74 Or App at 574.

injury occurred in the course of employment. That element concerns the time, place and circumstances of the injury. The second prong, which must also be examined, is whether the injury arose out of the employment; that is, whether a causal connection existed between the injury and the employment. Thus, although this is a unitary approach, "[e]ach element of the inquiry tests the work-connection of the injury in a different manner." 318 Or at 366. As the court explained, neither element is dispositive, and the Board must consider "all the circumstances" to determine if the claimant has shown a sufficient work-connection. 318 Or at 366, 369.

The analytical framework set out in *Norpac Foods* does not significantly change the nature of our inquiry under ORS 656.005(7)(a); it essentially incorporates the tests for work-connection that have been established through case law. However, we believe that reliance on the *Mellis* test, as the test of work-connection, is inconsistent with the *Norpac Foods* framework, because the *Mellis* test does not necessarily allow a meaningful consideration of each of the two elements of the inquiry. Strict adherence to the seven-factor test also does not allow consideration of the totality of the circumstances, as required by *Norpac Foods*. Accordingly, we conclude that the factors identified in *Mellis* should no longer be used as an independent and dispositive test of work-connection. Nonetheless, depending on the circumstances, some or all of those factors will remain helpful inquiries under the *Norpac Foods* two-prong analysis.

We now turn to employer's substantive arguments. Employer contends that the Board erred in concluding that claimant's injury occurred "in the course of" her employment. First, it contends that the Board addressed only three of the seven *Mellis* factors and that, in itself, is error. As discussed above, however, the Board need not mechanically apply the *Mellis* factors as a conclusive test of work-connection. Further, a review of the Board's order shows that it did consider factors pertinent to that element of the inquiry:

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"In gauging the relative benefit of attending the meeting to claimant and the employer, the employer clearly obtained the greater benefit in the form of potential business from the rodeo group. There is no doubt that the conversation [between claimant and the rodeo comptroller] occurred * * *. Claimant's past actions modeling western apparel or even attending rodeos does not by itself provide sufficient motivation for her to attend the meeting. Considering the circumstances in which claimant acted, it is clear that her primary motivation in attending the meeting was to solicit business on behalf of the bank. She was not on a personal mission.

"Claimant was not paid for attending the meeting. She was, however, rewarded for her solicitation efforts when she was allowed to draw a gift [at a later weekly meeting]. Regardless of the negligible value of what she received, that recognition was not an act of discouragement, but one of approval or, at a minimum, condonation of off-premises solicitation. A similar incentive was given when claimant assisted [a local] theater group outside the bank, confirming

her belief that the acquisition [*sic*] of new accounts away from the bank was not frowned upon.

“Upper management has indicated that it did not expect tellers to leave the bank to solicit business for very compelling business reasons primarily related to wage and hour regulations. The crux of the problem here, however, is that management’s expectations were not sufficiently communicated to all levels of personnel. There is nothing in this record to indicate that claimant was ever instructed not to seek business off the premises. Rather, an atmosphere was created in which it could have been reasonably expected that claimant might resort to outside solicitation to protect her job.

“Considering all of the factors governing determination of whether an injury is work-related, I conclude that there is a significant work-connection between claimant’s attendance at the rodeo meeting and subsequent departure.”

As can be seen, the Board considered the benefit to the employer, whether claimant was on a personal mission, and the remuneration for the activity. It also discussed whether the activity was contemplated by employer and whether the activity was directed by or acquiesced in by employer. The Board concluded that claimant’s attendance at the meeting, although not specifically required or authorized, was not beyond the type of off-premises activity contemplated

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by employer, and that employer’s conduct in rewarding claimant for her efforts after she had attended the meeting indicated an encouragement of and acquiescence in the conduct. We hold that the Board did properly analyze whether, under the totality of the circumstances, claimant was in the course of her employment when the injury occurred.

Employer also contends that the Board did not adequately consider the “arising out of” element of the work-connection test. We agree that the Board did not specifically draw a conclusion that the injury “arose out of” claimant’s employment. However, it did make findings regarding the causal connection between claimant’s employment and the injury. As we will discuss, those findings clearly support the conclusion that the injury did arise out of her employment. Accordingly, we do not believe that a remand is necessary in this case.

Employer first asserts that the injury on the sidewalk outside the evening rodeo meeting was not causally connected to a risk of claimant’s employment, because claimant was a certified bank teller whose duties were confined to the work day at the bank, and she was not authorized to conduct sales activities after work or outside the bank premises. That argument, however, is based on employer’s view of the facts, which the Board rejected. As noted, the Board found, and the evidence supports the finding, that after-hours, off-premises sales activities were encouraged and rewarded by employer. Therefore, employer’s reliance on its view that claimant’s duties were confined to the bank premises during banking hours is unavailing.

Employer also argues that, even if claimant's job included sales and community service activities after bank hours and off bank premises, there was no causal link between those activities and claimant's sidewalk injury. According to employer, there can be no causal connection where "[t]he record does not show any risk peculiar to claimant's employment that was not experienced by the traveling members of the general public." Employer misstates the law pertaining to the compensability of street injuries.³ A rule

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that requires an employee to prove a risk peculiar to the particular employment, to establish a causal connection between a street injury and employment, is "primitive and almost obsolete." See Arthur Larson, 1 *Workmen's Compensation Law* § 9.20 at 3-64 (1994) (footnote omitted). According to Larson, the majority rule in street and highway injury cases is the "actual-risk" test, under which an injury arises out of the employment "if in fact the employment subjected the employee to the hazards of the street, whether continuously or infrequently." Larson, 1 *Workmen's Compensation Law* § 9.10 at 3-63; § 9.40 at 3-70 to 3-73.

In this case, the Board found that claimant's off-premises activity, although not specifically required or authorized, was not beyond the type of business solicitation contemplated by employer. The Board also found that employer's conduct in rewarding claimant for her efforts was an act of condonation, if not approval, of the off-premises activity. Those findings support the conclusion that, however infrequent, claimant's employment subjected her to the hazards of the street. Accordingly, the Board's findings lead to the conclusion that complaint's injury arose out of her employment.

In summary, we hold that the Board did not err in holding that claimant's injury arose out of and in the course of employment and, therefore, was compensable.

Affirmed.

³ Employer erroneously relies on the standard for establishing an exception to the "going and coming" rule. See *Kiewit Pacific v. Ennis*, 119 Or App 123, 126, 849 P2d 541 (1993). The "going and coming" rule, and its exceptions, are relevant to the "in the course of" prong of the inquiry, but they do not resolve the issue of whether the injury "arose out of" the claimant's employment. *Norpac Foods*, 318 Or at 368.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gayle J. Williams, Claimant.

SAIF CORPORATION
and Southcoast Lumber Co.,
Petitioners,

v.

Gayle J. WILLIAMS,
Respondent.

(91-10443; CA A76540)

On remand from the Oregon Supreme Court, *SAIF v. Williams*, 320 Or 406, 884 P2d 867 (1994).

Judicial Review from Workers' Compensation Board.

Argued on remand March 27, 1995.

David L. Runner, Assistant Attorney General, argued the cause for petitioners. With him on the briefs were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

James L. Edmunson argued the cause for respondent. With him on the briefs was Malagon, Moore, Johnson & Jensen.

Before Riggs, Presiding Judge, and Richardson, Chief Judge, and Leeson, Judge.

LEESON, J.

Affirmed.

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LEESON, J.

This case is on remand from the Supreme Court for reconsideration in the light of *SAIF v. Allen*, 320 Or 192, 881 P2d 773 (1994). *SAIF v. Williams*, 320 Or 406, 884 P2d 867 (1994). On reconsideration, we affirm the Board's order awarding an attorney fee under ORS 656.386(1).

Claimant sustained a compensable injury in March 1986. In December 1990, she submitted to SAIF for reimbursement mileage and meal vouchers that related to physicians' visits. Claimant received neither payment nor written notice of acceptance or denial within 90 days. ORS 656.262(6). Her attorney filed a request for a hearing and demanded payment of the unpaid reimbursements. SAIF then reimbursed claimant. The Board awarded an attorney fee under ORS 656.386(1), on the ground that claimant's attorney had been instrumental "in obtaining compensation on behalf of his client," and assessed a penalty equal to 25 percent of the reimbursements. ORS 656.262(10). SAIF petitioned for review, and we reversed the award of an attorney fee. *SAIF v. Williams*, 124 Or App 203, 861 P2d 1025 (1993). The Supreme Court allowed review and reversed and remanded for reconsideration.

SAIF argues that we should adhere to our previous reversal of the portion of the Board's order that awarded an attorney fee under ORS 656.386(1). It contends that, although an insurer's failure to pay or deny vouchers associated with medical bills for an accepted injury within 90 days of receiving the bill is, presumptively, a denial of the injury or condition for which compensation is sought, that presumption can be overcome by evidence showing that the denial was not intended to encompass the compensability of the claim. SAIF argues that the presumption is overcome in this case, because the record establishes that SAIF's failure to reimburse claimant within 90 days was due to an inadvertent filing error. Claimant responds that, whether or not the denial was inadvertent, it is presumed to encompass the compensability of the claim and that that presumption may not be overcome with evidence about the actual reason for the denial. Because SAIF failed to accept the claim within 90 days, claimant had to prepare for a hearing at which she would have been required to prove her entitlement to the

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unpaid benefits. Therefore, she contends, SAIF's failure to pay within the time required was a denial of her claim, for which her attorney is entitled to a fee under ORS 656.386(1).

We agree with claimant. SAIF's failure to respond within 90 days left claimant subject to the risk that the compensability of her claim had been denied. Although the denial was inadvertent, at the time when the claim was denied, claimant had no way to know whether the denial encompassed the compensability of the claim. Because of that, the denial is presumed conclusively to encompass the compensability of the claim, and attorney fees are available under ORS 656.386(1) if claimant's attorney was instrumental in obtaining compensation. *See Allen*, 320 Or at 217 (unless insurer makes clear that denial does not dispute compensability, claimant is subject to statutory burden to prove compensability).

SAIF argues that, notwithstanding *Allen*, under *SAIF v. Blackwell*, 131 Or App 519, 886 P2d 1028 (1994), and *Karl v. Construction Equipment Co.*, 132 Or App 293, 888 P2d 94 (1995), an insurer may establish at the hearing the reason for the denial and may offer proof that the denial was not intended to encompass the compensability of the claim. Those cases do not stand for that proposition. An insurer's explanation as to its motive for denying a claim, or its explanation as to what was intended to be encompassed in the denial, is irrelevant for the purpose of determining the claimant's entitlement to an attorney fee under ORS 656.386(1). As the Supreme Court said in *Allen*, if the denial itself does not expressly state that it is limited to the bill not paid and does not encompass the compensability of the claim, it is presumed to encompass the compensability of the claim. 320 Or at 217. That presumption is conclusive as to the effect of the denial.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Ronald D. Addis, Claimant.

WINSTON-DILLARD RFPD,
Petitioner,

v.

Ronald D. ADDIS,
Respondent.

(92-14624; CA A84475)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 10, 1995.

Brad G. Garber argued the cause and filed the brief for petitioner.

Robert Wollheim argued the cause for respondent. With him on the brief were Allan Coons, Coons, Cole and Cary and Welch, Bruun, Green & Wollheim.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

EDMONDS, J.

Affirmed.

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Winston-Dillard RFPD v. Addis

EDMONDS, J.

Employer seeks review of the Workers' Compensation Board's order setting aside employer's denial of claimant's myocardial infarction claim. Employer argues the Board erred in ruling that the firefighters' presumption, ORS 656.802(4), applies to the claim.¹ We affirm.

The Board found that claimant, a firefighter, responded to a brush fire on May 26, 1992. After the fire had been controlled and while he was investigating the fire's cause, he began to have symptoms of a heart attack. He was taken to the hospital, where he was diagnosed as having

¹ ORS 656.802 defines "occupational diseases." The legislature has created a presumption, known as the firefighters' presumption, which presumes that certain diseases arise "out of and in the course of employment":

"Death, disability or impairment of health of fire fighters of any political division who have completed five or more years of employment as fire fighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as fire fighters is an 'occupational disease.' Any condition or impairment of health arising under this subsection shall be presumed to result from a fire fighter's employment. However, any such fire fighter must have taken a physical examination upon becoming a fire fighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment. Denial of a claim for any condition or impairment of health arising under this subsection must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the fire fighter's employment." ORS 656.802(4).

suffered a myocardial infarction. A subsequent angiogram revealed that claimant had cardiovascular disease, and that the disease had caused a 20 percent occlusion or blood clot of a coronary artery, which had led to the infarction. The attending cardiologist testified that claimant's myocardial infarction resulted from the increased blood flow and blood pressure in his arteries caused by the physical and emotional stress of fighting the fire on May 26. According to the physician, claimant's arterial walls had developed a covering of plaque over several years, and when the increased blood flow and pressure coursed through his arterial walls on May 26, the plaque ruptured from the walls causing the occlusion. Employer's medical expert agreed that the covering of plaque on the arterial walls led to the heart attack, but opined that there was no correlation between the increase in blood flow and pressure and the infarction, and that the clotting would have occurred regardless of claimant's activities on that day.

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Both physicians testified that the *only* method of detecting claimant's particular level of disease before the infarction was through an angiogram. That procedure requires a catheter to be inserted in the groin and threaded into the heart. Dye is then injected and x-rays taken. The test costs between \$5,000 and \$6,000 and has a mortality/morbidity rate of three per 1,000. The doctors agreed that such a test is not routinely given to detect cardiovascular disease, and that neither doctor would have recommended its performance on claimant based on the lack of family history of cardiovascular disease and other risk factors associated with cardiovascular disease.

Before the infarction occurred, claimant had never been given an angiogram. He had undergone regular physical examinations, which included a cardiac stress test or stress electrocardiogram (EKG). Each time, the results of the test indicated that respondent did not suffer from advanced cardiovascular disease. The physicians agreed that the stress EKG is the customary test for detecting cardiovascular disease.

Employer argues that because claimant did not receive an angiogram, he failed to meet the predicate under ORS 656.802(4) that "any such fire fighter must have taken a physical examination upon becoming a fire fighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment." Employer relies on our holding in *SAIF v. Bales*, 107 Or App 198, 810 P2d 1346 (1991), in support of his argument that claimant failed to meet that requirement. It points out that in that case, we said:

"Our review of the legislative history indicates that the legislature intended as a predicate to the presumption that a physical examination under ORS 656.802[(4)] must be of the type that would reveal any evidence of 'any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease' for which a claimant later seeks compensation." 107 Or App at 201-02.

It concludes that because the testimony in this case shows that the disease would not have been revealed by any of the stress tests performed on claimant, the statute is inapplicable to his claim.

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In *Bales*, the claimant saw his family doctor for a fever, sore throat, cough and congestion. The doctor listened to his lungs, examined his eyes, ears, nose and throat, took his temperature, and determined that he had an upper respiratory tract infection. Four years later, the claimant complained to his doctor of shortness of breath and the doctor ordered pulmonary function studies, which revealed obstructive lung disease in the claimant. The claimant filed a workers' compensation claim for the lung disease under ORS 656.802(4), and the employer denied it. The Board held that the examination of the claimant in conjunction with his upper respiratory tract infection constituted a physical examination for purposes of the statute. We disagreed, reasoning that the doctor's listening to the claimant's lungs did not constitute an examination of the type contemplated by ORS 656.802(4).

Despite employer's arguments to the contrary, the evidence in *Bales* was significantly different from the evidence in this case. In *Bales*, the examination of the claimant was not to determine whether a disqualifying lung disease under ORS 656.802(4) was present, but to determine whether the claimant was suffering from a viral infection. In the present case, the tests performed on claimant were designed specifically to detect signs of cardiovascular disease. As we pointed out in *Bales*, the kind of physical examination that the legislature contemplated for the purposes of the statute was one that would be "rigid" or "competent" to demonstrate a disqualifying physical condition. 107 Or App at 202 n 3. The legislative committee that was considering the proposed bill heard testimony about the type of examinations that were currently being administered. One witness pointed out that one municipality administered EKGs as a required part of the examination. Minutes, Senate Labor and Industries Committee, March 8, 1981, p 1. In our view of the legislative intent, we can find no indication that the legislature intended that the predicate examination exclude any possibility of a disqualifying condition. Rather, its intent was to require the customary tests that the medical profession would use under the circumstances. There is substantial evidence in this case that those kind of tests were given to claimant and, accordingly, the Board did not err in applying ORS 656.802(4).

Cite as 134 Or App 98 (1995)

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Employer's other assignment of error does not require discussion.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Cleon Sinsel, Claimant.

Cleon SINSEL,
Petitioner,

v.

OREGON BOARD OF FORESTRY
and SAIF Corporation,
Respondents.

(WCB 92-10297; CA A81961)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 17, 1995.

Donald M. Hooton argued the cause and filed the brief for petitioner.

David L. Runner, Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Richardson, Chief Judge, and Edmonds and Armstrong, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

Cite as 134 Or App 200 (1995)

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PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board holding that his chest pains are not compensable. It appears that the Board analyzed the issue of compensability under our decision in *Mathel v. Josephine County*, 122 Or App 424, 858 P2d 450 (1993). After the Board's decision, the Supreme Court reversed our decision in *Mathel*. 319 Or 235, 875 P2d 455 (1994). We cannot determine whether the Board's decision would have been different had it addressed the issue consistent with the Supreme Court's reasoning. Consequently, we reverse the decision and remand to the Board for reconsideration in the light of the Supreme Court's opinion in *Mathel*.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Anne M. Maley, Claimant.

Steven E. TIMM, D.M.D.,
Petitioner,

v.

Anne M. MALEY;
SAIF Corporation;
SAIF Corporation (NCE);
and CNA Insurance Companies,
Respondents.

(91-09137, 90-06629, 91-03931, 91-02379;
CA A85268)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 17, 1995.

James L. Edmunson argued the cause and filed the brief for petitioner.

Gene Platt argued the cause for respondent CNA Insurance Companies. With him on the brief was Cummins, Goodman, Fish & Peterson, P.C.

David W. Hittle and Burt, Swanson, Lathen, Alexander, McCann & Smith waived appearance for respondent Anne M. Maley.

Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and Steven Cotton, Special Assistant Attorney General, waived appearance for respondent SAIF Corporation (NCE).

Jerald P. Keene and Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., waived appearance for SAIF Corporation.

Before Richardson, Chief Judge, and Edmonds and Armstrong, Judges.

EDMONDS, J.

Affirmed.

EDMONDS, J.

Steven Timm, the noncomplying employer (Timm (NCE)), seeks review of the Workers' Compensation Board's order, entered after we remanded for reconsideration, *Timm v. Maley*, 125 Or App 396, 401, 865 P2d 1315 (1993), holding that he was responsible for claimant's claim. Timm (NCE) asserts that the order is not supported by substantial evidence. ORS 183.482(7); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). We affirm.

Timm (NCE) was insured by CNA Insurance Companies (CNA) from October 1986, to March 17, 1988. He was in noncomplying status from March 18, 1988, to September 22, 1988. Beginning September 23, 1988, he was insured by SAIF Corporation (SAIF). Claimant worked for Timm (NCE) as a dental assistant from October 1983 to May 1989. She has a history of nonwork related back injuries that resulted in her receiving sporadic chiropractic treatment both before and after she began working for Timm (NCE). Complaining of significant new pain and numbness in her left leg and foot, claimant began receiving treatment from Dr. Mann on September 25, 1987. On the first visit, Mann noted tightness in her back and tenderness in her left sacroiliac. He diagnosed her condition as a hypermobile left sacroiliac with chronic left sacroiliac ligament sprain and secondary low back tightness.

Mann's notes reveal that claimant's condition remained relatively the same for several months after that time. Then in May 1988, Mann reported:

"The patient's course changed dramatically in early May of 1988 with complaint of marked exacerbation of pain. * * * She had marked limitation in range of motion of the low back with generalized tenderness of the sacroiliac areas. * * * The patient's pain did not seem to respond to aggressive therapy and her pain behavior seemed to become quite dramatic until our last visit of 7/12/88 after which she was not seen until 2/13/89."

Mann's notes on May 9, 1988, also report that the tenderness in claimant's left sacroiliac radiated to the sacrotuberous area and that she had "occasional vague radicular symptoms into the legs." He concluded:

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Timm v. Malcy

"I do feel that the job as a dental assistant and the positioning she was in for many years had a definite major impact on the previous underlying problem and that her medical needs and requirements for care would not have existed without this repeated stress."

Also, in mid-May, claimant cut back her work hours because of her back problems. In June, claimant filed a workers' compensation claim, which was denied by both CNA and Timm (NCE).

In its original disposition of this claim, the Board determined that claimant's disability arose in May 1988, when claimant began to miss work because of her condition. Consequently, it allocated responsibility for the claim to Timm (NCE). On review, we said that initial responsibility for the claim is assigned to the employer for whom claimant was employed when she became disabled. *Timm*, 125 Or App at 401. When the claimant's first need for medical treatment does not coincide with the date when she first begins taking time off work because of the disability, the date of disability is the date the claimant begins receiving medical treatment for the compensable condition. The employer for whom the claimant works on the date of disability may escape responsibility by showing that subsequent employment contributed independently to the cause of the condition. We remanded for reconsideration of the date of disability and the assignment of responsibility. *Id.* at 401.

On remand, the Board concluded that the date of the first compensable treatment was September 25, 1987, and it assigned responsibility for the claim initially to CNA. It then found that claimant's condition had worsened in May, June and July 1988, and that her employment during that time independently contributed to the worsening of her condition. Therefore, it ultimately assigned responsibility for the claim to Timm (NCE). Timm (NCE) seeks review of the Board's determination, but does not challenge the Board's determination of the date of disability. Rather, he argues that there is not substantial evidence for the Board's finding that claimant's condition worsened in May, June and July 1988, and that her employment with him during the time he was a noncomplying employer independently contributed to the worsening.

Cite as 134 Or App 245 (1995)

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First, Timm (NCE) argues that there is no evidence of a worsening of the condition during the months in question, but only a worsening of symptoms¹ and increased pain. Thus, he asserts that the evidence is insufficient to support the assignment to him of responsibility for the claim. In the light of Mann's reports, we conclude that there is substantial evidence to support the Board's finding that claimant suffered more than a mere increase in symptoms. Contrary to Timm (NCE)'s argument, the Board was not required to completely discount claimant's exacerbation of pain as evidence of a worsened condition. *Weller v. Union Carbide*, 288 Or 27, 30 n 2, 602 P2d 259 (1979). Moreover, this is not a case in which the treating physician opined that there was only an increase in symptoms.² When the evidence of the dramatic exacerbation of pain is considered with the evidence that claimant suffered from a "marked limitation in range of motion" in her low back, that the tenderness had radiated into the sacrotuberous area and that claimant was required to curtail the number of hours she worked, the Board could reasonably infer that claimant's condition worsened during the period in which Timm (NCE) was noncomplying.

Timm (NCE) also argues that there is no evidence to support the finding that the worsening was *caused* by claimant's employment with Timm (NCE). He argues that the worsening could just have easily been caused by claimant's non-work related activities. Mann concluded that the repeated stress of claimant's continued employment with Timm (NCE) had a "major impact" on her underlying condition. In the light of Mann's opinion, there is substantial evidence to support the Board's finding that claimant's employment during the time Timm was uninsured caused a worsening of her condition.

Affirmed.

¹ See *Bracke v. Baza'r*, 293 Or 239, 250, 646 P2d 1330 (1982) ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer.").

² See *Indemnity Co. v. Weaver*, 81 Or App 493, 497, 726 P2d 400 (1986) (concluding that where the claimant's physician determined that the employment had worsened the symptoms, but not the underlying condition, the Board did not err in finding that the employment had not caused a worsening of condition).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Sheila A. St. Clair, Claimant.

SAIF CORPORATION
and Oregon Health Sciences University,
Petitioners,

v.

Sheila A. ST. CLAIR,
Respondent.

(WCB 93-03298; CA A83803)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 10, 1995.

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.

Meagan Flynn argued the cause for respondent. With her on the brief was Pozzi Wilson & Atchison.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DEITS, P. J.

Affirmed.

DEITS, P. J.

Employer seeks review of an order of the Workers' Compensation Board that awarded claimant a penalty under ORS 656.268(4)(g), because her award of permanent partial disability was increased on reconsideration by the Department of Insurance and Finance (Department).¹ We affirm.

Claimant suffered a compensable injury to her low back. When her condition became medically stationary, employer issued a notice of closure awarding her 14 percent unscheduled permanent partial disability. The award was based on the range of motion measurements from an examination by her treating physician. Claimant requested reconsideration of the award. Pursuant to ORS 656.268(7), she was examined by a panel of medical arbiters. On reconsideration, the Department applied the range of motion measurements of the arbiters and increased the award to 24 percent. Because the increase in the award resulted in an increase in claimant's compensation of more than 25 percent and because she was determined to be at least 20 percent disabled, the Board

¹ The Department has since been renamed the Department of Consumer and Business Services.

awarded her a penalty under ORS 656.268(4)(g). The Board refused to apply OAR 436-30-050(12) and (13), which would have precluded imposition of a penalty under these circumstances, based on its conclusion in a previous case that the rule was invalid.

The pertinent statute is ORS 656.268(4)(g), which provides:

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

Cite as 134 Or App 316 (1995)

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The administrative rule on which employer relies, OAR 436-30-050 provides, in part:

“(12) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. *If an increase in compensation results from new information obtained through a medical arbiter examination or from the promulgation of a temporary emergency rule, penalties will not be assessed.*

“(13) For the purpose of section (12) of this rule, a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20 percent disabled.” (Emphasis supplied.)

The parties agree that the increase in claimant's award did not result from any misconduct by insurer; rather, it resulted from the new information obtained from the panel of medical arbiters. Employer argues that because of that, the Board erred in imposing a penalty here.

The Board concluded that it was required by the statute to impose a penalty. It held that the language of ORS 656.268(4)(g) was clear; that if, on reconsideration, the Department orders an increase by 25 percent or more of the amount of compensation and the worker is found to be at least 20 percent disabled, a penalty must be imposed regardless of the reason for the increase. The Board refused to apply OAR 436-30-050, which would allow an exception to the imposition of the statutory penalty when the increase in the award was due to new information obtained through a medical arbiter's exam, because of its previous determination that the rule is invalid due to its inconsistency with the statute.

Employer argues that the language of ORS 656.268(4)(g) is ambiguous. It relies on the inclusion of the term “penalty” in the statute to support its argument. It is

employer's contention that the reference to a penalty indicates that the legislature intended that an employer must engage in misconduct or wrongdoing; in other words, it must engage in conduct that should be punished before a penalty

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may be imposed. Accordingly, employer urges that we hold that the statute does not allow the imposition of a penalty in a case such as this one, where the insurer has not engaged in any conduct that should be punished. It also contends that the Director's rule allowing an exception to the imposition of the penalty is consistent with the statute.

We begin by considering the text and context of the statute, along with the rules of construction that bear directly on how to read the text and its interpretation in context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). If the text and context of the statute reveal that there is only one plausible interpretation, we give the statute that meaning and need not resort to legislative history to inform us about the legislature's intent.

We conclude that the statute is unambiguous. The language of ORS 656.268(4)(g) requires the insurer to pay an additional 25 percent if two conditions are met. The claimant's compensation must be increased on reconsideration by 25 percent and the total award of permanent disability must be at least 20 percent. There are no exceptions to the penalty in the statutes; in particular, there is nothing in the language of the statute that requires unreasonable conduct or wrongdoing by the insurer before the penalty may be imposed. We may not read into a statute an additional requirement that is simply not there. ORS 174.010. Accordingly, we conclude that the Board did not err in imposing a penalty on employer in these circumstances and that the Board was correct that the Director's rule is inconsistent with the statute.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Elva McBride, Claimant.

SAVIN CORPORATION,
Petitioner,

v.

Elva McBRIDE,
Respondent.

(92-12747; CA A83356)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 13, 1994.

Darren L. Otto argued the cause for petitioner. With him on the brief was Scheminske & Lyons.

Steven D. Bryant argued the cause for respondent. With him on the brief was Bryant, Emerson, Fitch & McCord.

Before Deits, Presiding Judge, and Riggs and Haselton, Judges.

DEITS, P. J.

Affirmed.

Cite as 134 Or App 321 (1995)

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DEITS, P. J.

Employer seeks review of a Workers' Compensation Board order setting aside its denial of compensability of claimant's low back condition. The issue is whether claimant, a traveling employee, was on a distinct departure from her employment at the time that she was injured in a motor vehicle accident. We affirm.

Claimant worked for employer as a field engineer. Her job duties involved repair and preventive maintenance on copy machines. Claimant worked throughout central Oregon. She lived in Bend and received her job assignments by contacting employer's Portland office by telephone. She was dispatched by the Portland office to specific job sites. Her normal work hours were 8:00 a.m. to 4:30 p.m., Monday through Friday. She was considered "clocked out" following the last call of the day. Claimant used her own car to get to her work assignments and was paid a car allowance of \$200 per month and mileage at nine cents per mile, with 30 miles each day excluded.

On June 10, 1992, claimant was performing her normal duties as a field engineer. She completed an assignment in LaPine at about 3:30 p.m. She then contacted her employer and was dispatched to repair a copier at a location in Redmond. Claimant went to the job site in Redmond, but was unable to do the work because the customer was not there.

She called employer and was told that the work order had been canceled and that she was released for the day. Rather than return directly to her home in Bend, however, claimant decided to stop at a nearby bank to obtain a form that she needed for a court matter in which she was involved. As the Board found, she

“went to a bank located at Sixth and Cascade Streets, in Redmond, Oregon, to conduct some personal business, a diversion of three to five blocks from the route on which she would return to Bend, Oregon. The bank business took some five minutes.”

Claimant then returned to her car and began driving back to her home in Bend. As she drove through Redmond, she was hit by another car from behind and was injured. The accident took place a few blocks before she returned to the

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route that she would have used to return home if she had not gone to the bank. Claimant filed a workers' compensation claim with employer, which was denied on the basis that claimant was not in the course and scope of her employment when the accident occurred. The Board concluded that the claim was compensable and set aside employer's denial.

For an injury to be compensable under Oregon's workers' compensation law, it must “arise out of” and be “in the course of” employment. ORS 656.005(7)(a). As explained in *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366, 867 P2d 1373 (1994), we use a unitary work-connection test in which the “arising out of” and “in the course of” elements are both part of a single inquiry, which is whether the relationship between the injury and the work is sufficient to make the injury compensable.

The Board concluded here that claimant was a traveling employee. We have held that a person who has the status of a traveling employee is continuously within the course and scope of employment while traveling, except when it is shown that the person has “engaged in a distinct departure on a personal errand.” *Proctor v. SAIF*, 123 Or App 326, 330, 860 P2d 828 (1993); see also *Slaughter v. SAIF*, 60 Or App 610, 654 P2d 1123 (1982). In most instances, we have used Larson's explanation of this principle:

“Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually held compensable.” Arthur Larson, 1A *Workmen's Compensation Law* § 25.00, 5-275 (1990) (quoted in *Proctor*, 123 Or App at 329; *PP&L v. Jacobson*, 121 Or App 260, 262, 854 P2d 999 (1993); *Slaughter*, 60 Or App at 613).

Thus, when travel is part of the employment, “the risk of injury during activities necessitated by travel remains an

incident to the employment," even though the employee may not actually be working when the injury occurs. *Jacobson*, 121 Or App at 263 (citing *SAIF v. Reel*, 303 Or 210, 216, 735 P2d 364 (1987)).

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The parties agree that claimant was a traveling employee and that her stop at the bank was a personal errand. However, employer argues that claimant's personal errand was a "distinct departure" and that the Board erred in concluding otherwise. In determining whether a traveling employee's injury is compensable, we consider whether the activity that resulted in the injury was reasonably related to the employee's travel status. *Proctor*, 123 Or App at 330; *Slaughter*, 60 Or App at 616.

In holding that claimant's injury was compensable, the Board explained that

"claimant had traveled to Redmond on a work assignment, when she learned that the work order had been canceled and she was released for the rest of the day. Claimant stopped at a bank before traveling homeward to Bend, because she believed the banks in Bend would have been closed if she had driven home first. Thus, claimant's bank errand was for her personal convenience. There is no contention that claimant's belief or conduct was unreasonable, or that she disobeyed the employer in going to the Redmond bank. Under these circumstances, we conclude that claimant's personal bank errand in Redmond was reasonably related to her work status as a traveling employee."

The Board also found, and employer does not challenge the finding, that claimant's errand to the bank took her only "a few blocks from her normal route home" and the bank business took "some five minutes."

We agree with the Board's conclusion that claimant's personal errand was not so unrelated to her travels as to be excluded from the broad scope of coverage for traveling employees. See *Slaughter*, 60 Or App at 616 (holding that not all activities are covered under the general rule of continuous coverage). The Board's uncontested findings establish that claimant traveled to Redmond at the direction of employer to perform a work assignment. The use of her personal car to travel between her job assignments and her home was approved of and contemplated by employer. Her errand at the Redmond bank was necessitated by travel because she reasonably believed that the Bend branch, to which she would normally go, would have closed before she could get there.

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In addition, and despite employer's contention to the contrary, substantial evidence supports the Board's finding that claimant's trip to the bank was not in violation of employer's directives. Cf. *Hackney v. Tillamook Growers*, 39 Or App 655, 658-59, 593 P2d 1195 (1979) (the claimant's

disregard of the employer's direction made the personal errand "distinct"). Although claimant's personal errand was a "departure" from her business, that departure was minimal in terms of both time and space. Such a departure is so transitory and slight as to be disregarded as insubstantial. *Cf.* Larson, 1 *Workmen's Compensation Law* § 19.00.¹

We conclude that the Board did not err in holding that, under these facts, claimant's trip to the bank was not a distinct departure. The Board did not err in setting aside employer's denial of compensability.²

Affirmed.

¹ Our inquiry into whether a traveling employee has made a "distinct departure" for a personal errand is analogous to the analysis of whether an employee who is off work premises makes an identifiable deviation from the business trip or errand for personal reasons. *See, e.g., Underwood v. Pendleton Grain Growers*, 112 Or App 170, 827 P2d 948 (1992) (claimant was asked to fulfill business obligations on his way home from work, but four-hour deviation to drink beer and play pool removed him from the course of employment). In a discussion of deviations that take an employee out of the course of employment, Larson has observed that some deviations for personal reasons are so minor as to be insignificant:

"[T]he courts now generally recognize that human beings do not run on tracks like trolley cars, and therefore uphold awards in situations like the following: getting cigarettes during a trip to or from work in the employer's conveyance; running across the street in the course of a delivery trip to buy a little food; driving one's daughter to school, dropping one's wife off at church, leaving a message with one's sister about working late, picking up mail for vacationing friends, crossing the street during a beer break to retrieve one's lunch, stopping at one's home to get a raincoat and leave some meat; crossing the road during a delivery trip to have a glass of beer at 2:00 in the afternoon; or to get a newspaper; making a personal phone call; looking for a ring; picking up two young ladies and taking them home while driving a car to test its brakes; buying a toy during spare time to take home to a child; and even picking cherries from a customer's cherry tree." Larson, 1 *Workmen's Compensation Law* § 19.63 at 4-434 (footnotes omitted).

² Because we conclude that claimant's personal errand to the bank was not a distinct departure, we need not address employer's second assignment of error regarding the Board's findings as to when the departure was completed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGONIn the Matter of the Compensation of
Nancy E. O'Neal, Claimant.SAIF CORPORATION
and Robert Tewell,
*Petitioners,**v.*Nancy E. O'NEAL,
Respondent.

(WCB 91-12978; CA A81987)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 6, 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.

Charles Maier filed the brief for respondent.

Before Deits, Presiding Judge, and Riggs and Haselton, Judges.

DEITS, P. J.

Affirmed.

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DEITS, P. J.

SAIF seeks review of an order of the Workers' Compensation Board that requires it to pay an out-of-compensation attorney fee award directly to claimant's attorney, despite the fact that the compensation due to claimant has been paid in full. We affirm.

On July 19, 1991, claimant left work because of a compensable back injury. Her employer was noncomplying and, on August 21, 1991, the Compliance Division referred the case to SAIF for processing. The Compliance Division believed, at that time, that claimant's hourly wage was \$5.50. On September 3, 1991, SAIF began paying temporary total disability (TTD) to claimant for the period beginning on August 21, 1991. Eventually, SAIF accepted the claim, and claimant was also paid for all time loss from the date of the injury to August 21. On September 12, 1991, claimant filed a hearing request. She sought increased TTD, as well as penalties and attorney fees, for SAIF's alleged unreasonable failure to pay TTD in a timely manner. On October 23, 1991, claimant filed a supplemental request for a hearing, seeking additional TTD on the basis that SAIF had miscalculated the rate for her temporary disability. Her hourly wage apparently was \$6.00, rather than \$5.50. SAIF received a copy of the supplemental hearing request, and, soon after that, it recalculated her benefits based on a wage of \$6.00 per hour and paid her the full amount of the increased benefits due.

Claimant sought review of the Board's decision in this court, arguing that she was entitled to a penalty for SAIF's delayed payment of the full amount of time loss ultimately due to her. We held that she was not entitled to a penalty. *O'Neal v. Tewell*, 119 Or App 329, 850 P2d 1144 (1993). She also argued that she was entitled to an attorney fee under ORS 656.386(1), because of her attorney's success in obtaining additional compensation after the request for hearing was filed but before a hearing was held. We held that claimant was not entitled to an attorney fee under ORS 656.386(1), because that subsection requires that the appeal be from an order or decision denying compensation and compensation was not denied here. We held, however, that attorney fees may be available to claimant under ORS 656.386(2) and remanded to the Board to reconsider the

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attorney's request for fees under that subsection. *O'Neal v. Tewell*, *supra*, 119 Or App at 332.

On remand, the Board concluded that claimant's attorney was entitled to receive "25% of the increased TTD, not to exceed \$1,050" and that SAIF must pay that amount directly to claimant's attorney, even though the full amount of compensation owing to claimant had already been paid. The Board explained:

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

"In the event that the increased TTD has already been paid to claimant, this order will have created an overpayment of compensation equal to the attorney fee granted herein. Should such circumstances exist, *SAIF is authorized to recover the overpayment created by this order against claimant's future permanent disability awards under this claim.*" (Emphasis supplied.)

SAIF argues that the Board erred in ordering it to pay an out-of-compensation attorney fee directly to the attorney when it had already paid the full amount of compensation due to claimant.¹ SAIF first argues that the Board's action was inconsistent with the language of ORS 656.386(2). That statute authorizes the award of attorney fees in a case such as this and provides that such fees are to be paid "from the claimant's award of compensation." SAIF contends that the Board's order is inconsistent with the statutory language, because by requiring SAIF to pay fees directly to claimant's attorney the Board is awarding fees *in addition to* the compensation already paid to claimant and, therefore, the award of fees is not "from the claimant's award of compensation."

¹ The same argument was made to this court in *SAIF v. Rapaich*, 130 Or App 216, 881 P2d 830 (1994). However, we did not decide this question in that case because we held that the Board's order did not provide for an attorney fee *in addition to* compensation.

The Board concluded that under these unique circumstances, it was permissible to require SAIF to pay the attorney fee directly to the attorney, even though claimant had received the full amount of compensation then due. The Board's conclusion was based on its determination that, through its unilateral action, SAIF created the necessity of ordering the additional payment; that had SAIF followed proper procedures, the attorney fees could, and would, have been paid out of claimant's compensation. In reaching its conclusion, the Board relied on the fact that additional compensation remained due at the time that claimant requested a hearing, that SAIF was aware of claimant's representation by counsel *before* it paid claimant in full, that claimant's attorney had taken all necessary action to secure the fee and that SAIF failed to notify the attorney that it was going to pay the full amount of compensation to claimant.

The Board explained the rationale for its decision:

"When extended to its logical conclusion, SAIF's position would lead to an unworkable system. Specifically, according to SAIF, at any time prior to a litigation order, a carrier could pay disputed compensation to a claimant without also notifying the claimant's counsel concerning arrangements regarding the payment of an 'out-of-compensation' attorney fee. Such a result would not only be inconsistent with the litigation process which encourages full disclosure between litigants and their legal representatives, but would also inevitably lead to instances of 'gamesmanship' concerning the recovery of an attorney fee to which an attorney was rightfully entitled. Neither result would be consistent with the express purpose of the workers' compensation system to reduce litigation and eliminate the adversarial nature of the compensation proceedings to the greatest extent practicable. See ORS 656.012(2)(b). In conclusion, we decline to support such reasoning, particularly where, as here, claimant's attorney had taken whatever action was available to secure his receipt of an attorney fee and SAIF was aware of that legal representation."

SAIF argues that it had no alternative but to make the payments to claimant, because, if it had not, it would have been subjected to penalties for delay in paying the increased benefits. However, as the Board explained, SAIF did have an alternative:

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"SAIF's reasoning overlooks a readily-available mechanism with which every party or practitioner before this forum is well-acquainted.

"That resolution method is a stipulation. In other words, if SAIF was concerned about potential 'penalty' ramifications and its authority to pay an 'out-of-compensation' attorney fee, it should have contacted claimant's attorney and arranged for the preparation of a stipulated agreement for Referee approval. In this way, the issues raised by claimant's hearing request could have been fully resolved and the hearing request formally dismissed.

“In the event that negotiations for a stipulation did not bear fruit, SAIF could then have paid the disputed compensation directly to claimant. Such a procedure would have provided justification for SAIF’s conduct in defense of any subsequent charge of unreasonable claim processing. Moreover, had SAIF been unsuccessful in pursuing resolution of the dispute through negotiations, it is entirely conceivable that we would have concluded that it would be inequitable to now require SAIF to pay the attorney fee award directly to claimant’s attorney. Because SAIF did not avail itself of this opportunity to resolve this dispute in a manner which would involve the full participation of all litigants and their respective legal representatives, but instead essentially preempted an orderly resolution process, we do not consider it inequitable to direct SAIF to pay our ‘out-of-compensation’ attorney fee award directly to claimant’s attorney.”

We agree with the Board’s conclusion. Although it is true that ORS 656.386(2) specifies that the out-of-compensation attorney fee must be paid from the claimant’s award of compensation, when the employer’s unnecessary and unilateral action makes the additional award necessary, the statute should not be read to preclude the Board from ordering the carrier to pay the fees directly to the attorney. The employer should not be allowed to rely on the statute to avoid having to pay the fee directly to the attorney. In these unique circumstances, it was permissible to require SAIF to pay claimant’s attorney directly and recover that amount from claimant’s future permanent disability awards.²

SAIF also contends that the Board’s decision here is inconsistent with our decision in *Lebanon Plywood v. Seiber*, 113 Or App 651, 833 P2d 1367 (1992). In *Seiber*, the claimant did not receive a procedural overpayment that he would have received had the employer not delayed in processing the claim. We held that the Board lacked authority to order an overpayment for benefits to which claimant was only procedurally, not substantively, entitled. We noted that an employer is subject to penalties if it unreasonably delays in the payment of benefits and that might be an appropriate remedy. This case, however, involves a different situation. In *Seiber*, there was no need for an overpayment; the claimant was simply attempting to obtain *extra* benefits that he would have received had the claim been correctly processed. Here, by contrast, there was a need for an overpayment because claimant’s attorney was not paid out of claimant’s award of compensation as he should have been. Because the necessity for the overpayment was created by SAIF’s unilateral and unnecessary action, we believe that the Board had authority to remedy the situation by ordering the overpayment.

SAIF also argues that the Board’s rule, OAR 438-15-085(2), is inconsistent with ORS 656.386, because the application of the rule may result in an out-of-compensation award of attorney fees being paid from some source other than a

² A different question is presented by circumstances where no additional compensation was due to a claimant at the time of the hearing request or thereafter. We are not deciding that question here.

claimant's compensation. However, it is unnecessary to address SAIF's challenge to the rule on this basis, because neither the Board nor we rely on it to authorize the Board's action here. *See Weyerhaeuser Co. v. Sheldon*, 86 Or App 46, 738 P2d 216 (1987).

Finally, SAIF also argues that the Board's order requiring it to recover the amount of the attorney fees paid from claimant's future permanent disability awards violates ORS 656.234(1), because it illegally assigns a claimant's future benefits. That statute provides:

"No moneys payable under this chapter on account of injuries or death are subject to assignment prior to their receipt by the beneficiary entitled thereto, nor shall they pass by operation of law. All such moneys and the right to receive them are exempt from seizure on execution, attachment or garnishment, or by the process of any court."

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However, we believe that the Board's action is not an assignment of future benefits but, rather, a lien for attorney fees upon future compensation authorized by ORS 656.388(2). We conclude that the Board did not err in these unique circumstances in ordering SAIF to pay attorney fees directly to claimant's attorney.

Affirmed.³

³ SAIF does not rely on OAR 438-15-085(1), which provides:

"If the claimant consents in the attorney retainer agreement, the defense or the Board may order the payment of approved attorney fees directly to the claimant's attorney in a lump sum when the fee is to be paid out of an award of compensation for permanent disability. The lump sum shall not be due until the award of compensation becomes final."

Accordingly, we do not address what application, if any, that rule might have in this case.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Kevin R. Lathrop, Claimant.

Kevin R. LATHROP,
Petitioner,

v.

FAIRVIEW TRAINING CENTER
and SAIF Corporation,
Respondents.

(91-03523; CA A85032)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 31, 1995.

Charles Maier filed the brief for petitioner.

Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DEITS, P. J.

Affirmed.

DEITS, P. J.

Claimant seeks review of the Workers' Compensation Board's order denying his request that SAIF be required to pay an out-of-compensation attorney fee directly to his attorney. We affirm.

Claimant sustained a compensable low back injury in 1988. His claim was accepted by SAIF in October 1988. In October 1989, SAIF closed the claim, and claimant objected. By stipulation, SAIF agreed to reopen the claim. The stipulated order stated:

"Claimant's attorney shall receive 25 percent of the additional permanent partial disability awarded at next closure, amount not to exceed \$2,800.00."

SAIF closed the claim and paid claimant \$2,240, the full amount of permanent partial disability due. Under the stipulated agreement, claimant's attorney's share of the increased compensation was \$560. That amount, however, was sent by SAIF directly to claimant, not to his attorney.

Claimant requested a hearing, arguing that SAIF should have paid the attorney fee directly to his attorney and

that, because it did not do so, SAIF should now be required to pay the fee to his attorney in addition to the compensation that it already paid to claimant. Claimant also contended that SAIF's failure to pay the attorney directly constituted unreasonable resistance to the payment of compensation and that, accordingly, he was entitled to a penalty under ORS 656.262-(10). The referee concluded that under OAR 438-15-085(1), because the retainer agreement between claimant and his attorney did not specifically authorize a direct payment to the attorney, and because the stipulation between the parties did not authorize direct payment, SAIF did not act improperly in paying the full amount due directly to claimant. The Board summarily affirmed the referee's order.

On review, claimant argues that the Board erred in concluding that the attorney retainer agreement between claimant and his attorney must include specific consent to direct payment of the attorney fees to his attorney before such direct payment may be ordered by the Board. Claimant

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relies on ORS 656.386(2)¹ and OAR 438-15-010,² which provide that an attorney fee shall be paid out of claimant's award of compensation and shall be a lien upon claimant's compensation. He contends that there is nothing in the language of either the statute or the rule that requires that claimant must consent in the retainer agreement to direct payment to an attorney before the Board may order it. Claimant argues that once the parties agree that the attorney is to receive a specific portion of claimant's award, a lien is created that may only be satisfied by direct payment of the award of attorney fees to the attorney.

Claimant is correct that ORS 656.386(2) and OAR 438-15-010 do designate the source of the award of attorney fees. However, these provisions do not specify a procedure for payment of the award. Under ORS 656.388(2), the Board is given the authority to specify the method of payment:

"Any claim for payment to a claimant's attorney by the claimant so approved shall, *in the manner and to the extent fixed by the referee, board, or such court*, be a lien upon compensation." (Emphasis supplied.)

¹ ORS 656.386(2) 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."

² The version of OAR 438-15-010 in effect at the time of issuance of the Board's order provided, in part:

"(2) Attorney fees for an attorney representing a claimant shall be paid out of the claimant's compensation award.

"(3) An approved fee awarded or allowed to an attorney shall be a lien upon the claimant's compensation."

The Board did specify the manner of payment of attorney fees in its adoption of OAR 438-15-085(1),³ which provides:

"If the claimant consents in the attorney retainer agreement, the referee or the Board may order the payment of

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approved attorney fees directly to the claimant's attorney in a lump sum when the fee is to be paid out of an award of compensation for permanent disability. The lump sum shall not be due until the award of compensation becomes final." (Emphasis supplied.)

Here, the Board concluded that the retainer agreement between claimant and his attorney did not satisfy the requirements of OAR 438-15-085(1). Based on that conclusion, the Board held that SAIF was not obligated to make the direct payment. We hold that the Board did not err in reaching the above conclusions. Consequently, it did not err in denying claimant's request for an order requiring SAIF to pay the attorney fees directly to his attorney.

Affirmed.

³ The Board has authority to adopt rules that are reasonably required in the performance of its duties. ORS 656.726(4) provides:

"The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. Such rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Ryan F. Johnson, Claimant.

SAFEWAY STORES, INC.,
Petitioner,

v.

Ryan F. JOHNSON,
Respondent.

(WCB 93-02394; CA A84056)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 25, 1995.

Kenneth L. Kleinsmith argued the cause for petitioner. With him on the brief was Meyers, Radler, Replogle & Bohy.

G. Duff Bloom argued the cause for respondent. With him on the brief was Coons, Cole, Cary & Wing, P.C.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Award of attorney fees under ORS 656.386(1) reversed; otherwise affirmed.

WARREN, P. J.

Employer seeks review of an order of the Workers' Compensation Board that awarded permanent partial disability to claimant and a penalty and attorney fee. We affirm in part and reverse in part.

Claimant's work involved frequent exposure to low temperatures. After a few years on the job, he suffered a work-related worsening of his underlying Raynaud's Phenomenon, which, until that time, had been asymptomatic. Employer contested the compensability of claimant's condition. We affirmed the Board's order, in which it held that claimant had a compensable worsening of an occupational disease. *Safeway Stores, Inc. v. Johnson*, 129 Or App 147, 877 P2d 679 (1994). Later, employer issued a notice of closure that did not provide for scheduled permanent partial disability (PPD). Claimant sought reconsideration and the appointment of a medical arbiter. On reconsideration, the Department of Consumer and Business Services awarded claimant 63 percent scheduled PPD. See OAR 436-35-110(7)(d).

Employer appealed the PPD award. Next, employer issued a "partial denial" of that award, asserting that the

award constituted a claim for benefits. Claimant cross-appealed the partial denial. The referee affirmed the award of PPD, awarded claimant a prevailing party attorney fee, set aside the partial denial and assessed a penalty. Employer sought review and the Board affirmed, in part.¹

Employer requests review of the Board's order. Its first assignment is that the Board erred in concluding that claimant has a work-related permanent partial disability. Employer argues that the Board erroneously interpreted its first order, in which employer asserts the Board found only that claimant's *symptoms* were compensable. From that premise, it contends that claimant is not entitled to PPD, because he currently has no work-related symptoms.

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The Board's first order said, in part:

"Based on the medical evidence in this case, we find that claimant has Raynaud's Phenomenon, an idiopathic underlying condition which results in vasospasms of the small blood vessels that * * * [cause] pain and discoloration of the hands and fingers. The vasospasms are triggered by stimuli such as cold exposure and emotional distress; however, those stimuli do not affect the underlying hyperactivity of the phenomenon itself. The vasospasms and resulting symptoms are the only manifestations of the phenomenon. Prolonged exposure to triggering stimuli can cause permanent tissue damage.

"[There is medical evidence] that Raynaud's Phenomenon is a predisposition which is not necessarily symptomatic until there is harmful exposure * * * .

"Based on this record, we conclude that claimant was disabled and required treatment for symptoms which are the only manifestations of Raynaud's Phenomenon. Therefore, we find that claimant's symptoms *are* the disease for purposes of ORS 656.802." (Emphasis in original.)

In its later order, in which it upheld the award of PPD, the Board said:

"In our prior order, we found that claimant has Raynaud's Phenomenon, an [idiopathic], underlying condition. We also found that, for the purposes of establishing compensability under ORS 656.802, the symptoms of Raynaud's Phenomenon were the disease. We relied on [medical evidence] that claimant's cold exposure at work was the major contributing cause of the Raynaud's symptoms, to find the claim compensable. Thus, although Raynaud's Phenomenon is only manifested through symptoms, *any impairment caused by the symptoms is due to claimant's compensable occupational disease.*" (Emphasis supplied.)

¹ The Board reversed a part of the referee's order that awarded an attorney fee based on the referee's conclusion that employer's partial denial was unreasonable. See ORS 656.382(1). Claimant does not cross-petition to raise that issue.

We find nothing contradictory in the language of those two orders. The Board's first order held that claimant was entitled to compensation for a work-related worsening of his Raynaud's Phenomenon. In its second order, the Board found that, although claimant's particular symptoms had abated, he suffered permanent partial impairment as a result of those

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symptoms. That finding is supported by substantial evidence.² The Board did not err in affirming the award of PPD to claimant.

Employer's next assignment is that the Board erred in assessing an attorney fee under ORS 656.386(1),³ which provides, in part, that where the employer denies the claim, if the claimant finally prevails in a hearing before the referee or on appeal to the Board, then the referee or Board must allow a reasonable attorney fee. Employer essentially argues that no basis exists for an award of attorney fees under ORS 656.386(1), because its partial denial was a nullity. We agree.

The right to attorney fees under ORS 656.386(1) "is predicated on the existence of a 'claim for compensation * * *.'" *SAIF v. Allen*, 320 Or 192, 201, 881 P2d 773 (1994). A claim for compensation includes a written request for compensation for medical services or a compensable, work-related injury. ORS 656.005(6), (8); *Allen*, 320 Or at 201. Here, employer contested the compensability of claimant's worsening of an occupational disease. Claimant prevailed. Later, employer issued a notice of closure on that claim. Claimant contested that notice, because it did not award him PPD. On reconsideration, he received an award of PPD.

Employer requested a hearing to contest that award. It then sent claimant a "partial denial," in which employer said that it considered the award of scheduled permanent partial disability to be a claim for benefits. An award of PPD is compensation; it is *not* a written request for compensation.

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ORS 656.005(8). That employer mischaracterized the nature of the award is irrelevant, because "[w]here the only compen-

² Employer, in its first assignment, also argues that if there is no basis on which to award PPD to claimant, then claimant is not entitled to a penalty under ORS 656.268(4)(g) and to a reasonable attorney fee under ORS 656.382(2). Because of our disposition of the issue of claimant's entitlement to PPD, we need not address that argument.

³ 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."

sation issue on appeal is *the amount of compensation or the extent of disability*, * * * ORS 656.386(1) is not the applicable attorney fee statute * * *." *Short v. SAIF*, 305 Or 541, 545, 754 P2d 575 (1988). (Emphasis supplied.) *See also Allen*, 320 Or at 204 (ORS 656.386(2) controls the payment of attorney fees in cases in which the referee awards additional compensation for PPD).

When the Board affirmed the award of PPD, claimant prevailed on the issues of the extent of his disability and the amount of compensation. Because claimant did not have a claim for compensation pending, the predicate for an award of attorney fees under ORS 656.386(1) did not exist. Accordingly, we conclude that the Board erred in awarding claimant attorney fees under ORS 656.386(1).

Award of attorney fees under ORS 656.386(1) reversed; otherwise affirmed.

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<u>656.212</u> 96,610,672,917		<u>656.245(3)(b)</u> 193	<u>656.262</u> 193,460,541,672,1060, 1114
<u>656.212(2)</u> 1109	<u>656.236(1)</u> 38,55,207,217,304, 433,609,651,691,706, 858,870,901,954,997, 1049,1093,1107	<u>656.245(3)(b)(A)</u> 193	<u>656.262(1)</u> 193,293,324,411,617, 649,1085
<u>656.214</u> 121		<u>656.245(3)(b)(B)</u> 14,83,99,119,136,478, 510,514,531,548,849, 1139	<u>656.262(2)</u> 1139
<u>656.214(2)</u> 514,634,849,1019	<u>656.236(1)(a)</u> 81,214,997,1049,1068, 1074,1095,1098	<u>656.245(5)</u> 193	<u>656.262(4)(a)</u> 672
<u>656.214(2)(a)</u> 514	<u>656.236(1)(a)(C)</u> 1095	<u>656.245(6)</u> 1041	<u>656.262(6)</u> 59,64,133,208,243, 253,277,306,324,377, 454,493,541,556,560, 628,632,652,672,681, 707,742,763,780,909, 955,988,994,1004, 1007,1043,1052,1055, 1171,1193
<u>656.214(3)</u> 514	<u>656.236(1)(b)</u> 485,1095	<u>656.248(13)</u> 300,1041	
<u>656.214(4)</u> 514	<u>656.236(1)(c)</u> 914,1062,1095,1105	<u>656.260</u> 193,293,324,377,411	
<u>656.214(5)</u> 11,310,439,478,514, 634,667,769,833,849	<u>656.236(2)</u> 304	<u>656.260(1)-(9)</u> 193	
<u>656.216(1)</u> 492	<u>656.236(6)</u> 55	<u>656.260(3)</u> 193	
<u>656.218</u> 46,414,718	<u>656.245</u> 33,51,54,193,213,279, 427,447,507,517,541, 551,556,714,752,829, 891,1180	<u>656.260(4)</u> 193	
<u>656.218(2)</u> 414			<u>656.262(6)(b)</u> 994

<u>656.262(6)(c)</u> 395,994	<u>656.268(3)(a)</u> 403,610,917	<u>656.273(1)</u> 8,64,91,94,100,103, 137,169,177,216,227, 232,276,279,517,541, 550,681,786,829,843, 926,1153,1180	<u>656.283(2)</u> 24,556,560,621,654, 677,771,1016
<u>656.262(6)(d)</u> 1068,1109,1114	<u>656.268(3)(b)</u> 96,139,1082		<u>656.283(2)(a)</u> 329,621,654,724
<u>656.262(8)</u> 91	<u>656.268(3)(c)</u> 230		
<u>656.262(9)</u> 541,734,872	<u>656.268(4)</u> 1035	<u>656.273(1)(b)</u> 232	<u>656.283(6)</u> 731
<u>656.262(10)</u> 17,59,123,156,163, 165,167,253,300,318, 335,381,398,403,423, 499,617,628,700,765, 776,886,891,981,1000, 1021,1052,1089,1114, 1193,1214	<u>656.268(4)(a)</u> 454	<u>656.273(2)</u> 64	<u>656.283(7)</u> 1,41,44,146,193,315, 347,351,444,481,483, 504,512,623,678,723, 731,786,986,1057, 1065
<u>656.262(10)(a)</u> 91,96,258,283,377, 443,984	<u>656.268(4)(e)</u> 1,309,986	<u>656.273(3)</u> 8,64,100,232,276	<u>656.289(3)</u> 19,68,82,84,304,383, 702,703,767,811
<u>656.265</u> 40	<u>656.268(4)(f)</u> 1	<u>656.273(4)(a)</u> 459,499,754	<u>656.289(4)</u> 33,217,688,804
<u>656.265(1)</u> 182,289	<u>656.268(4)(g)</u> 1,28,84,163,512,539, 544,721,849,1202, 1217	<u>656.273(4)(b)</u> 459,806,1069	<u>656.295</u> 19,68,82,84,304,383, 702,703,767,811,1171
<u>656.265(4)(a)</u> 40,182,923	<u>656.268(5)</u> 1,189,295,745,986, 1171,1186	<u>656.273(8)</u> 64,87,100,227,232, 829,843,890	<u>656.295(2)</u> 19,82,84,304,383,702, 703,767,811
<u>656.266</u> 13,127,135,147,186, 319,413,430,501,634, 661,681,712,742,780, 849,872,904,909,970, 1019,1103	<u>656.268(6)</u> 295	<u>656.277</u> 806,994	<u>656.295(5)</u> 71,119,141,146,172, 238,273,282,293,295, 324,353,379,395,417, 433,463,481,512,678, 747,754,758,816,863, 988,1041,1065
<u>656.268(1)</u> 16,208,219,761,1028	<u>656.268(6)(a)</u> 119,208,478	<u>656.277(1)</u> 672,908,994	<u>656.295(6)</u> 1050,1059
<u>656.268(2)</u> 525	<u>656.268(6)(b)</u> 28,309,481,512,986, 1085,1089,1171	<u>656.277(2)</u> 672,908,994	<u>656.295(8)</u> 789,1064,1097
<u>656.268(2)(a)</u> 1085	<u>656.268(6)(f)</u> 1089	<u>656.278</u> 33,34,51,137,213,263, 495,499,858,882,965, 1069,1214	<u>656.298</u> 528,1171
<u>656.268(3)</u> 96,610,991,1082,1091	<u>656.268(7)</u> 119,189,208,282,295, 406,432,478,525,548, 661,849,1025,1099, 1202	<u>656.278(1)(a)</u> 34,213,270,292,1069, 1108	<u>656.298(1)</u> 789
	<u>656.268(11)</u> 395	<u>656.283 to .304</u> 649	<u>656.298(3)</u>
	<u>656.268(13)</u> 406,442,1019,1035	<u>656.283</u> 24,193,293,300,324, 377,411,632,1006, 1089,1171	<u>656.298(6)</u> 1,514,550,1153
	<u>656.273</u> 33,68,100,103,263, 276,420,427,447,495, 517,672,692,829,858, 882,908,965,986,994, 1052,1153,1180	<u>656.283(1)</u> 193,263,324,395,499, 556,560,979,994,1060, 1171	
		<u>656.283(1)(a)</u> 1043	

<u>656.307</u> 34,91,115,167,213, 345,356,740,866,955, 1003,1055	<u>656.319(1)(a)</u> 391,460,789,955,1072	<u>656.340(6)(b)(A)</u> 329,621,1016	<u>656.382(2)--cont.</u> 1027,1035,1047,1050, 1052,1063,1072,1082, 1085,1096,1104
<u>656.307(1)</u> 356	<u>656.319(1)(b)</u> 391,460,789,955,1072	<u>656.340(6)(b)(B)</u> 771	<u>656.382(3)</u> 754
<u>656.307(2)</u> 115,161,356	<u>656.319(4)</u> 436,1171	<u>656.340(6)(b)(B)(i)</u> 1016	<u>656.386</u> 1209
<u>656.307(5)</u> 356,740,878	<u>656.319(6)</u> 1109	<u>656.340(6)(b)(B)(ii)</u> 1016	<u>656.386(1)</u> 20,24,31,45,59,71,75, 80,86,91,94,100,105, 110,117,123,139,147, 162,163,165,167,193, 211,222,224,226,227, 244,248,253,258,263, 265,275,280,281,283, 300,313,322,345,347, 364,373,377,411,419, 423,451,462,463,483, 493,530,624,628,658, 663,684,685,692,700, 725,727,740,742,749, 750,758,763,801,843, 845,866,868,878,884, 886,887,894,917,924, 929,936,959,1004, 1007,1010,1040,1109, 1117,1167,1170,1193, 1209,1217
<u>656.308</u> 236,265,340,435,822, 961	<u>656.327</u> 24,71,107,193,255, 283,311,328,427,463, 556,632,700,829	<u>656.340(6)(b)(B)(iii)</u> 634,771,1153	
<u>656.308(1)</u> 31,114,182,236,340, 466,507,734,843,852, 887,961,1010,1120	<u>656.327(1)</u> 24,54,71,193,328, 377,423,628,632,685, 754	<u>656.340(7)</u> 612	
<u>656.308(2)</u> 153,238,287,340,466, 656,711,822,955,961	<u>656.327(1)(a)</u> 283,754,891,1043	<u>656.340(9)(c)</u> 612	
<u>656.310(2)</u> 319,742	<u>656.327(1)(b)</u> 463,754	<u>656.340(12)</u> 612	
<u>656.313</u> 28,332,454,460,492, 688,1082	<u>656.327(1)(c)</u> 632	<u>656.382</u> 253	
<u>656.313(1)</u> 991	<u>656.327(2)</u> 24,28,71,158,192,222, 628,632,685,700,754	<u>656.382(1)</u> 1,59,71,105,163,257, 258,293,311,313,332, 411,443,463,544,617, 714,745,754,803,804, 984,996,1078,1217	
<u>656.313(1)(a)</u> 332,492,1082	<u>656.327(3)</u> 193,556,560	<u>656.382(2)</u> 13,17,18,31,35,45,48, 61,71,77,87,94,114, 115,117,128,129,131, 133,139,163,169,177, 182,188,189,208,230, 232,236,238,243,248, 250,253,257,286,287, 293,299,300,306,309, 315,340,351,356,361, 367,377,385,387,399, 402,411,420,423,429, 436,444,450,454,620, 627,634,652,663,667, 672,681,692,705,707, 711,721,723,724,730, 734,740,742,749,752, 754,765,769,776,809, 816,819,822,826,840, 852,857,861,874,879, 890,898,923,932,939, 944,945,947,948,950, 969,974,976,984,986, 992,996,998,1000, 1002,1003,1020,1024	<u>656.386(2)</u> 163,208,300,381,387, 403,439,444,462,616, 790,848,981,994,1035, 1085,1209,1214,1217
<u>656.313(1)(a)(A)</u> 984,991,1082,1089	<u>656.331</u> 804		<u>656.388(1)</u> 1,89,107,163,255,311, 313,463,725,829,891, 915,967,1040,1043, 1112
<u>656.313(1)(b)</u> 492	<u>656.331(1)(b)</u> 804		<u>656.388(2)</u> 1209,1214
<u>656.313(3)</u> 460	<u>656.340</u> 33,495,771,898,1153		
<u>656.313(4)(c)</u> 33,688	<u>656.340(5)</u> 621,771,1153		<u>656.390</u> 754
<u>656.313(4)(d)</u> 33,688,977	<u>656.340(6)</u> 1153		<u>656.576</u> 488,955
<u>656.319</u> 460,556,560,1171	<u>656.340(6)(a)</u> 329,621,771,1016, 1153		<u>656.576 to .596</u> 858,955
<u>656.319(1)</u> 457,460	<u>656.340(6)(b)</u> 1016		

<u>656.578</u> 488,882	<u>656.726(3)(f)(C)</u> 299,1103	<u>656.802(3)(a)</u> 110,147,179,681	<u>734.510 et seq.</u> 533
<u>656.580(2)</u> 488,882	<u>656.726(4)</u> 499,1214	<u>656.802(3)(b)</u> 110,143,147,179,221, 397,681,859	<u>734.510(4)</u> 533
<u>656.587</u> 882,1078	<u>656.735</u>	<u>656.802(3)(c)</u> 110,143,147,179,681	<u>734.510(4)(a)&(b)</u> 533
<u>656.593</u> 495,533,1078	<u>656.740</u> 546,1006	<u>656.802(3)(d)</u> 110,147,179,681	<u>734.510(4)(b)(B)</u> 533
<u>656.593(1)</u> 57,406,488,495,533, 882,1078	<u>656.740(1)</u> 1006	<u>656.802(4)</u> 903,1195	<u>734.520</u> 533
<u>656.593(1)(a)</u> 533	<u>656.740(3)</u> 546,1006	<u>656.804</u> 507,1120	<u>734.570(1)</u> 533
<u>656.593(1)(b)</u> 533	<u>656.740(4)</u> 546,612,1006	<u>656.807</u> 822	<u>734.570(2)</u> 533
<u>656.593(1)(c)</u> 406,488,495,533,882, 965	<u>656.740(4)(c)</u> 279,546,612,1006	<u>656.807(1)</u> 822,845	<u>734.640</u> 533
<u>656.593(1)(d)</u> 533,882	<u>656.745</u> 803	<u>659.030(1)(a)</u> 553	<u>734.640(1)&(3)</u> 533
<u>656.593(2)</u> 406,488,495,533,882	<u>656.802</u> 110,143,322,451,497, 660,681,726,909,919, 970,1117,1120,1157, 1195,1217	<u>659.121</u> 553	<u>734.695</u> 533
<u>656.593(3)</u> 57,406,488,495,882, 965,1078	<u>656.802(1)</u> 110,143,373,970,1120, 1157	<u>659.121(3)</u> 553	<u>743.556(16)(b)(D)</u> 193
<u>656.600</u> 486	<u>656.802(1)(a)</u> 1117	<u>659.410</u> 553	<u>767.025</u> 1163
<u>656.704</u> 193,1006	<u>656.802(1)(b)</u> 179,859,872	<u>659.410(1)</u> 553	
<u>656.704(2)</u> 560	<u>656.802(1)(c)</u> 160,248,501,822,909, 1010	<u>659.415</u> 553	
<u>656.704(3)</u> 115,193,293,300,324, 377,379,399,411,423, 556,560,1006	<u>656.802(2)</u> 17,61,110,123,143, 147,179,186,244,248, 326,340,373,451,454, 466,498,501,528,623, 681,727,750,819,822, 836,845,872,884,905, 953,961,1010,1040, 1117,1120	<u>659.415(1)</u> 553	
<u>656.726</u> 979	<u>656.802(3)</u> 110,681,919,970	<u>659.420</u> 553	
<u>656.726(3)</u> 833		<u>659.420(1)</u> 553	
<u>656.726(3)(f)</u> 514,833		<u>670.600</u> 48	
		<u>689.515</u> 556	
		<u>705.105</u> 1153	

<u>Rule</u>	<u>436-10-100(5)</u>	<u>436-30-036(1)</u>	<u>436-35-003(2)</u>
Page(s)	891	610,947	35,99,667,769,906, 1019
<u>137-76-010(3)</u>	<u>436-10-100(9)</u>	<u>436-30-036(4)(a)</u>	<u>436-35-005(1)</u>
895	59	35	840
<u>137-76-010(6)</u>	<u>436-10-100(12)</u>	<u>436-30-045(5)(a)</u>	<u>436-35-005(2)</u>
895	891	616,692,950	417
<u>137-76-010(8)</u>	<u>436-10-100(22)</u>	<u>436-30-045(5)(d)</u>	<u>436-35-005(5)</u>
297,895	886	616,950	99,387,1019,1074
<u>436-10-005(1)</u>	<u>436-10-100(23)</u>	<u>436-30-045(7)</u>	<u>436-35-005(8)</u>
1139	886	979	514
<u>436-10-005(1)(c)</u>	<u>436-10-130(6)</u>	<u>436-30-045(7)(a)</u>	<u>436-35-005(9)</u>
1139	803	979	444
<u>436-10-005(20)</u>	<u>436-15-005(15)</u>	<u>436-30-045(7)(b)</u>	<u>436-35-005(10)</u>
1139	193	979	1025
<u>436-10-005(29)</u>	<u>436-15-008</u>	<u>436-30-050</u>	<u>436-35-007</u>
54	193	1202	310
<u>436-10-008(2)</u>	<u>436-15-008(2)</u>	<u>436-30-050(2)</u>	<u>436-35-007(1)</u>
423	193	745	386
<u>436-10-040(1)(a)</u>	<u>436-15-008(3)</u>	<u>436-30-050(4)</u>	<u>436-35-007(3)</u>
328,829	193	1	857
<u>436-10-040(2)(a)</u>	<u>436-15-030(1)(l)</u>	<u>436-30-050(4)(e)</u>	<u>436-35-007(3)(b)</u>
829	193	745	11,439,667,833
<u>436-10-046(1)</u>	<u>436-15-030(1)(n)</u>	<u>436-30-050(4)(f)</u>	<u>436-35-007(5)</u>
193	193	745	1069
<u>436-10-050(2)</u>	<u>436-15-110(1)</u>	<u>436-30-050(12)</u>	<u>436-35-007(6)</u>
311	193	1202	849
<u>436-10-050(7)</u>	<u>436-30-008(1)</u>	<u>436-30-050(13)</u>	<u>436-35-007(8)</u>
311	119,478,1085	1202	548,1025
<u>436-10-060(3)</u>	<u>436-30-008(3)</u>	<u>436-30-055</u>	<u>436-35-007(9)</u>
423	478,1085	514	83,261,857,1025
<u>436-10-060(22)</u>	<u>436-30-035</u>	<u>436-30-055(1)(a)</u>	<u>436-35-007(17)</u>
423	1028	514	1059
<u>436-10-060(23)</u>	<u>436-30-035(1)</u>	<u>436-30-055(1)(c)</u>	<u>436-35-010(2)</u>
423	35,403,790	634	504
<u>436-10-070</u>	<u>436-30-035(2)</u>	<u>436-30-055(3)</u>	<u>436-35-010(6)</u>
803	35	514	386,387,417,531,967, 1074
<u>436-10-080</u>	<u>436-30-035(4)</u>	<u>436-30-055(5)</u>	<u>436-35-010(6)(a)</u>
548	35	514	531
<u>436-10-090(6)</u>	<u>436-30-035(7)</u>	<u>436-35-003(1)</u>	
59	1028	35,667,769,906	

<u>436-35-080</u> 417	<u>436-35-270(3)(e)</u> 14,35,667	<u>436-35-360(19)</u> 189	<u>436-60-030(2)</u> 403,610,672,1171
<u>436-35-110(2)</u> 504	<u>436-35-270(3)(g)</u> 1,35,667,813,906	<u>436-35-360(20)</u> 189	<u>436-60-030(4)(a)</u> 139
<u>436-35-110(2)(a)</u> 504	<u>436-35-270(3)(g)(B)</u> 14,813	<u>436-35-360(21)</u> 189	<u>436-60-030(4)(b)</u> 917,1171
<u>436-35-110(4)</u> 417	<u>436-35-270(3)(g)(C)</u> 14,813	<u>436-35-360(22)</u> 189	<u>436-60-030(5)</u> 335
<u>436-35-110(5)</u> 1103	<u>436-35-280</u> 14,667,813,906	<u>436-35-390(7)(a)</u> 840	<u>436-60-030(5)(c)</u> 335
<u>436-35-110(6)</u> 1039	<u>436-35-280(4)</u> 634,769	<u>436-35-390(7)(a)(A)-(D)</u> 840	<u>436-60-030(6)(a)</u> 139
<u>436-35-110(6)(d)</u> 1039	<u>436-35-280(6)</u> 189,634,769	<u>436-35-440</u> 973,1103	<u>436-60-030(11)(b)</u> 917
<u>436-35-110(7)(d)</u> 1217	<u>436-35-280(7)</u> 1,189,634,769	<u>436-35-440(1)</u> 973	<u>436-60-050(4)</u> 891
<u>436-35-110(9)(a)</u> 504	<u>436-35-300(3)</u> 906	<u>436-35-440(2)</u> 1103	<u>436-60-060(1)</u> 492
<u>436-35-200(4)</u> 174	<u>436-35-300(4)(e)</u> 444,667	<u>436-35-450</u> 973	<u>436-60-095(3)</u> 752
<u>436-35-230(3)</u> 386	<u>436-35-300(6)</u> 634	<u>436-35-450(1)(b)</u> 973	<u>436-60-145</u> 207
<u>436-35-230(5)</u> 857	<u>436-35-310(1)</u> 667,813,906	<u>436-60-005(9)</u> 433,901	<u>436-60-145(1)</u> 81,214,1068
<u>436-35-230(6)</u> 1103	<u>436-35-310(2)</u> 35,769,813,906	<u>436-60-005(22)</u> 955	<u>436-60-145(3)(j)</u> 858,997,1049
<u>436-35-230(9)</u> 857,1031	<u>436-35-310(3)</u> 14,35,189,667	<u>436-60-010(1)</u> 403	<u>436-60-145(4)(a)</u> 901
<u>436-35-230(10)</u> 1031	<u>436-35-310(3)(a)</u> 1	<u>436-60-020(7)</u> 6	<u>436-60-145(4)(e)</u> 865
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