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(Pages 1-608)

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

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

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In the Matter of the Compensation of
RAYMOND L. MACKEY, Claimant
WCB Case No. 91-08671
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. Mackey v. Dow Corning, Inc., 129 Or App 302 (1994). The court has reversed our prior order, Raymond L. Mackey, 45 Van Natta 776 (1993), which held that claimant was barred from challenging the adaptability factor at hearing because he did not first raise that issue during the reconsideration proceeding under ORS 656.268. The court has reversed and remanded for reconsideration in light of Leslie v. U.S. Bancorp, 129 Or App 1 (1994).

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A December 11, 1990, Notice of Closure increased claimant's unscheduled permanent disability for a low back injury from 10 to 24 percent. On April 14, 1991, claimant requested reconsideration of the Notice of Closure using the Department's reconsideration request form. The form provided that the worker must check a box for each issue he wished to challenge on reconsideration. Although claimant checked a box indicating that he disagreed with the insurer's rating of his unscheduled permanent disability, he also checked a box which indicated that he did not object to the adaptability factor used in the Notice of Closure.

A June 25, 1991 Order on Reconsideration increased claimant's total unscheduled permanent disability award from 24 to 27 percent. Claimant requested a hearing on the reconsideration order.

The Referee concluded that because claimant did not specifically challenge the adaptability factor at the time of reconsideration, he was barred from raising that issue at hearing. Consequently, the Referee affirmed the Order on Reconsideration's award of unscheduled permanent disability.

On Board review, we affirmed the Referee's order. Raymond L. Mackey, supra. Relying on ORS 656.268(4)(e) and (5), we reasoned that a party was precluded from contesting an issue at hearing which that party had not contested during the reconsideration proceeding.

Citing Leslie v. U.S. Bancorp, supra, the court has reversed our order. Specifically, the court has remanded for reconsideration in light of Leslie.

In Leslie, the court held that a claimant who did not raise her entitlement to scheduled disability at the reconsideration proceeding was not statutorily precluded from raising that issue at hearing before the referee. In a footnote, the Leslie court stated that it need not decide whether the Board has the discretion to require a claimant to first raise an issue at the time of reconsideration before raising that issue at hearing. 129 Or App at 5, note 6.

Here, SAIF asserts that we possess the discretion to preclude claimant from challenging his adaptability factor for the first time at hearing. To assist us in further considering this contention on remand, the parties have submitted supplemental briefs addressing whether the Board has discretion to require an issue to be raised by a party at the reconsideration proceeding before that issue can be raised at hearing.[1]

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[1] SAIF also has requested oral argument. Claimant opposes the request. 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 B. Trevitts, 46 Van Natta 1767 (1994); Ruben G. Rothe, 44 Van Natta 369 (1992).

Here, through their appellate briefs and supplemental briefs on remand, the parties have fully addressed the impact of relevant Board and court decisions on the issues before the Board. Inasmuch as the parties' positions regarding these issues have 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, n. 2 at 283 (1993).

SAIF contends that the Board has discretion to promulgate a rule requiring parties to raise issues on reconsideration before those issues may be considered at hearing. In response, claimant argues that there is no statutory authority to limit the issues raised at hearing to those raised on reconsideration. Lacking such statutory authority, claimant reasons that there is also no Board discretion to limit the scope of issues which may be raised at hearing. For the following reason, we agree with claimant.

In Darlene K. Bentley, 45 Van Natta 1719 (1993), we relied on Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), to conclude that since evidence that was not introduced in the reconsideration process could be raised at hearing, there should likewise be no limitation on the issues raised at the hearing. We noted in Bentley that Smith specifically held that although ORS 656.268(5) limits the evidence that may be submitted during the reconsideration proceeding, there is no similar limitation on evidence that may be submitted at the hearing. Inasmuch as the reconsideration proceeding and the hearing constitute separate and distinct proceedings with different evidentiary records, we reasoned that the issues raised at those proceedings may also be different. See Darlene K. Bentley, supra.

The Court of Appeals reviews the Board's orders pursuant to the Administrative Procedure Act. ORS 656.298(6); Tri-Met, Inc. v. Albrecht, 308 Or 185, 188 (1989). The applicable portions of that Act provide, in part, that the court "shall remand the order to the agency if it finds the agency's exercise of discretion to be: (A) outside the range of discretion delegated to the agency by law; (B) inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or (C) otherwise in violation of a constitutional or statutory provision." ORS 183.482(8)(b).

Here, were we to require parties to raise an issue at the reconsideration proceeding prior to raising that issue at hearing, we would be acting inconsistently with our holding in Darlene K. Bentley, supra. Thus, in essence, SAIF is requesting that we disavow the Bentley rationale.

SAIF argues that requiring parties to raise issues first at the reconsideration process achieves the legislative goal of reduced litigation. SAIF further argues that allowing parties to raise issues at hearing that were not raised on reconsideration defeats the reduced litigation goal. Although the procedure advocated by SAIF would likely further reduce litigation, we are not convinced that the existing reconsideration process does not already significantly reduce litigation. In other words, the implementation of the reconsideration proceeding itself results in the resolution of disputes without the necessity of requesting a hearing.

Thus, the legislative goal of reducing litigation is furthered by the reconsideration process even though parties may raise issues at the hearing which were not raised at the reconsideration level. Furthermore, in light of the Smith court's interpretation of the relevant statutes, our decision in Bentley is consistent with the statutory scheme as well as the legislative intent of reduced litigation.

Based on the foregoing reasoning, we continue to adhere to our reasoning in Bentley that issues raised at the hearing level need not have been previously raised at the reconsideration level. Consequently, assuming that we have discretion to require parties to first raise an issue at the reconsideration level, we decline to exercise that discretion.

Moreover, because there is no statutory authority for requiring that a party raise an issue at the reconsideration level prior to raising the issue at hearing, we are doubtful that we have discretion to make such a rule. In this regard, an agency may not alter, amend, enlarge or limit the terms of an applicable statute. See Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325, 328 (1992) (citing Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988)). In other words, rather than merely filling in a statutory interstice as SAIF argues, we would be altering, amending or enlarging the terms of the applicable statutes by mandating the parties to first raise an issue at the reconsideration level when the applicable statutes do not so require.

We note that the Director has, by Bulletin, prescribed a request for reconsideration form which requires parties to check a box for each potential issue raised during the reconsideration proceeding. See OAR 436-30-050(4); Director's Bulletin 227, December 21, 1990. Likewise, the Board has a longstanding "policy" which requires parties to preserve issues for appeal by first raising them at hearing. See, e.g., Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not presented at hearing). However, neither the Director's Bulletin nor the Board's policy, require parties to raise a "hearing" issue during the reconsideration proceeding.

In light of such circumstances, we are not inclined to adopt a rule which restricts the issues which a party can raise at a hearing. This is particularly true when the record in the reconsideration proceeding under ORS 656.268 and the hearing under ORS 656.283(7) are statutorily different. See Safeway Stores, Inc. v. Smith, supra.

Finally, were we to implement a rule requiring issues to be raised first at the reconsideration proceeding, we would effectively be instituting a system which limits the evidence to be introduced at hearing regarding an Order on Reconsideration. Such an approach would be contrary to the statutory scheme as explained in Smith. Therefore, lacking an express statutory mandate, we decline to adopt the restrictive approach to raising issues and presenting evidence advocated by SAIF.

Accordingly, we decline to promulgate a rule or reach a decision requiring parties to first raise an issue at the reconsideration proceeding. We now turn to the merits of the adaptability issue.

The applicable disability rating standards are those in effect on the date of the December 11, 1990 corrected Notice of Closure. WCD Admin. Orders 15-1990 and 20-1990.

Under those standards, the adaptability factor for workers who are working at modified work at the time of determination shall be based on the difference between the physical capacity necessary to perform the regular work and the physical capacity necessary to perform the modified job according to the table in former OAR 436-35-310(3)(d). Former OAR 436-35-310(3)(a). Strength factors, for prior strength, are derived from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT). Former OAR 436-35-310(3)(d). Here, claimant had returned to modified work at the time of determination.

At the time of his injury, claimant was employed as a utility person. This job combined the jobs of front-end loader operator, DOT 512.666-010, and furnace helper, DOT 921.683-042. In performing his job as a utility person, claimant drove a front-end loader 90 percent of the time. The remaining time, he shoveled heavy rock, operated a 90-pound jackhammer and added electrodes to the furnace while using a large wrench and exerting greater than 50 pounds of pressure. (Tr. 7-9). The furnace helper job required claimant to shovel material into the furnace. That position was classified as heavy because it required lifting and throwing 40 to 50 pounds of material in addition to the five-pound shovel.

The SCODDOT describes the furnace helper job, DOT 512.666-010, as heavy. The front-end loader operator job, DOT 921.683-042, is listed as a medium strength job. Claimant's "post-injury" modified job in shipping and receiving requires claimant to lift 25 pounds occasionally and 10 pounds frequently. (Tr. 11-12). Claimant's modified job is in the light category. See former OAR 436-35-270(3)(g).

Although most of claimant's job involved work in the "medium" category as a front end loader operator, claimant's regular job also involved furnace helper work which is classified as "heavy." We have previously found that more than one DOT may arguably describe a claimant's work. See, e.g., Arliss J. King, 45 Van Natta 823 (1993). Here, if the DOT description for front end loader operator was used to determine prior strength, claimant's heavy furnace helper duties which were a regular, albeit lesser, part of his job would be ignored. Because the adaptability factor is based on strength demands, we find it reasonable to consider both claimant's job duties and the physical demands of his job in determining the proper DOT to be assigned to his job. Consequently, we conclude that furnace helper, (DOT 512.666-010), most appropriately describes claimant's job. See Andrea M. Gildea, 45 Van Natta 2293 (1993); William L. Knox, 45 Van Natta 854 (1993). Accordingly, we conclude that claimant's prior strength was heavy.

According to the table in former OAR 436-35-310(3)(d), claimant's adaptability factor is 2.5 (the difference between claimant's prior strength, heavy, and his new strength, light). The parties do not dispute any of the other factors used in determining claimant's unscheduled permanent disability. Thus, claimant's age factor (1) is added to his education factor (4) to equal 5. When that value is multiplied by the adaptability factor (2.5), the result is 12.5. This value is added to claimant's impairment factor (22) to equal 34.5. That value is rounded to the next higher whole number. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the standards is 35 percent.

Claimant seeks a penalty pursuant to ORS 656.268(4)(f). Specifically, claimant argues that the Notice of Closure was unreasonable because it utilized an adaptability factor of 1 and failed to make a scheduled disability award. On this basis, claimant argues that the employer's claims processing was unreasonable and warrants a penalty pursuant to ORS 656.268(4)(f). We conclude that ORS 656.268(4)(f) is inapplicable.

ORS 656.268(4)(f) provides:

> "If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this subsection, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, 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."

By its terms, ORS 656.268(4)(f) applies where a carrier unreasonably closes or refuses to close, a claim. See Cindy A. Schrader, 46 Van Natta 175 (1994) (The Board found the employer's closure of the claim unreasonable and assessed an ORS 656.268(4)(f) penalty where there was no persuasive evidence that claimant was medically stationary at the time of closure). Here, however, claimant does not contend that the closure of the claim was unreasonable. Rather, claimant contends that the value the insurer gave for the adaptability factor was unreasonably low and that the insurer should have made a scheduled award. Because ORS 656.268(4)(f) does not, by its terms, apply to the instant case, we conclude that a penalty under ORS 656.268(4)(f) is inappropriate.

Claimant also seeks a penalty pursuant to ORS 656.268(4)(g). ORS 656.268(4)(g) authorizes a penalty where: (1) a claim is closed by the insurer or self-insured employer; (2) the worker's permanent disability award is increased by the Department on reconsideration by 25 percent or more; and (3) the worker is at least 20 percent permanently disabled. If the statutory requirements are met, the claimant is automatically entitled to the penalty without regard to whether the carrier's action was reasonable. Kevin Northcut, 45 Van Natta 173 (1993).

Here, the Notice of Closure awarded claimant 14 percent unscheduled permanent disability, for a total award of 24 percent. The June 25, 1991 Order on Reconsideration increased claimant's award from 24 to 27 percent unscheduled permanent disability. Because the Department did not increase claimant's permanent disability award by 25 percent or more, ORS 656.268(4)(g) does not apply. Accordingly, claimant has not established entitlement to a penalty under this section.

Finally, claimant argues that he is also entitled to an attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable claims processing. Based on this record, we find no evidence that SAIF engaged in unreasonable resistance to the payment of compensation.

At the time of claim closure, claimant was functioning at a medium level of physical demand and was released to a modified job in shipping and receiving. (Tr. 11-12; Exs. 12-1; 15). Claimant's duties in this position were consistent with his physical restrictions as agreed to by Dr. Kitchel. (Ex. 15). In addition, as we have already noted, two DOT descriptions, one medium and one heavy, arguably could have governed claimant's prior strength. Specifically, the DOT for front end loader operator (a job in the medium strength category) could arguably appropriately describe claimant's prior job. Thus, although claimant's subsequent testimony supported a finding that his modified work was light and we have found that claimant's prior job should be classified as heavy, SAIF had evidence at the time of closure that claimant was released to modified work at the medium level (Exs. 12-1; 15) and his prior job was arguably in the medium strength category. Given these circumstances, we are not persuaded that SAIF's finding that claimant's adaptability was 1 (based on a prior strength of medium and a new strength of medium) was unreasonable or amounted to unreasonable resistance to the payment of compensation.

Finally, we do not find SAIF's failure to make a scheduled award to be unreasonable. Although the Referee subsequently awarded scheduled permanent disability for a chronic condition of claimant's left leg, Dr. Kitchel's closing report does not explicitly indicate that claimant was unable to repetitively use his left leg. Furthermore, after reviewing the same report by Dr. Kitchel, the Department did not award scheduled disability in its reconsideration order. In light of such circumstances, we do not find SAIF's failure to include a scheduled award in claimant's Notice of Closure to constitute unreasonable resistance to the payment of compensation. Accordingly, we decline to award an attorney fee pursuant to ORS 656.382(1).

In a case in which a claimant finally prevails in respect to any claim or award for compensation after remand from the Supreme Court, Court of Appeals or Board, the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991). Here, claimant has finally prevailed on the extent of unscheduled permanent disability issue. Therefore, claimant is entitled to a reasonable attorney fee for services concerning the issue before the Board and the Court of Appeals.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the Board and court levels concerning the extent of claimant's unscheduled permanent disability is $3,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services and appellate briefs to the Board and court), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Finally, we have taken into consideration that claimant's counsel will receive an "out-of-compensation" attorney fee payable from claimant's increased permanent disability award.

Accordingly, on reconsideration, the Referee's order dated November 7, 1991 is modified. In addition to the Notice of Closure, Order on Reconsideration and Referee awards totalling 27 percent (86.4 degrees), claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability for a total unscheduled award to date of 35 percent (112 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable by SAIF. For services before the Board and court, claimant's attorney is awarded $3,500, payable by SAIF. The remainder of the Referee's order is affirmed.

IT IS SO ORDERED.

Chair Neidig and Board Member Haynes specially concurring.

We join with the majority's decision. However, we write separately to express our belief that the legislature did not intend for the reconsideration proceeding and the hearing to involve different evidentiary records and issues.

Beginning with Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), the court has interpreted the statutes dealing with the mandatory reconsideration process in such as way as to create two separate proceedings with different bodies of evidence. Not only may new evidence, not admitted in the reconsideration proceeding, be admitted at hearing, new extent of disability issues which were not raised before the Director may now be raised at the hearing. See Leslie v. U.S. Bancorp, 129 Or App 1 (1994).

As expressed by the dissent in Darlene K. Bentley, 45 Van Natta 1719 (1993), the reconsideration process is a mandatory process which must be completed before the Hearings Division has jurisdiction to address issues arising from a Determination Order or Notice of Closure. By allowing issues to be raised at hearing which were not raised on reconsideration, the mandatory reconsideration process is circumvented and rendered meaningless. In addition, the legislative goal of reducing litigation is not served by the policy of allowing new issues to be raised on reconsideration. In fact, litigation is encouraged because parties are allowed a second chance to raise new issues and bring in new evidence at hearing. Finally, by not requiring all extent of disability issues to be raised at the reconsideration level, a party is allowed to go to hearing without exhausting all the administrative remedies available.

Notwithstanding all of the concerns expressed in the dissent in Bentley, the court decisions addressing the interrelationship between the reconsideration and hearing proceedings have indicated that there is no statutory authority to require parties to raise issues first on reconsideration. Given that lack of statutory authority, we conclude that we are without discretion to require parties to preserve issues by raising them on reconsideration. Such authority or discretion can only materialize if the legislature clarifies its intentions regarding the reconsideration proceeding and the viability of "post-reconsideration" issues at hearing. It is our hope that this decision will prompt legislative action designed to close this apparent "loophole" in the reconsideration process.

In the Matter of the Compensation of
JERRY J. RAINES, Claimant
WCB Case No. 94-00273
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

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

Claimant requests review of those portions of Referee Menashe's order which: (1) denied claimant's request for temporary total disability (TTD) at a higher rate; and (2) declined to assess a penalty for SAIF's allegedly unreasonable recalculation of claimant's TTD rate. In his brief, claimant argues entitlement to temporary partial disability (TPD) for the period from January 5, 1993 through May 3, 1993 and requests a penalty for SAIF's allegedly unreasonable failure to pay TPD. On review, the issues are temporary disability and penalties.

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

Claimant contends that he was "regularly employed," and therefore eligible for TTD calculated as though he worked full-time regularly. Alternatively, claimant argues that, even if he was not "regularly employed," his TTD should not have been calculated based on earnings during the 26 weeks preceding his injury because there were extended gaps in his employment. We disagree.

To begin, we agree with the Referee that claimant was not "regularly employed" within the meaning of ORS 656.210(2)(c). Nonetheless, we acknowledge that claimant's TTD rate would be calculated based on average earnings derived from four to 26 weeks of pre-injury earnings, if "periods of extended gaps" in earnings existed within the 26 weeks before his injury. Former OAR 436-60-025(5)(a) (WCD Admin. Order 1-1992).[1] Accordingly, we must determine whether extended gaps existed.

We determine whether extended gaps existed on a case-by-case basis. Dena L. Barnett, 43 Van Natta 1776 (1991). Determining what is an extended gap includes not only consideration of the length of the break in work, but also whether the gap caused a change in the work relationship between employer and employee. Steven B. Caldwell, 44 Van Natta 2566, 2567 (1992).

In this case, claimant earned no wages during 2 two-week periods within the 26 weeks before his May 19, 1992 work injury (one in December and one in April). During this 26 week period, he also had 3 single weeks without earnings and variable wages for the remaining weeks. However, particularly considering the apparent seasonal nature of claimant's roofing work and its dependence on the availability of jobs, we are not persuaded that these gaps in earnings caused a change in the relationship between him and his employer. On the contrary, these employment gaps were well within the parties' reasonable expectations.[2]

Under these circumstances, we do not find that claimant's periods without earnings during the 26 week period before his injury constitute "extended gaps" within the meaning of OAR 436-60-025(5)(a). Compare Qualified Contractors v. Smith, 126 Or App 131 (1994) (Where there was a one-month gap in earnings, TTD was properly calculated under the "extended gap" provisions of the rule). Consequently, we conclude, as did the Referee, that SAIF properly recalculated claimant's TTD based on claimant's average weekly earnings for the 26 weeks of employment prior to the injury. See Steven B. Caldwell, supra.

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[1] Unless such gaps existed within 4 weeks of the injury. If those circumstances had arisen, the intent at the time of hire would have controlled. Former OAR 436-60-025(5)(a) (Amended effective August 28, 1994, WCD Admin. Order 94-055).

[2] Claimant generally went to the employer's place of business every morning, to be sent to work or sent home, because the employer usually put those present to work first. (See Tr. 38, 57). However, if the weather was bad, claimant would sometimes call the employer to determine whether showing up at work would be a waste of his time. (Tr. 42).

Finally, we note that claimant seeks TPD and a penalty for nonpayment of TPD. He did not make this argument at hearing. Instead, he advocated for a higher TTD rate and a penalty for failure to pay TTD at a higher rate, and requested that the reconsideration order's "premature closure" finding be affirmed. Under these circumstances, we are not inclined to consider claimant's TPD argument on review. In any event, the claim is reopened. Thus, the TPD dispute (if any) can be resolved at the time of claim closure.

ORDER

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

Board Member Gunn dissenting.

ORS 656.210 sets out the method for determining a worker's temporary total disability (TTD) benefits during medical treatment. Specifically, an injured worker's TTD benefits "shall be based on the wage of the worker at the time of injury." ORS 656.210(2)(b)(A). In addition, the statute provides that the director may prescribe methods for establishing the weekly wage (for TTD calculation purposes) for workers not regularly employed (as well as those with no remuneration or whose remuneration is not based solely on daily or weekly wages). Further, the statute states that "'regularly employed' means actual employment or availability for such employment." ORS 656.210(2)(c) (emphasis added). Thus, in my view, the statute clearly limits the applicability of the director's rules regarding temporary disability calculation to those workers who are not actually employed or not available for actual employment.

In this case, it is equally clear that claimant was available for actual employment at least since July 3, 1991, when he began working for SAIF's insured. Under these circumstances, I would say that the majority's application of the director's rules is in error. Instead, I would find that claimant's temporary disability must be calculated based on his wage at the time of injury ($17.14 per hour), multiplied by 40 hours per week, to arrive at his weekly wage at the time of injury. See ORS 656.210(2)(b)(A)&(c).

Any other interpretation of the statute, including the majority's, unfairly and unnecessarily discriminates against construction trade workers, including claimant, who are available for actual employment, but only actually work when work is available and weather permits.

Moreover, even if the director's rule concerning extended gaps in employment should apply in this case, I would find that the parties intended that claimant would be a full-time employee when he was hired. See OAR 436-60-020(7). Under these circumstances, I fail to see how this case differs from Qualified Contractors v. Smith, 126 Or App 131 (1994), where the court agreed that the journeyman worker was "regularly employed" and upheld our conclusion that his TTD benefits should be calculated based on full-time employment. Under these circumstances, I must respectfully dissent.

In the Matter of the Compensation of
DIANA TRAVER, Claimant
WCB Case No. 93-08959
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Turner-Christian and Haynes.

Claimant requests review of Referee Spangler's order that upheld the insurer's denial of claimant's aggravation claim for a right shoulder and right arm condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. The last arrangement of compensation is a March 29, 1991 Opinion and Order, which increased claimant's scheduled permanent disability award for the right arm to 50 percent and claimant's unscheduled permanent disability award for the right shoulder to 22 percent. (Ex. 23). Prior to that order, there was no medical evidence predicting future flare-ups of claimant's right shoulder and arm condition.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions regarding the aggravation issue, with the following exception and supplementation.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1). To prove a compensable worsening of her unscheduled right shoulder condition, claimant must show that increased symptoms or a worsened underlying condition caused her to be less able to work, thus resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687, rev den 312 Or 150 (1991); Leroy Frank, 43 Van Natta 1950 (1991). To prove a compensable worsening of her scheduled right arm condition, claimant must show that increased symptoms or a worsened underlying condition caused her to sustain an increased loss of use or function of that body part. Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993); Dennis Hutchison, 46 Van Natta 539 (1992).

In addition, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3). Finally, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than a waxing and waning of symptoms contemplated by the last arrangement of compensation. ORS 656.273(8).

The Referee implicitly found that the last arrangement of compensation contemplated future waxing and waning of symptoms. We disagree. When there is medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, supra at 106 Or App 690. However, a history of past flare-ups alone is not sufficient. Id.

Here, claimant made an aggravation claim in March 1993. (Ex. 38-2). The last arrangement of compensation is a March 29, 1991 Opinion and Order, which increased the permanent disability awarded by the initial Determination Order to a total award of 50 percent scheduled permanent disability for claimant's right arm injury and 22 percent unscheduled permanent disability for her right shoulder injury. (Ex. 23). That order does not state that future waxing and waning of symptoms were contemplated.

Furthermore, even though claimant had a history of past flare-ups prior to that order, there was no medical evidence predicting future flare-ups of claimant's right shoulder and arm condition. Although Dr. Becker, claimant's former treating physician, predicted future flare-ups in a September 10, 1991 letter, that prediction was not in existence when the last arrangement of compensation was made in March 1991. Instead, the medical evidence in existence at the time of the last award of compensation

does not support a finding that the order "contemplated" future waxing and waning of the compensable conditions. See Debra K. Donovan, 45 Van Natta 1175, 1176-77 (1993); Linda J. Hughes-Smith, 45 Van Natta 827, 828 (1993).

Nevertheless, we agree with the Referee's determination that claimant did not establish a worsening of her compensable condition. Because of claimant's history of frequent flare-ups, the issue of whether claimant's compensable right shoulder and arm conditions have worsened presents a complex medical question. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). Dr. Cox, treating M.D., provides the only medical opinion regarding whether claimant's compensable condition has worsened.

Following her injury, Dr. Becker, M.D., treated claimant. However, when Dr. Becker relocated out of state, claimant began treating with his associate, Dr. Cox. Dr. Cox initially examined claimant on March 2, 1993. (Ex. 38-2). At that time, he opined that claimant's condition had worsened and requested that the claim be reopened for physical therapy. Id. In his September 1993 examinations of claimant, Dr. Cox expressed concern regarding the amount of pain behavior claimant displayed. (Exs. 39-1, 39-2).

In an October 4, 1993 telephone conversation summary with the insurer's attorney, Dr. Cox again noted that claimant presented with considerable pain behavior. (Ex. 40-1). He also noted that claimant sustained no pathological worsening of her compensable condition. He stated that claimant had remained medically stationary throughout the time he had been treating her and needed only palliative care at the time of her alleged worsening in March 1993. Id. He also stated that, "[a]ssuming that [claimant] experienced a symptomatic worsening in March 1993, this worsening only presented a 'waxing and waning' of symptoms that one would anticipate given the extent of [claimant's] injury and the prior award of permanent disability for the accepted condition." Id.

On January 12, 1994, Dr. Cox was deposed. (Ex. 41). Dr. Cox explained that his initial March 1993 opinion that claimant's condition had worsened and was not medically stationary was made after a brief review of claimant's prior records and that he had since reviewed her records in more depth. (Ex. 41-12, 41-19-20). He did not retract his October 1993 opinion that claimant remained medically stationary throughout the time he treated her. In addition, although he opined that claimant had acute right biceps tendonitis, which he classified as a "new process," he also stated that the biceps tendonitis was "possibly" new and that claimant had no new pathology and no pathological worsening. (Ex. 41-17, -18, -21, -22). He opined that claimant had experienced a flare-up of her myofascial pain condition requiring palliative treatment, which was no more than what one would expect with that condition. (Ex. 41-22, -23, -24, -32). He also explained that his opinion regarding flare-ups was based on the diagnosis rather than any previous impairment rating. (Ex. 41-31).

Dr. Cox's opinions as to whether claimant's condition worsened vary considerably. However, we find that, read as a whole, his opinions do not establish that claimant's compensable condition worsened. In October 1993, Dr. Cox recanted his initial opinion that claimant's condition had worsened. (Ex. 40). Furthermore, at his deposition, he did not retract his earlier opinion that claimant remained medically stationary, which suppports a conclusion that claimant's condition had not worsened. In addition, Dr. Cox earlier stated that he was concerned about claimant's pain behavior; however, at his deposition, he did not appear to question the validity of claimant's pain complaints, although he acknowledged that they were subjective. On the other hand, even relying on claimant's pain complaints, Dr. Cox only concluded that claimant had sustained a flare-up, not a worsening of her condition.

In conclusion, Dr. Cox's opinions as a whole do not support a finding that claimant's condition worsened, either pathologically or symptomatically. Therefore, on this record, we agree with the Referee that claimant did not establish that her compensable condition worsened. Accordingly, claimant has not established a compensable aggravation.

ORDER

The Referee's order dated February 28, 1994 is affirmed.

In the Matter of the Compensation of
BRENT D. CHRISTENSEN, Claimant
WCB Case No. 93-03436
ORDER ON REVIEW (REMANDING)
Rasmussen & Henry, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Spangler's order that dismissed his request for hearing because claimant failed to appear at hearing. On review, the issue is the propriety of the dismissal. We remand.

FINDINGS OF FACT

On March 23, 1993, the Board received claimant's hearing request contesting the insurer's March 19, 1993 denial of his claim. Following several reschedulings, a hearing was eventually set for June 16, 1994.

Claimant, who was then unrepresented, failed to appear at the hearing. Thereafter, the Referee granted the insurer's motion to dismiss on the grounds of abandonment under OAR 438-06-071(2).

On June 16, 1994, the Referee issued an order dismissing claimant's hearing request based on his failure to appear at the hearing. On June 24, 1994, the Board received claimant's June 22, 1994 letter appealing the Referee's order. The return address on the envelope in which claimant's letter was contained carried an Oregon State Correctional Institution address. Contending that he was "detained and unable to attend the hearing," claimant sought the Board's "cooperation concerning this matter."

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. Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992); Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989). In Luthy, we treated a "post-hearing" request to reschedule a hearing as a motion for postponement.

Here, in response to the Referee's June 16, 1994 dismissal order, claimant has submitted a letter expressing dissatisfaction with the decision. Specifically, claimant asserts that he was "detained and unable to attend" the scheduled hearing.

Considering these circumstances, we interpret claimant's letter as a motion for postponement of the scheduled hearing. 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; Harold Harris, supra; Ray Eaglin, supra.

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 or a finding on whether postponement is warranted. Rather, as we have explained in similar rulings, we take this action because we consider the Referee to be 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. Olga G. Semeniuk, supra; Harold Harris, supra; Ray Eaglin, supra.

Accordingly, the Referee's order dated June 16, 1994 is vacated. This matter is remanded to Referee Spangler 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.

In the Matter of the Compensation of
KERRI A. HOUGHTON, Claimant
WCB Case No. 94-01016
CORRECTED ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Spangler's order which affirmed an Order on Reconsideration awarding 7 percent (22.4 degrees) unscheduled permanent disability for a neck condition. On review, the issue is extent of unscheduled permanent disability.

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

The January 13, 1994 Order on Reconsideration affirmed the SAIF Corporation's August 23, 1993 Notice of Closure, which awarded 7 percent unscheduled permanent disability for claimant's May 1992 neck injury claim. Claimant's previous November 1989 low back injury claim was closed by a July 1992 Notice of Closure, which awarded 18 percent unscheduled permanent disability.

At hearing, and on review, the parties dispute the applicability of OAR 436-35-007(3)(b). The Referee found that the rule was not limited to the same body part. Accordingly, because claimant had been previously compensated for her social-vocational factors, the Referee concluded that claimant was not entitled to be doubly compensated for those factors and, therefore, claimant was not entitled to an award of additional unscheduled permanent disability.

ORS 656.214(5) provides that unscheduled permanent disability due to a compensable injury shall be determined by comparing the worker before such injury and without such disability. If a worker suffers from disability due to preexisting injuries and has received unscheduled permanent disability for such disability, the prior disability award is considered in arriving at the appropriate permanent disability for the current injury. Philip A. Sterle, Jr., 46 Van Natta 506 (1994); Mary A. Vogelaar, 42 Van Natta 2846 (1990). This principle applies whether a series of accidents involves injury to the same or different unscheduled parts of the body. Mary A. Vogelaar, supra. OAR 436-35-007(3)(b) further provides:

> "(b) A worker is not entitled to be doubly compensated for a permanent loss of earning capacity in an unscheduled body part which would have resulted from the current injury but which had already been produced by an earlier injury and had been compensated by a prior award. Only that portion of such lost earning capacity which was not present prior to the current injury shall be awarded. The following factors shall be considered when determining the extent of current disability award:
>
> "(A) The worker's total loss of earning capacity for the current disability under the standards;
>
> "(B) The conditions or findings of impairment from prior awards which were still present just prior to the current claim;
>
> "(C) The worker's social-vocational factors which were still present just prior to the current claim; and
>
> "(D) The extent to which the current loss of earning capacity includes impairment and social-vocational factors which existed before the current injury."

We first determine the current extent of disability under the applicable standards. The parties have stipulated that claimant is entitled to an impairment value of 7 percent and that claimant's social-vocational factors equal 6 percent. Therefore, claimant's current unscheduled permanent disability is 13 percent.

We next compare this value with the prior award of unscheduled permanent disability to determine whether, and to what extent, the current disability figure includes unscheduled permanent disability present before the current injury. Only that portion of lost earning capacity which was not present prior to the current injury shall be awarded. This is not a mathematically precise process. Rather, we consider to what extent a prior loss of earning capacity resulted from the same permanent limitations and vocational factors as are relied upon in our subsequent evaluation of permanent disability. We will reduce the award by the amount that represents the previously compensated loss of earning capacity. Robert D. King, 45 Van Natta 1250 (1993); Mary A. Vogelaar, supra.

Prior to the 1989 low back injury, claimant worked as the catering supervisor and lead pantryperson. After her low back injury, claimant returned to the same job, but with restrictions on lifting no more than 20 pounds. As a result of her 1992 neck injury, claimant is restricted to light work with a 20 pound limit when lifting, carrying, reaching or pushing; she must also limit frequent neck movements. Claimant, however, returned to her same job. Thus, we find that the 1992 neck injury resulted in a similar loss of earning capacity as was considered in her award for the low back injury.

We take this into account in determining the extent to which the prior unscheduled permanent disability award for the back condition compensated claimant for the same permanent limitations and social-vocational factors as claimant's current permanent disability award for the neck condition. We conclude that 7 percent of the current award for the neck condition represents permanent disability that was not present prior to the 1992 neck injury. Therefore, claimant is entitled to an additional award of 7 percent unscheduled permanent disability due to her 1992 neck injury. Accordingly, we agree with the Referee's decision to affirm the Order on Reconsideration award.

ORDER

The Referee's order dated May 16, 1994 is affirmed.

December 8, 1994 Cite as 47 Van Natta 12 (1995)

In the Matter of the Compensation of
RICHARD R. BADE, Applicant
WCB Case No. CV-94007
CRIME VICTIM ORDER OF DISMISSAL (REMANDING)
Mary H. Williams, Assisant Attorney General

Applicant requested Board review of the Department of Justice's July 6, 1994 decision concerning his application for benefits under the Compensation Act for Victims of Crime. At hearing, applicant offered two written statements for admission into the record. Inasmuch as the documents were not considered by the Department in reaching its decision, the motion was denied. See ORS 147.155(5); OAR 438-82-040(3).

Claimant then moved to continue the hearing in order to produce one of the persons who had provided a statement and allow that person to testify. That motion was allowed. Subsequent correspondence informed the parties of the date of the continued hearing and requested submission of their respective positions regarding whether remand of the matter to the Department for its review of the documents was appropriate. In response, the Department agreed to review the statements and issue an order on reconsideration. (A copy of the Department's response is included with applicant's copy of this order and describes the method for applicant to submit his statements to the Department.)

In light of such circumstances, we interpret the Department's response as a withdrawal of its prior orders. Consequently, applicant's request for Board review is dismissed without prejudice. This matter is returned to the Department to proceed with its reconsideration. In the event that applicant is dissatisfied with the Department's new reconsideration order, he may request Board review of that decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNY L. ELWOOD, Claimant
WCB Case No. 94-00528
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Meyers, et al., Defense Attorneys

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

The self-insured employer requests review of Referee Galton's order that set aside its denial of claimant's synovial cyst claim. On review, the issue is compensability.

We adopt and affirm the Referee's order.

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

ORDER

The Referee's order dated April 12, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

Board Member Haynes dissenting.

I dissent. Claimant did not prove the compensability of his synovial cyst, and the Referee's order should be reversed.

Claimant has an accepted June 1992 low back injury and an accepted June 1993 low back injury. Claimant's synovial cyst was diagnosed in August 1993, after he experienced some radicular pain and paresthesia while participating in a work hardening program. Relying on the opinion of Dr. Schmidt, the treating doctor, the Referee found that claimant proved compensability. In particular, although characterizing Dr. Schmidt's opinion as "cautious medical testimony," the Referee found that it was expressed in terms of medical probability.

Dr. Schmidt's first reports indicated that a synovial cyst was unusual for a person of claimant's young age. (Exs. 29, 30). He found that, in view of the lack of symptoms before the June 1993 injury and "the tremendous amount of lifting" performed by claimant on his job, the most likely cause of the cyst was work. (Id.)

Dr. Schmidt then stated that, although his prior report had "proposed" that the cyst was related to work, such conditions were most frequently found in "degenerative lumbar spine conditions of the elderly." (Ex. 54). Dr. Schmidt added that "one can argue this either way." Dr. Schmidt also stated that a cyst "in such a young individual without reason to have degenerative spine disease, one could reasonably state that this is related to this repetitious rapid lifting that he did." (Id). Finally, Dr. Schmidt indicated that his lack of previous experience "with this type of cyst in a young individual [] tempers this opinion somewhat." (Id).

Claimant's family physician, Dr. Constien, agreed with Dr. Schmidt that "it is very difficult to attribute the synovial cyst to one particular area, but in the presence of repetitive activity and the onset of symptoms following this, it would seem reasonable to relate the cyst" to claimant's work activities. (Ex. 55). Dr. Constien found that he could not be more definitive because "there is a gray area here." (Id).

It is claimant's burden to prove a causal relationship between his synovial cyst and work activities to a medical probability rather than possibility. ORS 656.266; Gormley v. SAIF, 52 Or App 1055, 1060 (1981). Both Dr. Schmidt and Dr. Constien indicated such uncertainty regarding etiology of

the cyst that they proved only a possible causal relationship. Both physicians also provided no explanation how claimant's work (which he performed approximately fourteen months) could cause a synovial cyst. Nor did they explain why the cyst could not be degenerative; this is important is view of the agreement that such a condition is degenerative and the opinion of Dr. Rosenbaum, who conducted an IME, that, although unusual, synovial cysts occasionally do occur in young people. (Ex. 45-4). Thus, I also do not consider the opinions of Drs. Schmidt and Constien to be well-reasoned.

For both these reasons, I do not give any weight to Dr. Schmidt's and Dr. Constien's opinions. The majority apparently has affirmed the Referee for the same reason upon which the physicians based their opinions--an assumption that work activities must be the cause because claimant is a young person. Assumptions, however, simply are not sufficient; claimant must show a causal relationship by a preponderance of evidence to a medical probability with well-reasoned medical evidence. The medical evidence in this case simply does not rise to that level. Therefore, claimant did not prove his synovial cyst condition compensable.

In the Matter of the Compensation of
JAMES E. MILLER, Claimant
WCB Case No. 94-03742
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Bethlahmy's order that increased claimant's unscheduled permanent disability award for a cervical and dorsal condition from 22 percent (70.4 degrees), as awarded by an Order on Reconsideration, to 30 percent (96 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Dr. Chapman concurred with the report from Drs. Duff and Snodgrass. (Ex. 19). Dr. Chapman did not concur with the report from the occupational therapist, Katherine Thayer.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable cervicodorsal strain. In February 1993, Dr. Chapman, M.D., began treating claimant. On July 19, 1993, at the insurer's request, Drs. Duff and Snodgrass evaluated claimant. On July 20, 1993, also at the insurer's request, occupational therapist Katherine Thayer evaluated claimant to determine his physical capacities. An October 1993 Determination Order awarded claimant 20 percent unscheduled permanent disability.

Following claimant's request for reconsideration by the Department, claimant underwent a medical arbiter examination by Dr. Martens. Based on Dr. Martens' report, the Order on Reconsideration increased claimant's award to 22 percent.

Relying on Driver v. Rod & Reel Restaurant, 125 Or App 661 (1994), the Referee found that an occupational therapist qualified as a "physician" and that findings from such a person could be used to determine permanent disability. Based on Ms. Thayer's report, the Referee concluded that claimant was entitled to an adaptability factor of 4, resulting in an award of 30 percent unscheduled permanent disability.

On review, the insurer challenges the increased award, asserting that the Referee erred in relying on the report from the occupational therapist and not on findings from the panel of Drs. Duff and Snodgrass, Dr. Chapman and Dr. Martens. We agree.

In Driver v. Rod & Reel Restaurant, supra, the court held that the Board erred in concluding that a physical therapist did not satisfy the definition of "physician" in ORS 656.005(12) and remanded the

case to the Board. In a footnote, the court stated that it was not addressing whether ORS 656.245(3)(b)(B) applied to the dispute.

On remand, we first found that the physical therapist's impairment findings did not satisfy the standards and, therefore, provided no proof of disability. Sandie K. Driver, 46 Van Natta 769 (1994). We further noted that, with the exception of the medical arbiter, only the attending physician at the time of claim closure can make findings concerning a worker's impairment and that impairment findings from other physicians can be used only if ratified or adopted by the attending physician. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994); Donald R. Strom, 46 Van Natta 158 (1994). Thus, alternatively, we also found that the physical therapist's findings were not relevant because the Referee's order had found that another physician was the "attending physician" and the attending physician had neither ratified nor adopted the physical therapist's report. 46 Van Natta at 770.

"Attending physician" is a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b). Here, the record shows that Ms. Thayer saw claimant once in order to determine his physical capacities. (Ex. 17-1). We find no evidence that she was "primarily responsible for the treatment" of claimant's compensable injury. Therefore, even assuming that an occupational therapist is a "physician", inasmuch as Ms. Thayer was not the attending physician and no other physician ratified or adopted her report, we conclude that her findings are not relevant. See Sandie K. Driver, supra.

The parties dispute only the factor for adaptability. Specifically, because the parties agree that claimant's prior strength is medium, the issue is the appropriate category for claimant's residual functional capacity (RFC). According to Dr. Martens, the medical arbiter, claimant could not work above the waist level, work inside tanks, lift more than 35 pounds, or excessively stoop or bend. (Ex. 24-4). Dr. Chapman, claimant's treating physician, similarly indicated that claimant should avoid climbing in and out of tanks, lifting over 35 pounds, and perform no work at or above shoulder level. (Ex. 18).

We find these reports are entitled to more weight than that of Drs. Duff and Snodgrass, which found that claimant could perform all regular work activities other than climbing in and out of tanks. (Ex. 16-6). As the treating physician, Dr. Chapman's opinion is entitled to deference. Weiland v. SAIF, 64 Or App 810 (1983). Dr. Martens performed his examination during Director review and, therefore, his opinion is based on the most current information regarding claimant's condition.

Medium work consists of lifting a maximum of 50 pounds and frequently lifting 25 pounds. Former OAR 436-35-270(3)(g)(C) (WCD Admin. Order 6-1992). Light work is lifting a maximum of 20 pounds with frequent lifting of 10 pounds. Former OAR 436-35-270(3)(g)(B). Since claimant's restriction of lifting no more than 35 pounds is more than the requirement for light work but does not meet the full range for medium work, we find that claimant's initial RFC classification is M/L. See former OAR 436-35-310(3). Moreover, because claimant also is at least restricted from climbing in and out of tanks and working above waist level, we agree with claimant that his RFC classification properly is light. See former OAR 436-35-310(4); former OAR 436-35-270(3)(e). Therefore, claimant's adaptability is 3. See former OAR 436-35-270(3).

The parties agree that claimant's impairment is 14 percent and age and education values together are 4. Multiplying the value of 4 with the adaptability factor of 3 results in 12. Adding the value of 14 percent results in 26 percent unscheduled permanent disability. See former OAR 436-35-280.

ORDER

The Referee's order dated July 14, 1994 is modified. In lieu of the Referee's increased unscheduled permanent disability award and in addition to the Order on Reconsideration's award of 22 percent (70.4 degrees), claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability, giving him a total award to date of 26 percent (83.2 degrees) unscheduled permanent disability for his cervicodorsal condition. The Referee's attorney fee award payable for increased permanent disability from the Order on Reconsideration award is modified accordingly.

In the Matter of the Compensation of
ESTHER M. ANDERSON, Claimant
Own Motion No. 93-0245M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's September 16, 1994 Notice of Closure which closed her claim with an award of temporary disability compensation from March 2, 1993 through August 23, 1993. The insurer declared claimant medically stationary as of August 24, 1993. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the September 16, 1994 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.

By Second Own Motion Order on Reconsideration dated September 23, 1993, we reopened claimant's 1977 injury claim for the payment of temporary disability benefits beginning March 2, 1993, the day she was hospitalized for right ankle surgery. Meanwhile, on August 24, 1993, Dr. Boyd, claimant's treating orthopedic surgeon, declared the ankle condition medically stationary. Due to oversight, however, SAIF did not issue a notice of closure, and the claim remained open.

By letter dated August 19, 1994, Dr. Boyd reported that claimant is "unacceptably uncomfortable" due to a rotational deformity. He recommended a surgical re-orientation of the right ankle to correct the deformity. Thereafter, SAIF issued a Notice of Closure dated September 16, 1994, declaring claimant medically stationary as of August 24, 1993.

Dr. Boyd's August 19, 1994 report indicates that there is a reasonable expectation of further material improvement in claimant's condition. His report is unrebutted and, therefore, persuasive. Therefore, we do not find that claimant's compensable ankle condition was medically stationary on September 16, 1994, the date of claim closure. Accordingly, we set aside the Notice of Closure as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

We note that SAIF treated Dr. Boyd's August 19, 1994 report as a new request for own motion reopening of the claim. SAIF recommended that the Board deny authorization of temporary disability compensation on the ground that claimant was not in the work force at the "time of request for reopening dated August 19, 1994." However, inasmuch as claimant's claim had not been closed at the time of that report, claimant's claim was already open. Accordingly, claimant was not bound by the statutory requirements for claim reopening.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation created by 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
SUZANNE D. CRAYTOR, Claimant
WCB Case Nos. 93-12710 & 93-12957
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

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

The SAIF Corporation requests review of Referee Livesley's order which: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) assessed a penalty under ORS 656.262(10) for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm the Referee's order.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,100, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved. Finally, claimant is not entitled to an attorney fee for defending against the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated March 25, 1994 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,100, payable by the SAIF Corporation.

Board Member Haynes dissenting.

It is claimant's burden to prove that her work activities were the major contributing cause of her occupational disease. I am not persuaded that claimant has met her burden.

On August 22, 1993, claimant sustained an injury to her right shoulder while riding in a car. Claimant contends that her shoulder condition was caused in major part by her repetitive work activities, although the onset of symptoms occurred off work.

In order to establish compensability of an occupational disease claim, claimant must prove, by a preponderance of the evidence, that work activities were the major contributing cause of the disease or its worsening. ORS 656.802(2). Furthermore, because the onset of claimant's shoulder pain occurred while claimant was not in the course of her employment, the question of causation is medically complex. Therefore, expert medical evidence is required to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

On October 19, 1994, claimant was examined by Dr. Panum. Dr. Panum was more familiar with claimant's work activities than any doctor claimant had seen because he had visited claimant's work site several times in the capacity of ergonomic consultant. (Tr. 41). Dr. Panum stated that he was unable to definitely say whether claimant's right shoulder injury was a work injury. (Ex. 17).

On December 20, 1993, claimant saw Dr. Jensen, neurologist. (Ex 20). EMG testing of the muscles in the cervical region and right shoulder and arm revealed no abnormalities. Dr. Jensen was unable to provide an etiology of claimant's right shoulder pain. (Ex. 20-3).

The majority relies on the opinions of Dr. Lees and Dr. Jones. Claimant saw Dr. Lees one time on September 1, 1993. On December 9, 1993, Dr. Lees stated that claimant's condition:

> "is likely due to her extremely heavy repetitive work activities. That is, it is most probable that this condition was brought on from her responsibilities in the role of a "production worker" (as she reported to me) in her employment." (Ex. 18).

Significantly, on February 7, 1994, Dr. Lees changed his opinion, stating:

> "I feel that the trauma that [claimant] incurred in her boyfriend's car while turning her head could have hyperextended her abducted arm and caused an exacerbation of her underlying shoulder pathology. * * * It is certainly possible that the repetitive work activities involving her right upper extremity may have significantly contributed to an underlying right shoulder pathology." (Ex. 22). (Emphasis added).

Opinions couched in terms of possibilities and speculation are not persuasive. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981). Inasmuch as Dr. Lees first states that claimant's work is the likely cause of her shoulder condition, then changes his opinion to state a mere possibility, I do not find his opinion sufficient to prove compensability to a reasonable medical probability.

I also do not find Dr. Jones' opinion sufficient to sustain claimant's burden of proving that her work activities are the major contributing cause of her right shoulder condition. Dr. Jones, who apparently also saw claimant only one time, stated that he had never seen "someone" develop persistent subacromial bursitis as a result of raising the arm and placing it on a chair or car seat, but that it is not infrequent for individuals to sustain subacromial bursitis as a result of repetitive use of their upper extremity. (Ex. 23). Dr. Jones opinion is stated in general terms; he did not relate claimant's injury specifically to her work activities.

Claimant testified that, although she had sore shoulders from time to time due to different jobs at work, those problems always went away. (Tr. 6). Claimant further stated that the pain she had experienced in August 1993 after turning her head in the car was very different than any shoulder pain she felt at work. (Tr. 27).

For the abovestated reasons, I am not persuaded that claimant has met her burden of proving that her work activities are the major contributing cause of her right shoulder condition. Accordingly, I dissent.

In the Matter of the Compensation of
BONNIE J. JOHNSON-JACOBSON, Claimant
WCB Case No. 93-15359
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee Thye's order that found that claimant's back and shoulder injury claim was prematurely closed. On review, the issue is premature closure.

We adopt and affirm the Referee's order.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the premature closure issue is $250, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.[1]

ORDER

The Referee's order dated April 22, 1994 is affirmed. For services on review, claimant is awarded a $250 attorney fee, payable by the insurer.

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[1] Claimant submitted a one-page letter requesting that we affirm the Referee's order. Although claimant did not characterize her letter as a respondent's brief, it fits such a description because it supports the findings and conclusions reversed by the Referee and advocates our affirmance of that decision.

In the Matter of the Compensation of
DAVID A. MACY, Claimant
WCB Case No. 93-09397
ORDER OF DISMISSAL
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation has moved the Board for an order dismissing claimant's request for review of the Referee's October 13, 1994 order on the grounds that the other parties did not timely receive notice of the request. The motion is granted.

FINDINGS OF FACT

On October 13, 1994, the Referee issued an Opinion and Order. Parties to that order were claimant, SAIF, and its insured.

On November 14, 1994, (a Monday) the Board received claimant's request for Board review of the Referee's order. The request, which was dated October 29, 1994, was mailed by certified mail to the Board on November 12, 1994. The request did not indicate that copies of the request had been provided to the other parties.

On November 16, 1994, the Board mailed its computer-generated letter to all parties acknowledging claimant's request for review.

CONCLUSIONS OF LAW AND OPINION

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

Here, the 30th day after the Referee's October 13, 1994 order was November 12, 1994, a Saturday. Consequently, the final day to perfect an appeal from the Referee's order was Monday, November 14, 1994. Anita L. Clifton, 43 Van Natta 1921 (1991). Since claimant's request for Board review was mailed by certified mail to the Board on November 12, 1994, the request was timely filed. See OAR 438-05-046(1)(b).

Nevertheless, claimant must also establish that notice of his request for Board review was timely provided to the other parties. A review of this record does not support such a finding.

Claimant's request for review does not indicate that all parties to the proceeding before the Referee were provided with either a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. ORS 656.289(3); 656.295(2). Rather, the record suggests that SAIF's first notice of claimant's appeal occurred when it received the Board's November 16, 1994 acknowledgment letter. This inference is further confirmed by SAIF's unrebutted motion which states that its first notice of claimant's request for review occurred on November 17, 1994 when it received the Board's November 16, 1994 letter.

Inasmuch as November 16, 1994 is more than 30 days from the date of the Referee's October 13, 1994 order, we are persuaded that the other parties to this proceeding did not receive timely notice of claimant's request for Board review. Because the request is untimely, we lack authority to review the Referee's order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

Accordingly, the request for Board review is dismissed.[1]

IT IS SO ORDERED.

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[1] In the event that claimant can establish that he provided notice of his request for Board review to the other parties within 30 days of the Referee's October 12, 1994 order, he may submit such written information for our review. However, to be considered, such written information must be received 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 his written submission as soon as possible.

In the Matter of the Compensation of
SUSAN A. MICHL, Claimant
WCB Case No. 93-04959
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of that portion of Referee Davis' order which upheld the self-insured employer's denial of her left knee injury claim. The employer moves to strike claimant's reply brief on the grounds that it raises issues outside the scope of its respondent's brief. On review, the issues are motion to strike and compensability. We deny the motion to strike and reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

We first address the employer's motion to strike. Claimant did not file an appellant's brief, but instead filed a reply brief in response to the employer's respondent's brief. The employer contends that the reply brief should be stricken because it raises arguments that fall outside the scope of the respondent's brief.

In its respondent's brief, the employer discusses claimant's burden of proof and argues that the Referee correctly found that claimant had failed to satisfy it. In her reply brief, claimant's primary argument is that the Referee improperly expanded the scope of the employer's denial. Alternatively, claimant contends that, even assuming the Referee acted properly, claimant sustained her burden of proof.

It is within the Board's discretion to strike a party's brief. See Scott Petty, 46 Van Natta 1050 (1994). If a reply brief raises issues not raised before that time, those issues are not considered. Charles L. Pratt, 42 Van Natta 2029 (1990). However, we do not strike claimant's reply brief in this instance because claimant's "scope of denial" argument is directly related to the employer's discussion of the requisite burden of proof. Thus, claimant's contentions on that issue have been considered.

Compensability

On March 8, 1993, claimant, a certified nursing assistant, slipped and twisted her left knee at work. Claimant sought treatment that day at an emergency room and was diagnosed with a probable subluxation of the patella with reduction. (Ex. 2). The emergency room physician prescribed a brace and medication. Claimant subsequently sought treatment from Dr. Anderson, who diagnosed a work-related, recurrent patellar subluxation. (Ex. 5). Dr. Anderson noted that claimant had a prior history of patella subluxation and patellar tracking problems.

Claimant was later referred to an orthopedic surgeon, Dr. Nagel, who requested approval for surgery to prevent further dislocations of the patella. (Ex. 11). On April 15, 1993, Dr. Nagel opined that the March 8, 1993 accident was the "sole cause" of claimant's current injury. (Ex. 13). The employer, however, denied the claim. The only reason cited in the denial was that claimant's injury was not related to her work activities. (Ex. 14).

At hearing, claimant sought reversal of the denial, as well as a penalty for unreasonable denial. (Tr. 4). The employer's counsel did not object to the issues claimant raised and did not amend the denial. (Tr. 4, 5).

The Referee reasoned that a work incident on March 8, 1993 combined with a preexisting left knee condition to cause disability and a need for medical treatment. Applying the major causation

standard of ORS 656.005(7)(a)(B), the Referee found that the medical opinion of the only physician to address the causation issue, Dr. Nagel, was insufficient to satisfy claimant's burden of proof. Thus, the Referee upheld the employer's denial on the grounds that claimant's medical services were not caused in major part by the March 8, 1993 incident.

On review, claimant contends that the Referee erroneously addressed a "resultant condition" issue under ORS 656.005(7)(a)(B) which had not been raised either in the denial or at the hearing. We need not resolve this procedural argument because, even assuming that the Referee's application of ORS 656.005(7)(a)(B) constitutes a "new issue," and even if that "new issue" was properly raised, we find the claim compensable. We base this conclusion on the following reasoning.

While the medical record is clear that claimant experienced prior left knee problems, specifically patellar tracking difficulties, there is no medical evidence from either Dr. Nagel or Dr. Anderson that claimant's preexisting left knee condition and March 8, 1994 injury "combined" to cause disability or a need for medical treatment. In fact, Dr. Nagel opined that the March 8, 1993 incident is the "sole cause" of claimant's current left knee condition. (Ex. 13). Without medical evidence establishing a "combination" of the preexisting condition and the March 8, 1994 incident, we find that ORS 656.005(7)(a)(B) is not applicable to this claim. See Charles E. Crawford, 45 Van Natta 1007 (1993); Gary Stevens, 44 Van Natta 1179 (1992).

Given the above conclusion, there is no issue regarding whether the March 8, 1994 incident is the major contributing cause of claimant's disability or need for treatment under ORS 656.005(7)(a)(B). The issue instead is whether claimant proved the existence of an injury by medical evidence supported by objective findings, and, further, whether the industrial accident was a material contributing cause of claimant's disability and need for medical treatment. ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991).

The Referee found that claimant had proved the existence of the injury by medical evidence supported by objective findings. The Referee also concluded that claimant proved that a work incident occurred on March 8, 1993 in which she twisted her knee. The employer does not dispute these findings. Under these circumstances, we find Dr. Nagel's opinion sufficient to satisfy claimant's burden of proving material causation. We also note Dr. Anderson's opinion that claimant's subluxated left patella was work related. (Ex. 5). This provides an additional basis for our determination that claimant has proved material causation.

Thus, we conclude that claimant sustained a compensable injury on March 8, 1993 for which the employer is responsible. We, accordingly, set aside the employer's denial and remand the claim for processing.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's reply 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 April 13, 1994 is reversed. The employer's denial of claimant's March 8, 1993 injury claim is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded a reasonable assessed attorney fee of $3,000, to be paid by employer.

In the Matter of the Compensation of
JUDITH K. NIX, Claimant
WCB Case No. 93-02704
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

The self-insured employer requests reconsideration of that portion of our October 31, 1994 order that awarded claimant's attorney a fee equal to 25 percent of the increased compensation created by the order, not to exceed $3,800. The employer argues that our order creates an unauthorized overpayment. On November 23, 1994, we abated our order to further consider the employer's request. Having received the parties' respective positions, we proceed with our reconsideration.

We briefly review the procedural history. Claimant compensably injured her left shoulder in March 1990. A June 5, 1991 Determination Order awarded claimant 11 percent (35.20 degrees) unscheduled permanent disability. (Ex. 25). The self-insured employer requested reconsideration.[1] The August 2, 1991 Order on Reconsideration reduced claimant's award to 1 percent (3.20 degrees) unscheduled permanent disability. (Ex. 28). The employer paid the 1 percent award on August 22, 1991.

An earlier referee's order directed the employer to pay claimant the additional 10 percent unscheduled permanent disability that the employer had neglected to pay pending Department reconsideration of the 11 percent Determination Order award. The Referee further held that the employer was entitled to a $3,200 credit for this overpayment to be offset against any future award of permanent disability. On November 29, 1993, we affirmed the earlier referee's order. Judith K. Nix, 45 Van Natta 2242 (1993).

The present case arises from a January 1992 aggravation claim. Following closure of that reopened claim, an August 13, 1992 Determination Order awarded no additional permanent disability. A January 22, 1993 Order on Reconsideration affirmed the Determination Order. Referee Crumme affirmed the Order on Reconsideration.

On Board review, claimant argued that she was entitled to an additional award of unscheduled permanent disability on the basis that the shoulder surgery changed her condition. In our October 31, 1994 order, we concluded that claimant was entitled to an additional 12 percent (38.40 degrees) unscheduled permanent disability award. We awarded claimant's attorney a fee of 25 percent of the increased compensation created by our order, not to exceed $3,800. In addition, we adopted and affirmed that portion of Referee Crumme's order that held that the employer was authorized to offset its overpayment of $3,200 against future permanent disability compensation that may be awarded.

On reconsideration, the employer requests that our attorney fee award be clarified or modified. Relying on Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), the employer argues that claimant is responsible for paying a portion of the fee out of her previously overpaid permanent disability benefits.

Claimant contends that the employer's argument ignores OAR 438-15-085(2) and she asserts that Jane A. Volk, supra, does not apply to this dispute. We disagree with claimant's contention.

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.

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[1] We note that the Referee Crumme found that claimant requested reconsideration of the June 1991 Determination Order. (O & O p. 2). In our October 31, 1994 Order on Review, we adopted the Referee's findings of fact. On reconsideration, we correct the Referee's finding to say that the employer requested reconsideration of the June 1991 Determination Order.

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, we concluded that an order by the Board to the employer to pay the fee would create an improper overpayment. Therefore, we delineated an alternative method for recovery by the claimant's counsel of the attorney fee.

Furthermore, we rejected the claimant's assertion in Volk that our decision violated OAR 438-15-085(2), which prohibits the application of an offset for prior overpayments of compensation before allowance of an "out-of-compensation" attorney fee award. We reasoned that if we had determined that the claimant's counsel was not entitled to an attorney fee, that decision would have violated the rule. Instead, we concluded that the claimant's counsel was entitled to an out-of-compensation attorney fee. Nevertheless, we held that since the compensation was already in the claimant's possession, counsel must seek payment directly or indirectly from the claimant.

Here, a June 5, 1991 Determination Order awarded claimant 11 percent unscheduled permanent disability. On reconsideration, claimant's award was reduced to 1 percent. Following closure of claimant's aggravation claim, the August 13, 1992 Determination Order did not award any additional unscheduled permanent disability. That Determination Order was affirmed by the January 22, 1993 Order on Reconsideration, as well as by Referee Crumme's order. On review, through claimant's attorney's efforts, we increased claimant's award by 12 percent (38.40 degrees), for a total award of unscheduled permanent disability to date of 13 percent (41.60 degrees). Claimant's increased 12 percent award (38.40 degrees) is valued at $3,840. In our October 31, 1994 order, we awarded claimant's attorney 25 percent of this 12 percent increased compensation, not to exceed $3,800. Thus, claimant's attorney is entitled to 25 percent of $3,840, a total of $960.

As previously described, pursuant to the prior litigation, the employer previously paid claimant's award of 11 percent (35.20 degrees), a total of $3,520. Since claimant was only entitled to a 1 percent award pursuant to the August 2, 1991 Order on Reconsideration ($320), the employer had a credit of $3,200 that represented a prior overpayment of compensation to claimant.

Unlike in Jane A. Volk, supra, claimant in this case has not already received the full amount of the compensation award. As a result of our October 31, 1994 order, claimant is entitled to an additional 12 percent unscheduled permanent disability, valued at $3,840. A portion of claimant's increased 12 percent award, the $3,200 overpayment that she has already received (i.e., the previously overpaid 10 percent unscheduled permanent disability), represents a "substantive increase" in her compensation award. In contrast, the remainder of $640 (i.e., the additional 2 percent unscheduled permanent disability - the difference between the 13 percent total awarded to date and the 11 percent previously paid) represents an actual increase in her award.

Under these circumstances, we conclude that claimant's attorney fee award should be divided into two parts. One portion of the attorney fee is based on the "substantive increase," and one portion of the fee is based on the actual increase. The employer shall pay claimant's attorney 25 percent of the actual increase of $640, equal to $160, directly to claimant's attorney.[2]

Claimant's attorney is also entitled to 25 percent of the "substantive increase" of $3,200. Since the "substantive increase" of $3,200 has already been paid to claimant, her 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.

In conclusion, as supplemented herein, we adhere to and republish our October 31, 1994 Order on Review. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[2] We note that claimant's attorney may be able to recover the entire $640 from the employer if claimant agrees with such a distribution or claimant's attorney is able to comply with the procedural requirements discussed in Jane A. Volk, supra, before the employer has paid the permanent disability award to claimant.

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

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Referee Davis' order which: (1) partially affirmed a Director's order under ORS 656.327(2) finding certain chiropractic treatments not appropriate; (2) declined to consider evidence offered at the hearing; and (3) declined to award an attorney fee under ORS 656.386(1) for her counsel's efforts regarding the Director's order. On review, the issues are medical services, evidence and attorney fees. We affirm in part and reverse in part.

Preliminary Matter

The Referee confined his review to the record developed before the Director. The Referee took this action in reliance on the Board's decision in Iola W. Payne-Carr, 45 Van Natta 335 (1993), aff'd mem Payne-Carr v. Oregon Portland Cement Company, 126 Or App 314 (1994). However, the Referee received evidence offered by both parties, as well as claimant's testimony, under an offer of proof.

Subsequent to the hearing in this case, we issued our decision in Julie Sturtevant, 45 Van Natta 2344 (1993), in which we disavowed our holding in Payne-Carr and concluded that, on the basis of the text and context of ORS 656.327(2), the legislature intended referees to find facts independently based on an evidentiary record developed at hearing. Id. at 2347.

We adhered to our rationale in Sturtevant in our recent decision in Ruby L. Goodman, 46 Van Natta 810, 812 n.3 (1994). In Goodman, we acknowledged that the Court of Appeals affirmed Payne-Carr without opinion on February 19, 1994. Payne-Carr v. Oregon Portland Cement Company, supra. Nevertheless, we noted that the Board had found alternatively in Payne-Carr that the result would have been the same if the Board considered the additional evidence offered by the claimant. Iola Payne-Carr, supra, 45 Van Natta at 337. We reasoned that the court's affirmance could have been based on either this alternative finding, or the Board's conclusion that referee review of a Director's order under ORS 656.327(2) is limited to the record developed before the Director.

Accordingly, because we do not interpret the court's affirmance of Payne-Carr as necessarily inconsistent with Sturtevant, we continue to follow Sturtevant. See Willie A. Sowers, 46 Van Natta 1054 (1994). Therefore, we conclude that the Referee's review in the present case was improperly limited to the record developed before the Director. Instead, the parties were entitled to a hearing before the Referee, during which they could present evidence regarding the appropriateness of claimant's chiropractic treatments.

Here, although the Referee did not consider the evidence offered at hearing, he did receive it under an offer of proof. Neither party contends that remand to the Referee is necessary. Therefore, on review, we consider the evidence submitted by the parties at hearing (Exs. 30A, 33), as well as claimant's testimony. The additional findings of fact are made accordingly.

FINDINGS OF FACT

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

In September 1992, claimant's current attending physician, Dr. Puziss, reported that claimant's pain was decreased with twice weekly manipulative and other treatments by Dr. Day, chiropractor, as prescribed by Dr. Puziss in August 1992. Dr. Puziss found claimant's chronic lumbosacral facet syndrome somewhat improved, but with persistent lumbosacral facet irritation. He recommended reducing chiropractic treatments to once per week. (Ex. 30A).

On December 7, 1992, the employer closed the claim by a Notice of Closure, awarding 5 percent (16 degrees) unscheduled permanent disability for claimant's low back condition. (Ex. 33).

Claimant's back pain gradually improved while she was undergoing chiropractic treatment, reaching the point of greatest improvement when the treatments ended. (Tr. 7, 11). Claimant required more frequent chiropractic treatments when she was involved with school activities, such as sitting for long periods or carrying a backpack. (Tr. 9). At the time of the hearing, she was no longer receiving chiropractic treatment. (Tr. 7).

We modify the Referee's finding of ultimate fact as follows. The record, as developed before the Director and the Referee, contains substantial evidence in support of the Director's decision as to treatment between January 16, 1992 through the date of the Director's order.

CONCLUSIONS OF LAW AND OPINION

Director's order

Pursuant to ORS 656.327(2), the Director's order may be modified only if it is not supported by substantial evidence in the record. Substantial evidence exists to support a finding when the record, reviewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990); Queener v. United Employers Insurance, 113 Or App 364 (1992).

Claimant compensably injured her low back in August 1991. She began chiropractic treatment with Dr. Day for an acute lumbar strain. In September 1991, Dr. Saks assumed claimant's medical care, continuing to prescribe chiropractic treatment, including manipulation, electrical stimulation, and intersegmental traction with heat or ice, until March 15, 1992. (Exs. 5-2, 7, 11, 14, 18, 24).

In May 1992, the employer requested Director review of claimant's chiropractic treatment under ORS 656.327, as provided by Dr. Day beginning January 16, 1992. (Ex. 23).

On August 19, 1992, the Director issued an order finding that the employer was not required to reimburse for the chiropractic treatments rendered on November 7, 1991 and after December 5, 1991. The Referee concluded that, regarding treatment on and after January 16, 1992, the period for which the employer requested review, substantial evidence supported the Director's order. The Referee affirmed that portion of the Director's order pertaining to treatment on and after January 16, 1992 through August 19, 1992, the date of the Director's order, but set aside that portion of the Director's order pertaining to chiropractic treatment prior to January 16, 1992.

After our review of the record, including the evidence submitted at hearing, we agree with the Referee that substantial evidence supports the Director's order.

During the period in question, Drs. Day, Saks and Puziss all opined that claimant's back condition was gradually improving, and they recommended continued chiropractic therapy. At one point, in January 1992, Dr. Saks noted that claimant's improvement had not been adequate during the previous two months, and he recommended physical therapy in addition to chiropractic treatment. (Ex. 11). However, none of the doctors elaborated on his reasons for recommending continued chiropractic therapy. (See Exs. 27, 18, 29, 30A).

On the other hand, Dr. Case, orthopedist, who examined claimant at the employer's request on April 17, 1992, did not believe that continued chiropractic treatment was reasonable or necessary for treating claimant's condition. (Ex. 22-4). Instead, he believed that it was "highly likely" that the extensive chiropractic treatment claimant had received was perpetuating her symptoms. (Ex. 22-5). He recommended that claimant cease all chiropractic and physical therapy, and pursue a more vigorous active exercise program instead. (Id).

In view of this evidence, we find that a reasonable person could conclude that chiropractic treatment during the period in question was not appropriate. Therefore, we conclude that substantial evidence supports the Director's order with respect to whether chiropractic therapy from January 16, 1992 to and including August 19, 1992, was appropriate. Accordingly, we affirm that portion of the Referee's order. See ORS 656.327(2).

Attorney Fees

The Referee declined to award claimant an assessed attorney fee under ORS 656.386(1), reasoning that, although his order setting aside part of the Director's order benefitted claimant, there was no "denied claim" within the meaning of ORS 656.386(1).[1] In so holding, the Referee relied on the Court of Appeals decision in SAIF v. Allen, 124 Or App 183 (1993). We reverse.

There are three prerequisites for an attorney fee award under ORS 656.386(1). One, the claimant must initiate an appeal. Two, the appeal must be from an order or decision denying the claim for compensation. Three, the claimant must finally prevail on the issue of compensation. Shoulders v. SAIF, 300 Or 606, 611 (1986).

Here, claimant appealed from a Director's order in a medical services dispute holding that the employer was not required to reimburse claimant for certain chiropractic services. Thus, the first criterion for an attorney fee under ORS 656.386(1) is satisfied.

Next, we consider whether claimant appealed from an "order or decision denying the claim for compensation."

Subsequent to the Referee's order in this case, the Supreme Court reversed the Court of Appeals decision in SAIF v. Allen, 124 Or App 183 (1993) interpreting that phrase. Allen v. SAIF, 320 Or 192 (1994). The Supreme Court held that an attorney fee is available under ORS 656.386(1) when an employer or insurer denies a claim for medical services, but does not deny compensability of nor responsibility for claimant's injury or condition, and claimant's attorney is instrumental in obtaining compensation without a hearing. 320 Or at 195, 197. In reaching its conclusion, the Supreme Court held that a claim for medical services constitutes a claim for compensation within the meaning of ORS 656.386(1). 320 Or at 222. Thus, we conclude that claimant's claim for chiropractic services constitutes a "claim for compensation" within the meaning of ORS 656.386(1).

Next, we determine whether claimant prevailed over an "order or decision denying" the claim for compensation.

We have previously held that when a claimant prevails in a proceeding under ORS 656.327 before the Director, an attorney fee under ORS 656.386(1) is not available. Marycarol Molin, 46 Van Natta 1782, 1784-85 (1994) (no fee for attorney's efforts in obtaining compensation without a hearing); accord James V. Johnston, 46 Van Natta 1813 (1994). However, when a claimant prevails before the Referee or Board in a proceeding under ORS 656.327, we have held that attorney fees are available under ORS 656.386(1). Sherry Y. Drobney, 46 Van Natta 964 (1994).

In both cases, the key to our analysis was determining whether there had been a "decision denying the claim for compensation" within the meaning of ORS 656.386(1). In Drobney, we held that a carrier's request for Director review under ORS 656.327(1) does not constitute a denial of the claim for compensation. 46 Van Natta at 965. But, we held that a Director's order declaring medical treatment not compensable does constitute an order denying claimant's medical service claim. Id.

Here, the employer sought Director review under ORS 656.327(1) regarding the appropriateness of chiropractic treatment on and after January 16, 1992. (Ex. 23). The Director held that chiropractic treatment on November 5, 1991 and after December 5, 1991 was not appropriate, and the employer was not required to reimburse claimant for those medical services. (Ex. 30). At hearing, the Referee set aside that portion of the Director's order which pertained to medical services rendered prior to January 16, 1992.

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[1] ORS 656.386(1) provides, in relevant part:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee."

Inasmuch as the Director's order constitutes an order denying a claim for compensation, a portion of which was set aside by the Referee (pertaining to reimbursement for chiropractic treatment prior to January 16, 1992), we find that claimant did prevail against an order denying her claim for compensation. Thus, the second and third criteria under Shoulders are also satisfied.[2]

Accordingly, we conclude that claimant is entitled to an assessed attorney fee under ORS 656.386(1) for her counsel's efforts in partially setting aside the Director's order. Sherry Y. Drobney, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the claim for medical services prior to January 16, 1992 is $300, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 28, 1994 is affirmed in part and reversed in part. That portion of the Referee's order which declined to award an attorney fee under ORS 656.386(1) is reversed. Claimant is awarded an assessed attorney fee in the amount of $300 for her attorney's efforts in setting aside that portion of the Director's order pertaining to reimbursement for medical services prior to January 16, 1992. The remainder of the Referee's order is affirmed.

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[2] In Allen, the Supreme Court explained that the third criterion identified in Shoulders, supra, does not bar an attorney fee award when a claimant prevails on an issue regarding the compensability of a claim for medical services. Allen v. SAIF, supra, 320 Or at 206.

Board Member Hall specially concurring.

I recognize the limitations placed on our review of Director's orders concerning a medical services dispute. Nevertheless, because of potential conflicts between our review for substantial evidence and long-standing rules of evidence and proof, I write separately to raise the following concerns.

ORS 656.327(2) provides, in pertinent part:

> "Review of the [Director's] order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board, except that the order of the director may be modified only if the order is not supported by substantial evidence in the record."

While the Director's order may not be modified if it is supported by substantial evidence, the Referee's review is nevertheless conducted pursuant to ORS 656.283 following established Board procedures.

In Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526, 533 (1993), the Supreme Court resolved the legal issue of "whether a referee has authority, when reviewing a vocational assistance decision of the director under ORS 656.283(2), to find facts independently before exercising his or her power." (emphasis supplied). In other words, the referee's role in reviewing vocational assistance disputes is to develop a record, and to independently find facts from which to conclude whether the Director's order survives review under ORS 656.283(2). Id. at 537.

We have applied the Colclasure reasoning to review of the Director's orders in medical services cases under ORS 656.327(2). Julie Sturtevant, 45 Van Natta 2344 (1993). Thus, the procedure upon review of a Director's medical services order is substantially the same as the procedure for reviewing the Director's vocational assistance orders. The Referee's role on review is to develop the record, independently find facts, and then determine whether the Director's order survives review (i.e., is supported by substantial evidence in the whole record).

Certain rules regarding the weighing of evidence, particularly expert medical evidence, have developed over time and are now firmly rooted in the application of Workers' Compensation Law. One such rule is the deference ordinarily given to the opinion of the treating doctor. See SAIF v. Weiland, 64 Or App 310, 814 (1983) (see also cases cited therein). The record in this case reveals nothing to indicate that such rules of evidence and proof were applied by the Director to the medical evidence herein. One may ask whether the Director's decision would be the same if such rules were applied by the Director.

In Queener v. United Employers Insurance, 113 Or App 364 (1992), the court explained:

> "Claimant also asserts that the Board erred by refusing to defer to the treating physician's opinion without persuasive reasons. When this court had *de novo* review in workers' compensation cases, we tended to give greater weight to the conclusions of a claimant's treating physician, unless there were persuasive reasons not to do so. *See Taylor v. SAIF*, 75 Or App 583, 585, 706 P2d 1023 (1985). In 1987, the legislature eliminated *de novo* review and confined this court to reviewing the record for substantial evidence to support the Board's findings. ORS 183.482(8)(c); ORS 656.298(6); *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884(1990)."

Implicit in the court's explanation in Queener is a statement that, since 1987, the court no longer applies rules for independently weighing evidence. As the court also noted, citing Armstrong v. Asten-Hill Co., 90 Or App 200, 206, 753 P2d 312 (1988), whichever way the Board finds the facts will probably have substantial evidentiary support and the court need not choose sides. 113 Or App at 368. In Queener, however, the record was developed under the Board's rules for contested cases, including the application of the rules for the weighing of evidence. In other words, at some point in the review process those rules of evidence were applied.

The present case illustrates the dilemma. The Director does not develop a contested case record in medical services disputes. Thus, the Director is never required to apply rules of evidence and proof in reaching an administrative decision. Under these circumstances, the Referee should have the authority to apply conventional rules of proof to the record developed at hearing and before the Director. Otherwise, the parties will never have the opportunity for an open weighing of the evidence consistent with well-accepted principles of proof. After applying rules of proof, such as deference to the treating physician's opinion, the Referee then can decide whether substantial evidence still exists to support the Director's order.

In the Matter of the Compensation of
DARRELL C. STEVENS, Claimant
WCB Case No. 94-00759
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Livesley's order that awarded a penalty pursuant to ORS 656.268(4)(g). On review, the issues are jurisdiction and penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his right arm and shoulder on October 27, 1991. His claim was closed by a Notice of Closure which awarded 19 percent unscheduled permanent disability and 6 percent scheduled permanent disability. Claimant requested reconsideration, and on October 15, 1993, the Department issued an Order on Reconsideration which increased his unscheduled award from 19 percent

to 29 percent and his scheduled award from 6 percent to 7 percent. The Order on Reconsideration did not award a penalty pursuant to ORS 656.268(4)(g). Neither claimant nor the self-insured employer appealed the Order on Reconsideration and that order became final by operation of law.

Subsequently, claimant requested a hearing seeking a penalty pursuant to ORS 656.268(4)(g). That statute provides for a 25 percent penalty if: (1) a claim is closed by the insurer or self-insured employer; (2) the worker's permanent disability award is increased by the Department on reconsideration by 25 percent or more; and (3) the worker is at least 20 percent permanently disabled.

Even though the Order on Reconsideration which increased claimant's permanent disability award had become final, the Referee found that claimant was not barred from seeking a penalty pursuant to ORS 656.268(4)(g). On review, the self-insured employer contends that claimant is not entitled to a penalty pursuant to ORS 656.268(4)(g) because he failed to appeal the Reconsideration Order which has now become final by operation of law. We agree.

Subsequent to the date of the Referee's order, we issued our opinion in Michael S. Bland, 46 Van Natta 871 (1994). In Bland, an Order on Reconsideration had increased the claimant's scheduled permanent disability award from 4 percent to 20 percent, but had not assessed a penalty pursuant to ORS 656.268(4)(g). After the statutory time period for requesting a hearing on the Order on Reconsideration had run, the claimant requested a hearing seeking a penalty under ORS 656.268(4)(g). The claimant argued that the statute was mandatory and that, therefore, it was unnecessary to request a hearing challenging the reconsideration order. On Board review, we disagreed with the claimant's argument. Relying on ORS 656.268(6)(b) we held that since claimant disagreed with the reconsideration order's failure to award a penalty, his remedy was to request a hearing challenging the Order on Reconsideration within 180 days of the Notice of Closure. Because the claimant's hearing request on the Order on Reconsideration was not filed within the statutory time limit, we dismissed the claimant's hearing request.

The Bland holding is also consistent with the reasoning recently expressed in Mast v. Cardinal Services, Inc., 132 Or App 108 (1994). In Mast, the court affirmed the Board's order in Vena K. Mast, 46 Van Natta 34 (1994), which had declined to award a penalty under ORS 656.268(4)(g) because the Board had subsequently reduced the claimant's permanent disability award below the 20 percent minimum level provided in the statute. Although the Mast court agreed with the claimant that the Department should have assessed a penalty under the statute, the court did not believe that the legislature intended that a penalty be sustained if the permanent disability award was subsequently reduced below the statutory threshold levels.

In reaching this conclusion, the Mast court discussed the relationship between a "268(4)(g)" penalty and the claimant's permanent disability award. Inasmuch as the assessment of a penalty under ORS 656.268(4)(g) is directly linked to the disability award and since both parties are entitled to request a hearing regarding the reconsideration order, the Mast court reasoned that the penalty is likewise subject to review and modification consistent with the Board's action on the disability award.

Here, as in Mast and Bland, claimant's remedy, if he objected to the reconsideration order's failure to award a penalty, was to request a hearing within 180 days of the mailing date of the Notice of Closure. However, claimant did not timely appeal the Order on Reconsideration and that order is now final. Because the order is final, we are without authority to consider claimant's request for a penalty. Consequently, we vacate the Referee's order and dismiss claimant's hearing request. Michael S. Bland, supra.

ORDER

The Referee's order dated April 7, 1994 is vacated. Claimant's request for hearing is dismissed.

Board Member Gunn specially concurring.

In light of the Mast decision, it appears that the court views the "268(4)(g)" penalty as entirely dependent on the permanent disability award and, as such, subject to the review procedures set forth in ORS 656.268(6)(b). I am constrained to adhere to that reasoning. Nevertheless, had I been writing on a clean slate, I would have reached a different conclusion. Since my reasons for such a conclusion have not been previously contained in a Board decision, I offer them at this time.

The Director has no discretion to decide whether or not to award a penalty under ORS 656.268(4)(g). If the Order on Reconsideration increases claimant's permanent disability by more than 25 percent and claimant is at least 20 percent disabled, the penalty "shall" be awarded.

Thus, when such circumstances arise, claimant should not be required to appeal the Order on Reconsideration itself. Instead, he should simply be entitled to seek the statutory penalty award by requesting a hearing free of the filing limitations of ORS 656.268(6)(b).

The Bland decisions relies on Nelson v. SAIF, 43 Or App 155, 159 (1979), which provides that workers' compensation benefits are creatures of statute; and therefore, time limits are to be strictly observed. In Bland, the majority applied the 180-day time limit set forth in ORS 656.268(6)(b). It is not unreasonable to apply this limitation to benefits a claimant would seek under reconsideration. However, here, we are not talking about a claimant's benefits, but rather, as recognized by the Mast court, a mandatory penalty that should have been imposed by the Director.

In other words, if a party is objecting to a compensation award either granted or omitted in an Order on Reconsideration, the statutory time limitations of ORS 656.268(6)(b) must be followed. On the other hand, the mandatory penalty under ORS 656.268(4)(g) arises as a result of the increased compensation granted by the Order on Reconsideration. There is no statutory requirement that the penalty be included within the Order on Reconsideration itself. Inasmuch as the mandatory penalty arises separately from the Order on Reconsideration, the filing limitations of ORS 656.268(6)(b) should have no application.[1]

Finally, the majority's decision places a claimant in a procedural dilemma. The majority's reasoning requires a claimant, who is seeking an "omitted" mandatory penalty, to place at risk the increased compensation awarded by the reconsideration order. Once a claimant has been forced to appeal a reconsideration order to receive a statutorily mandated penalty, a carrier can subsequently choose to contest the increased disability awarded by reconsideration. Likewise, in accordance with ORS 656.313, the carrier can also stay the payment of that appealed compensation. If the carrier is successful, the compensation will be reduced, thereby eliminating or reducing the penalty as was the case in Mast. If the carrier is unsuccessful, claimant will be deprived of the increased compensation until the appeal is completed. Finally, if the only issue for claimant is the penalty, his attorney will not receive a fee for obtaining that penalty (unless the carrier's conduct is also found unreasonable).

In conclusion, the majority's decision confuses a penalty with compensation and, in doing so, erroneously applies the statutory time limitations for contesting an Order on Reconsideration onto a penalty appeal. In addition, the majority's holding provides incentives for increased litigation by carriers. The decision also requires a claimant to place his compensation at risk and to retain an attorney who will provide services which in all likelihood will go uncompensated. Finally, the majority's conclusion necessitates the expending of all of these efforts to obtain a penalty the law says is mandatory. See Mast v. Cardinal Services, Inc., supra.

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[1] Based on my interpretation of the statutory scheme, there is no express time limitation for seeking review of the Director's failure to award the mandated penalty. Without an express statutory directive, it would appear that neither the Director nor this Board are authorized to impose such a restriction. See Benino T. Orn, 46 Van Natta 254 (1994) (Board declined to impose time limit on appeals from Director's order under ORS 656.327(2) when statute was silent as to specific time period within which to seek review).

In the Matter of the Compensation of
RAYMOND H. TIMMEL, Claimant
WCB Case Nos. 93-09859 & 93-08557
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Betsy Byers (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Spangler's order that: (1) set aside its denial of claimant's current low back condition; and (2) upheld that portion of the SAIF Corporation's denial that disclaimed responsibility for the same condition. SAIF cross-requests review of the Referee's assessed attorney fee award. On review, the issues are responsibility and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Relying on Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), the Referee concluded that, as the carrier with the last accepted low back condition, Liberty is responsible for claimant's current low back condition. Liberty argues that, in light of the enactment of ORS 656.308(1), Kearns is no longer good law and, therefore, does not apply to this case. We disagree.

Kearns created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. Encompassed in the "Kearns presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. See id. at 587. The carrier with the last accepted injury can rebut the Kearns presumption by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. Id. at 588.

In 1990, the legislature enacted ORS 656.308(1), which provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer." Or Laws 1990 (Special Session) ch 2, § 49.

ORS 656.308(1) applies if a worker sustains a "new compensable injury" involving the same condition as that previously processed as part of an accepted claim. See SAIF v. Yokum, 132 Or App 18 (1994). Responsibility is then assigned to the carrier with the most recent accepted claim for that condition. Smurfit Newsprint v. DeRosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or need for treatment involves a condition different than that which has already been processed as part of a compensable claim. See Armand J. DeRosset, supra.

We have held that, in the context of successive accepted injuries involving the same condition, ORS 656.308(1) governs the determination of responsibility for further compensable disability or need for treatment involving that condition. Bonni J. Mead, 46 Van Natta 1185 (1994). However, where a claimant has several accepted claims for injuries involving the same body part, but not the same condition as that for which the claimant currently seeks compensation, Kearns remains valid law, notwithstanding the enactment of ORS 656.308(1). See, e.g., SAIF v. Yokum, supra (court applied the last injurious exposure rule in a case to which ORS 656.308(1) did not apply); John J. Saint, 46 Van Natta 2224, 2226 (1994) (when ORS 656.308(1) did not apply, the "substantive rule of liability" prong of the last injury rule continues to operate to allocate responsibility).

Here, claimant does not assert that he sustained "a new compensable injury" involving the same condition as that previously processed as part of a compensable claim. Indeed, the record reveals that claimant's accepted low back strain claims involve that same body part, but not the same condition as that for which he presently seeks compensation (an L4-5 disc herniation). Accordingly, we proceed to analyze this case under Kearns. See John J. Saint, supra; Fred A. Nutter, supra.

Claimant has injured his low back at least twice. In 1988, while working for SAIF's insured, claimant sustained a lumbar strain, which SAIF accepted as nondisabling. (Exs. 2, 3). Claimant sustained a disabling lumbosacral strain in 1990, while working for Liberty's insured. (Ex. 5). Liberty accepted that condition. (Ex. 7-2). That claim was closed in February 1991 without an award of permanent disability. (Ex. 11).

Claimant's current low back condition arose in 1993, when he began to experience left leg and foot pain, along with his ongoing low back pain. (Ex. 13-1). Dr. Dunn, treating physician, diagnosed L4-5 herniated nucleus pulposus. (Id. at 2). Claimant has had continual low back pain since his 1988 back injury. (E.g., Ex. 23-3, -8). The Referee found claimant's current low back condition compensable; neither carrier contests that finding.

As the carrier with the last accepted claim involving the same body part, i.e., the low back, Liberty is presumptively responsible for claimant's L4-5 herniation. Kearns, supra. To rebut the Kearns presumption, Liberty must establish that there was no causal connection between claimant's current low back condition (the L4-5 disc herniation) and the last (i.e., 1990) accepted low back strain claim. Kearns, supra, 70 Or App at 588. For the following reasons, we conclude that Liberty has not met that burden.

Three physicians rendered opinions regarding the cause of claimant's L4-5 herniation. Dr. Dunn, treating physician, concluded that the L4-5 herniation was "clearly" related to claimant's 1988 injury with SAIF's insured. (Ex. 13-2). We do not rely on that opinion, because Dr. Dunn was not aware of claimant's 1990 injury with Liberty's insured. Somers v. SAIF, 77 Or App 259 (1986) (probative weight is given to opinions that are both well-reasoned and based on complete information).

Dr. Donahoo, orthopedic surgeon, examined claimant on SAIF's behalf. Donahoo concluded that, based on claimant's history, his 1990 injury was more than 51 percent of the cause of his L4-5 herniation. (Ex. 19-9). In particular, Donahoo focused on a traumatic chiropractic treatment that claimant had received after the 1990 injury. (Id. at 3, 8-9). Donahoo, however, had an inaccurate history of claimant's symptoms following the 1988 back injury. He recorded that claimant was "'not having symptoms hardly at all'" after that injury. (Id. at 2). The record reveals that claimant actually had continual low back symptoms following his 1988 back injury. (E.g., Ex. 23-9; Tr. 16). Because Dr. Donahoo was not aware of that history, we conclude that his report is entitled to minimal probative weight. See Somers v. SAIF, supra.

Last, Dr. Dickerman, neurologist, examined claimant on Liberty's behalf. After considering an extensive and accurate history, Dickerman concluded that, because claimant's 1988 back injury involved both lifting a heavy object and a rotational component (while the 1990 back injury did not), claimant's current back condition was more likely than not related to the 1988 injury. (Ex. 23-9).

We conclude that Dr. Dickerman's conclusion is not sufficient to relieve Liberty of responsibility for claimant's current L4-5 herniation. Dickerman's report discusses only the contribution of the 1988 injury; it does not address the possibility that claimant's 1988 and 1990 injuries concurred to cause his current disability. Because Dickerman did not rule out that claimant's 1990 low back injury independently contributed to his current low back condition, we conclude that Liberty has failed to rebut the presumption that it is responsible for that condition. See Hallmark Furniture v. SAIF, 81 Or App 316 (1986) (physician's failure to address possibility that two injuries concurred to cause the claimant's current disability held insufficient to rebut Kearns presumption).[1]

For the foregoing reasons, we affirm the Referee's decision assigning responsibility for claimant's L4-5 herniated nucleus pulposus to Liberty.

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[1] Liberty asserts that this matter is governed by ORS 656.005(7)(a)(B). Even assuming that Kearns did not apply to this case, in the absence of any evidence that either of claimant's compensable injuries combined with a preexisting disease or condition to result in claimant's current back condition, we would reject that argument.

Attorney Fees

The Referee assessed an attorney fee, payable by SAIF, for claimant's counsel's services in setting aside SAIF's compensability denial. At hearing, only SAIF contested the compensability of claimant's current low back condition. SAIF argues that there is no valid precedent for the Board's authority to assess a fee for services at hearing against a non-responsible insurer under ORS 656.386(1). In particular, SAIF argues that, because it cites cases regarding the entitlement to fees at the Board level pursuant to ORS 656.382(2), Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993), is not good law.

Hayes holds that, when the non-responsible carrier creates the need for the claimant to establish the compensability of a claim, that carrier is responsible for payment of an attorney fee at hearing pursuant to ORS 656.386(1). See Raymond E. Merideth, Jr., 46 Van Natta 431, 434 (1994). Hayes is binding on this Board. Furthermore, it has been this Board's longstanding policy to hold a carrier ultimately determined not responsible for a claimant's condition responsible for an attorney fee under ORS 656.386(1) if the carrier denies the compensability of the claim and the responsible carrier only denies that it is responsible for the claim. Dorothy J. Hayes, 44 Van Natta 792, 793 (1992) (quoted with approval in Hayes, supra, 119 Or App at 323); see also SAIF v. Bates, 94 Or App 666 (1989) (court upheld assessment of fee under ORS 656.386(1) against carrier that necessitated a claimant's participation to establish the compensability of the claim). For these reasons, we reject SAIF's attorney fee arguments.

Because of our de novo review of the Referee's order, which concerned the compensability of claimant's current low back condition, claimant's compensation remained at risk of disallowance or reduction on Board review due to Liberty's appeal. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod 119 Or App 447 (1993). Accordingly, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services rendered on review, payable by Liberty. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000. In reaching this decision, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for services rendered on Board review concerning the Referee's attorney fee award. Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The Referee's order dated November 12, 1993 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
KIRK J. FINDLAY, Claimant
WCB Case No. 93-09350
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

On December 15, 1994, we affirmed a Referee's order that upheld the insurer's partial denial of his occupational disease claim for a psychological condition. The parties have submitted a proposed "Joint Petition and Order of Bona Fide Dispute Settlement," which is designed to resolve all issues raised or raisable in this case. We treat such a submission as a motion for reconsideration of our December 15, 1994 order. We grant the motion and withdraw our prior order.

The proposed settlement seeks to resolve the compensability of claimant's "cracked tooth/tooth filling, anxiety / panic disorder, and stress," conditions which were disputed pursuant to the insurer's denials that were litigated in this proceeding. Because it appears that a bona fide dispute concerning the compensability of those conditions exist, we have no objection to that portion of the settlement. See

ORS 656.289(4); OAR 438-09-010(2). Furthermore, the agreement contains a provision stating that claimant retains his entitlement to future benefits arising under ORS 656.245, 656.273, 656.278 and 656.340 as those rights may be related to his accepted May 1993 injury claim. See OAR 438-09-010(3)(b).

However, because the proposed agreement fails to comply with OAR 438-09-010(2)(g) it cannot presently be approved. We base this conclusion on the following reasoning.

The settlement provides that $1,000 of the $2,000 in proceeds will be distributed to Dr. Maletsky as reimbursement for his outstanding medical billing. (Page 3, Lines 1 - 6). The agreement further contains claimant's specific acknowledgment that such a distribution exceeds the statutory reimbursement formula prescribed in ORS 656.313(4)(d). (Id.) Considering claimant's express acknowledgment of this "excess" medical service provider reimbursement, such a provision is approvable. See Charles E. Munger, 46 Van Natta 462 (1994).

Nevertheless, with the exception of the reference to Dr. Maletsky's bill, the settlement does not contain a provision stating whether that was the only medical service provider billing in the insurer's possession on the date the terms of the settlement were agreed on (October 31, 1994). If there were other billings in the insurer's possession, the settlement must list them along with the proposed reimbursement for those bills. See ORS 656.313(4)(c); OAR 438-09-010(2)(g).

Thus, we are unable to determine whether additional medical service provider billings were in the insurer's possession on October 31, 1994 and, if so, in what manner those bills will be reimbursed. Lacking such information, the proposed settlement cannot be approved.

Consequently, we are returning the proposed settlement to the insurer's attorney for clarification. On receipt of an amended agreement clarifying the matters addressed in this order, we shall expeditiously proceed with our review. Meanwhile, in order to retain jurisdiction over this case, our December 15, 1994 order shall remain abated.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN M. ROSSITER, Claimant
Own Motion No. 94-0618M & 94-0770M
INTERIM OWN MOTION ORDER CONSENTING TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1987 injury claim with the SAIF Corporation expired September 8, 1993. Claimant's aggravation rights with respect to his 1984 injury claim with SAIF expired February 7, 1990. Thus, those claims are subject to ORS 656.278.

Under OAR 438-12-032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. Id.

The record establishes that there has been a worsening of claimant's compensable injury requiring surgery. Inasmuch as claimant would be entitled to own motion relief if either of the own motion insurers is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307.

Inasmuch as the Board has postponed action on claimant's 1984 claim pending outcome of a hearing to determine responsibility for claimant's current condition (WCB Case No. 94-15465), the parties shall notify the Board of the Referee's decision regarding the responsibility issue. When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if one of the own motion carriers is found to be the responsible carrier; and/or (2) issue an order denying reopening of an own motion claim, if one of the own motion carriers is not found responsible, or if a non-own motion carrier is found to be the responsible carrier.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIRGIL C. SHORTEN, Claimant
WCB Case No. 93-11545
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of those portions of Referee Michael V. Johnson's order that: (1) declined to award temporary disability compensation for the period from July 2, 1992 until August 27, 1992; and (2) awarded 5 percent (16 degrees) unscheduled permanent disability for claimant's low back, whereas an Order on Reconsideration had awarded 13 percent (41.6 degrees). The insurer contends that claimant is not entitled to a permanent disability award and objects to the amount of the attorney fee requested by claimant. On review, the issues are temporary disability, 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.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

We adopt the portion of the Referee's "Conclusions of Law" entitled "Premature Claim Closure," with the following supplementation.

To begin, we note that claimant does not contend that he was not medically stationary when the November 3, 1992 Determination Order closed his claim. Instead, he argues that he is entitled to additional temporary disability compensation for the period from July 2, 1992 (the medically stationary date designated by the Determination Order) until August 27, 1992 (when he believes he became medically stationary). Thus, the issue is temporary disability, not "premature closure." In addition, because the claim is closed, the temporary disability issue is substantive, not procedural. See SAIF v. Taylor, 126 Or App 658 (1994).

Claimant's substantive entitlement to temporary disability is established by a preponderance of evidence in the entire record showing that he was disabled due to the compensable condition before becoming medically stationary. See ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Accordingly, we must decide whether claimant has established that he was not medically stationary on July 2, 1992, in order to determine whether he is entitled to temporary disability for periods thereafter.

We agree with the Referee that the express opinion of Dr. Risser, treating physician, standing alone does not clearly establish the exact date that claimant became medically stationary. (See Ex. 33). However, there is additional relevant evidence.

On July 2, 1992, claimant was examined by two doctors at Medical Consultants Northwest, who stated:

> "It is our opinion that [claimant] has recovered from his lumbosacral strain/sprains of December 27, 1991 and February 6, 1992, and that he is medically stationary. We find no permanent impairment in relation to his industrial injury. We believe that he had recovered from these injuries. If he has progressive gradual increase in symptomatology, it would be due to the progression of his osteoarthritis and not his industrial injuries, as he has recovered from these, in our opinion." (Ex. 31).

Three weeks later, Dr. Risser reviewed the Consultants' report and agreed that claimant has generalized osteoarthritis which is expected to progress. (Ex. 32). In late August 1992, Dr. Risser wrote:

> "[Claimant] does have underlying osteoarthritis or degenerative spine changes. However, the severe pain in his low back and hips began as a result of [his work injuries.] I do concur with [the Consultants] that he is medically stationary at this time * * *." (Ex. 33).

We read Dr. Risser's August 1992 concurrence with the Consultants' July 2, 1992 opinion (that claimant "is medically stationary at this time") as did the Referee. In other words, we do not find that Dr. Risser's opinion supports a conclusion that claimant was not medically stationary on July 2, 1992.

In addition, we note that Dr. Risser advised claimant about his "generalized osteoarthritis which is expected to progress gradually over time" and the likelihood that one of claimant's multiple lumbosacral disc herniations will "become intolerable due to pain or cause motor or sensory damage" sometime in the future. (See Ex. 32). In our view, Dr. Risser's prediction of claimant's future back problems does not negate his finding that claimant is presently medically stationary or suggest that claimant was not medically stationary on July 2, 1992.[1]

Accordingly, on this record, we agree with the Referee that claimant was medically stationary on July 2, 1992, as found by the Determination Order. Consequently, claimant has not established entitlement to temporary disability benefits for periods thereafter. See OAR 436-30-036(4)(a).

Permanent Disability

The Referee initially affirmed a 13 percent unscheduled permanent disability award, as provided by a Director's Reconsideration Order. See Opinion and Order dated March 11, 1994. On reconsideration of his initial order, the Referee reduced claimant's award to 5 percent. See Opinion and Order on Reconsideration dated May 2, 1994. We reinstate and affirm the Order on Reconsideration 13 percent unscheduled permanent disability award.

Only two aspects of the Referee's order regarding claimant's permanent disability award are disputed on review. Claimant contends that he is entitled to an adaptability value (and values for the other social and vocational factors) under the standards. The insurer argues that claimant's back impairment is not injury-related. We consider the parties' arguments in turn.

Adaptability

The Referee concluded that claimant is not entitled to values for the nonimpairment factors under the standards, reasoning that the DOT strength requirements for the job at injury and the return-to-work truck driving jobs are the same.[2] We disagree.

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[1] See OAR 436-30-035(4), stating, inter alia, that the date of the examination, not the date of the report, controls the medically stationary date. See also OAR 436-30-035(1)&(2).

[2] Pursuant to former 436-35-310(2), for workers who have a physician's release to regular work, or who have returned to regular work at the time of the determination, the value for the age, education and adaptability factors is zero.

Since the hearing in this matter, 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 November 3, 1992 Determination Order (those contained in WCD Admin. Order 6-1992) apply to claimant's claim. See Marlin D. Rossback, 46 Van Natta 2371 (November 16, 1994); Cornell D. Garrett, supra.

In determining the extent of permanent disability, the adaptability factor is a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual capacity (RFC) at the time of determination. Former OAR 436-35-310(1). Prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's job at injury. Former OAR 436-35-270(3)(g).

Here, claimant was working as an "Automotive Carrier Driver," DOT 904.383-010, when injured. The DOT describes this job as a medium-strength job.

After his injury, claimant returned to the same job for the same employer. However, claimant is permanently restricted from bending and lifting without a back brace and he has never been released to haul more that 4 loads per day. (See Exs. 32, 42-5; Tr. 12). Under these circumstances, a comparison of the strength demands of the job at injury (medium) and claimant's maximum RFC (medium, with restrictions) yields an adaptability factor of 2. See former OAR 436-35-310(3); see also former OAR 436-35-270(3)(e); Jim M. Greene, 46 Van Natta 1527, 1529 (1994); George O. Hamlin, 46 Van Natta 492, 493 (1994).

Injury-related Impairment

The insurer contends that claimant is not entitled to permanent disability benefits because he has not established that his impairment results from his work injury rather than his preexisting degenerative condition. However, we agree with the Referee that the opinions of Dr. Risser, treating physician, and Dr. Burr, medical arbiter, establish that the impairment rated herein is injury-related. Accordingly, we adopt the portions of the Referee's "Conclusions of Law" entitled "Unscheduled Permanent Partial Disability" and "Impairment/Level of Causation Required" on pages 9 through 11 of the Opinion and Order.

Calculations and Attorney Fees

We have determined that claimant is entitled to a value of 2 for adaptability and ratings for impairment under the standards. No other aspects of the Referee's permanent disability award are contested. Accordingly, because we find that the Referee initially calculated claimant's permanent disability correctly and awarded an appropriate attorney fee at the hearing level, we adopt those portions of the "Conclusions of Law, Unscheduled Permanent Partial Disability" entitled "Impairment," "Age and Education," "Adaptability," and "Attorney Fee," set forth on pages 9 and 10 of the Opinion and Order dated March 11, 1994 (i.e., We disagree with the Referee's calculations as contained in the May 2, 1994 Opinion and Order on Reconsideration).

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request that claimant's permanent disability award be reduced. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of permanent disability issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services and after considering the insurer's objections), the complexity of the issue, and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee for services related to the attorney fee or temporary disability issues.

ORDER

The Referee's order dated March 11, 1994, as reconsidered May 2, 1994, is affirmed in part and modified in part. In lieu of the Referee's "reconsideration" award of 5 percent (16 degrees) unscheduled permanent disability, the Order on Reconsideration award of 13 percent (41.6 degrees) unscheduled permanent disability is reinstated and affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order (the 8 percent increase from the Referee's 5 percent to the 13 percent award), not to exceed $3,800. The remainder of the Referee's order is affirmed. For services on review regarding the permanent disability issue, claimant's attorney is awarded a $750 attorney fee, payable by the insurer.

January 12, 1995 Cite as 47 Van Natta 38 (1995)

In the Matter of the Compensation of
RONALD E. SMITH, Claimant
WCB Case No. C4-03096
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Brad L. Larson, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Hall and Haynes.

On December 12, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On December 16, 1994, we requested that the parties submit an addendum to the CDA clarifying the consideration for the CDA. Specifically, the CDA stated that the total amount of consideration for the CDA was $15,000. From that amount claimant would receive $11,625, and claimant's attorney would receive an attorney fee of $3,375. (Pgs. 1, 3). The CDA further stated that the employer/insurer waived an existing overpayment of $14,670.74. (P. 3).

We requested clarification in light of the fact that we have previously held that, where an overpayment apparently has been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. See Timothy W. Moore, 44 Van Natta 2060 (1992); Raymond E. Clonkey, 43 Van Natta 1778 (1991). Furthermore, a carrier's contractual forebearance of its right to pursue an offset cannot serve as consideration for claimant's release of certain rights. See Timothy W. Moore, supra.

On January 6, 1995, we received the parties' addendum which stated: "The Employer/Insurer waives the existing overpayment of $14,670.74, this statement is not part of the consideration for this agreement." (Emphasis in original). In light of this clarification, we conclude that no part of the stated overpayment is intended to be included in the $15,000 total consideration for this CDA. Therefore, we find that the parties' CDA is in accordance with the terms and conditions prescribed by the Director. Accordingly, the CDA is approved. See ORS 656.236(1); OAR 438-15-052(1). An attorney fee of $3,375, payable to claimant's counsel, is approved.

The parties may move for reconsideration of the final Board order by filing a motion for consideration 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
BILLY C. CLARE, Claimant
WCB Case No. 94-01418
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Podnar's order which upheld the insurer's denial of his left elbow injury on the ground that claimant was not a subject worker. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

Claimant was hired in January 1994 to paint the restrooms in two drycleaning and laundry establishments. (Tr. 4-5, 16). Claimant was paid $60 per restroom for his work. (Id).

Claimant worked on the morning of January 11, 1994 and injured his left elbow in the course of that work. Claimant sought medical treatment.

CONCLUSIONS OF LAW AND OPINION

The first determination to be made in a subjectivity case is whether claimant was a "worker" within the meaning of ORS 656.005(28). See S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614, 630 (1994). The court explained:

> "The initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test. One who is not a 'worker' under that test is not subject to workers' compensation coverage, and the inquiry ends. The 'nonsubject worker' provisions of ORS 656.027 never come into play. If the initial determination made under ORS 656.005(28) is that one is a worker because 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." Id. at 630-31.

The factors to be considered under the traditional "right to control" test include: (1) direct evidence of the right to or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire at will without liability. Woody v. Waibel, 276 Or 189, 192 n.2 (1976); see also Michael L. Cole, 46 Van Natta 970 (1994). In addition, the Supreme Court has explained that "[t]he test of right to control does not refer to the right to control the results of the work but rather to the right to control the manner and means of accomplishing the result." Great American Ins. v. General Ins., 257 Or 62, 67 (1970).

Here, claimant was hired to paint two bathrooms in the owner's stores. (Tr. at 16). The owner's business is laundry and dry cleaning. (Tr. at 35). The owner did not intend for claimant to perform any other work for him after the painting job was completed. (Tr. at 38). Indeed, claimant considered himself to be an employee of a siding company, although he was on lay-off status at the time he performed the painting job. (Tr. at 10-12). The agreed-upon "wage" was $60 per bathroom, and claimant was paid upon completion of that specific job. (Tr. at 17, 37). Claimant supplied his own hand tools, but the owner provided painting supplies. (Tr. at 23, 39). The owner specifically required claimant to remove the toilet and sink from the wall, in order to paint behind the fixtures. (Tr. at 37). However, the owner did not control the manner or means with which claimant accomplished the painting job. (See Tr. 5). Thus, we find no evidence that the owner had a right to control the performance of claimant's work, other than to require it to be performed in a workmanlike manner. Finally, we find that the owner did not have the right to "fire" claimant at will without liability. (See Tr. at 37-38).

Under these circumstances, we conclude that claimant was not a subject worker when he was injured while painting. ORS 656.005(28) ("'Worker' means any person . . . who engages to furnish services for a remuneration, subject to the direction and control of an employer. . ."). Because we have found that claimant was not a subject worker, we need not determine whether any of the exceptions to

coverage listed in ORS 656.027 apply. S-W Floor Cover Shop, supra, 318 Or at 630. Accordingly, we agree with the Referee's determination that claimant was not a subject worker when he was injured.

ORDER

The Referee's order dated April 29, 1994 is affirmed.

January 13, 1995 Cite as 47 Van Natta 40 (1995)

In the Matter of the Compensation of
BRENDA L. CLINE, Claimant
WCB Case Nos. 93-14472 & 93-05901
ORDER ON REVIEW
Peter E. Baer, P.C., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Schultz's order that upheld the insurer's denials of claimant's injury and occupational disease claims for low back and right hip bursitis conditions. In its brief, the insurer contends that claimant's injury claim was untimely filed and should be barred. On review, the issues are timeliness of claim filing and compensability.

We adopt and affirm the Referee's order, with the exception of ultimate finding number 3, and with the following supplementation.

On January 29, 1993, claimant filed a claim for right hip and back pain, specifying the date of injury as January 16, 1992. (Ex. 13). On April 27, 1993, the insurer denied the claim. (Ex. 30). At hearing, claimant stated that her back and hip claim was based on a low back and hip injury that occurred in February 1992, not January 16, 1992, when she fell in the store's cooler. In response, the insurer contended that it was prejudiced by claimant's untimely filing of her injury claim. (Tr. 13, 14).

The Referee concluded that, although neither claimant nor the Person in Charge, Mr. Davis, were credible witnesses, claimant probably experienced a fall in the cooler and told the Person in Charge about it. Nevertheless, the Referee found that the insurer first had knowledge of the claim when it received the January 29, 1993 claim form. Presumably because he decided the merits of the case against claimant, the Referee did not reach the question of whether claimant established that she timely filed a claim. On review, the insurer contends that claimant's injury claim was untimely filed and should be barred. Thus, we supplement to address this issue on appeal.

The time limitations for filing a claim are jurisdictional and may be raised at any time. Therefore, the insurer's contention that the claim was not timely filed must be considered before addressing the merits. SM Motor Co. v. Mather, 117 Or App 176 (1992). We conclude that claimant filed her claim timely.

Under ORS 656.265, an injured worker must give written notice of the accident to the employer not later than 30 days after the accident. Failure to give notice bars a claim unless the employer had actual knowledge of the injury or had not been prejudiced by failure to receive the notice.

When credibility findings have been based on claimant's demeanor, we defer to the credibility findings of the Referee. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). However, when the Referee's credibility finding is based on the substance of the witness' testimony, rather than the witness' demeanor, we are equally capable of assessing credibility. Hultberg, at 285.

Here, we find that claimant fell in the cooler and told the Person in Charge that she had fallen. (Exs. 45, 50, 54, 60, 61, 70, 78, 79, 174, 177). When an individual in a supervisory position has knowledge of a worker's injury, that knowledge may be imputed to the employer. Colvin v. Industrial Indemnity, 301 Or 743, 747 (1986). Moreover, if the employer has knowledge of the injury, claimant's claim is not barred even if the employer was prejudiced by the late filing of the claim. Argonaut Ins.

Co. v. Mock, 95 Or App 1, 5-6, rev den 308 Or 79 (1989). Consequently, because the employer had knowledge of the worker's injury, claimant's failure to timely give written notice does not bar her claim. See ORS 656.265(4)(a).

Notwithstanding this conclusion was timely filed, we agree with the Referee's conclusion that the claim is not compensable. Consequently, we affirm the Referee's order which upheld the insurer's denials.

ORDER

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

January 13, 1995 Cite as 47 Van Natta 41 (1995)

In the Matter of the Compensation of
CARL A. CONTRERAS, Claimant
WCB Case No. 94-04507
ORDER ON REVIEW
Olson Law Firm, Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Kekauoha's order which upheld the SAIF Corporation's denial of claimant's cervical, thoracic and left shoulder injury claim. On review, the issue is course and scope of employment.

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

An architectural designer, claimant allegedly injured his neck, upper back and left shoulder on March 6, 1994 while moving furnishings at the residence of his employer's client, Mr. Henry. Claimant's employer was hired by Mr. Henry in December 1993 to remodel Mr. Henry's home. Claimant had drafted the plans for the project.

Finding that claimant had violated his employer's instructions by being at the job site on March 6, 1994, the Referee concluded that claimant's alleged injury arose outside the course and scope of his employment. In reaching this conclusion, the Referee determined that claimant's misconduct amounted to overstepping the boundaries of the ultimate work he was to perform for his employer. See Davis v. R&R Truck Brokers, 112 Or App 485, 491 (1992).

On review, claimant contends that the Referee improperly relied on the employer's hearsay testimony that Mr. Henry, who did not testify, had requested that claimant be kept off the job site. Claimant asserts that, if SAIF wanted to establish that Mr. Henry had asked to keep claimant off the job site, then SAIF should have called him to testify.

We find no error by the Referee in relying on the employer's testimony. Claimant did not object when the employer testified about Mr. Henry's statement. (Tr. 66). Therefore, claimant waived any objection to the employer's testimony. Moreover, we find that it was within the Referee's discretion to admit the employer's testimony, inasmuch it is well-settled that the Referee is not bound by common law or statutory rules of evidence and may conduct the hearing in any manner that will achieve substantial justice. See ORS 656.283(7); Patricia D. Carty, 46 Van Natta 1424 (1994) (citing Lyle A. McManus, 43 Van Natta 863 (1991)) (Referees have broad discretion in rendering evidentiary rulings).

In support of his conclusion that claimant violated the employer's instructions by being present at the Henry residence when he was allegedly injured, the Referee rejected claimant's assertion that he was present at the house in his capacity as the job foreman. The Referee found claimant's testimony that he was working at the Henry residence as a job foreman to be inconsistent with his time cards. They showed that, after December 18, 1993, claimant was at the Henry job site for only 20 minutes in February 1994 prior to the alleged March 6, 1994 injury. Since claimant had spent so little time at the Henry residence, the Referee reasoned that, if claimant was indeed the foreman at the Henry job site, he would have spent substantially more time there than 20 minutes.

Claimant contends there is no inconsistency because there was no work being done at the job site between December 1993 and March 6, 1994. Claimant relies on SAIF's counsel's representation in part of a question asked during cross-examination that no work was being done at the job site during this period. (Tr. 40).

Claimant never confirmed the information contained in counsel's question. Accordingly, SAIF's counsel's representation amounts to nothing more than an unsworn statement. Thus, it does not constitute evidence of the amount of work performed at the Henry residence between December 1993 and March 6, 1994. See Cruz v. SAIF, 120 Or App 65, 69 (1993); Thomas A. Hutcheson, 46 Van Natta 354, 356 (1994) (representations by a party's counsel do not constitute evidence).

In any event, the employer testified that, while claimant was initially considered a foreman at the Henry residence, he was later transferred. (Tr. 83). Therefore, based on this evidence, we agree with the Referee that claimant was not acting as a job foreman when he was allegedly injured on March 6, 1994. Even assuming that claimant was a foreman, we nevertheless accept the employer's credible testimony that claimant was prohibited from being at the Henry job site on March 6, 1994. Thus, we agree with the Referee that claimant acted outside the course and scope of his employment. See Davis v. K & K Truck Brokers, supra. Accordingly, his claim is not compensable. See ORS 656.005(7)(a).

ORDER

The Referee's order dated July 28, 1994 is affirmed.

In the Matter of the Compensation of
NANCY J. EDEN, Claimant
WCB Case No. 93-04139
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Brazeau's order which upheld the self-insured employer's denial of her claim for right knee condition. On review, the issue is compensability.

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

Claimant has preexisting chondrosis, which was identified as Grade III during an October 1992 surgery for a noncompensable right knee condition. The October 1992 surgery involved a partial medial meniscectomy of the right knee.

On December 31, 1992, claimant tripped over a coworker. She did not fall, but her right foot was brought up behind her left knee. Claimant sought treatment from Dr. Galt, who suspected a lateral meniscus tear of the right knee. Dr. Galt performed surgery on May 10, 1993, which revealed that the lateral meniscus was intact, but that the chondrosis had progressed to advanced Grade III and early Grade IV stage.

Dr. Galt opined that claimant's twisting-type mechanism of injury could cause abrasion and loss of articular cartilage into the joint. Thus, he concluded that it seemed reasonable that claimant's injury was the cause of the further deterioration in her knee joint.

Dr. Cronin disagreed. He opined that the change to early Grade IV chondrosis was a result of the natural progression of the disease post-op rather than the work incident. He noted that claimant complained of pain and swelling prior to the December 31, 1992 incident. Dr. Cronin explained that for a single traumatic incident to cause the chondrosis change, it would take a fall with longitudinal loading; i.e., impact on the limb, rather a twisting nonfalling injury such as claimant's. Dr. Cronin also stated that since claimant previously had a partially removed meniscus, increased damage could be expected between the October 1992 surgery and the May 1993 surgery.

Claimant argues that more weight should be given to the opinion of Dr. Galt than to Dr. Cronin's opinion. First, claimant contends that Dr. Galt did not concur with Dr. Cronin's opinion that the preexisting condition was the major cause of the current chondrosis condition.

In his April 10, 1993 report, Dr. Cronin stated that an arthroscopic examination was required to determine whether claimant's current knee condition was related to a lateral meniscus tear or to the preexisting chondrosis. Dr. Cronin further stated that if there was a lateral mensicus tear or other new acute pathology, then claimant's current knee condition was work related; but if there was no new pathology, then the knee condition was related to the underlying chondrosis.

Dr. Galt initially suspected that claimant sustained a new injury involving a lateral meniscus tear. However, when an MRI failed to indicate a tear, he recommended an arthoscopy to determine whether claimant had a tear or whether her knee problem was related to the chondrosis. Thus, Dr. Galt's opinion was not inconsistent with Dr. Cronin's April 1993 report.

Next, claimant contends that Dr. Cronin's opinion was based on inaccurate information regarding claimant's swelling prior to the December 1992 work incident. However, whether or not the location of the swelling was different would not change Dr. Cronin's opinion concerning whether the injury caused the chondrosis changes, since the location of the swelling was but one of the factors Dr. Cronin considered in rendering his opinion. Dr. Cronin testified that to establish that the injury caused a change in pathology, claimant's knee would have to be doing well prior to the injury, there would have to be a distinct change in the location of the swelling and pain, and a continuing worsening of the knee. However, the swelling noted in Dr. Galt's December 11, 1992 chart note indicated to Dr. Cronin that claimant's knee was not doing better, but rather that claimant continued to have problems following the October 1992 right knee surgery.

Lastly, claimant contends that although Dr. Galt did not use the words "the major contributing cause" to quantify causation, "magic words" are not required to establish compensability, and therefore his opinion is sufficient to meet her burden of proof. See McClendon v. Nabisco Brands, 77 Or App 412 (1986). Although "magic words" are not determinative, we find Dr. Galt's unpersuasive.

We find Dr. Galt's opinion to be speculative. In Gormley v. SAIF, 52 Or App 1055 (1981), the court found that the doctors' use of the words "could," "can," "it is reasonable to assume" and "we would like to assume" mitigated against a finding of medical causation in terms of probability. Therefore, the Gormley court concluded that, because claimant could not prove more than just the possibility of a causal connection, she failed to carry her burden of proof.

Here, Dr. Galt's use of "could cause" and "it seems reasonable" are also couched in terms of possibility rather than probability. Moreover, such an opinion is consistent with Dr. Cronin's opinion that it would be conjecture whether claimant's work incident was sufficient to cause the change in the chondrosis condition.

In addition, we find that Dr. Galt's opinion is further attenuated by his failure to address the role that claimant's prior meniscus surgery had on the progression of her chondrosis. Dr. Cronin explained that the meniscus helps the femur and tibia fit together so that the load shares over the whole joint surface. Dr. Cronin testified that increased knee damage was expected because with the partial removal of the meniscus, there is less meniscal cartilage to provide the load sharing effect.

Accordingly, for the reasons stated above, we find Dr. Cronin's opinion persuasive. His opinion establishes that the cause of claimant's knee condition is her preexisting chondrosis condition rather than the December 1992 work incident. Claimant has failed to establish a compensable claim.

ORDER

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

In the Matter of the Compensation of
JEFF McQUOWN, Claimant
WCB Case No. 94-02031
ORDER ON REVIEW
Nancy FA Chapman, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board members Neidig and Hall.

Claimant requests review of Referee Hazelett's order that decreased claimant's unscheduled permanent disability award for a low back condition from 6 percent (19.2 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the Referee's order except for that portion concerning the burden of proof. We provide the following supplementation.

The Referee found that, although the self-insured employer requested a hearing from the Order on Reconsideration, the burden of proof was on claimant to establish permanent impairment due to the compensable injury. Subsequent to the Referee's order, we issued Roberto Rodriquez, 46 Van Natta 1722 (1994), discussing which party has the burden of proving extent of permanent disability when the carrier requests a hearing challenging an award of permanent disability. The facts in Rodriquez concerned a carrier's request for hearing objecting to an Order on Reconsideration awarding permanent disability; the carrier asserted that there were no valid impairment findings supporting the award. Relying on ORS 656.283(7) and Harris v. SAIF, 292 Or 683 (1982), we held that, although the claimant has the initial burden of proving impairment, the party which appeals the prior preceding award has the burden of proof in that subsequent proceeding. 46 Van Natta 1723-24.

Here, the employer requested a hearing challenging the Order on Reconsideration, asserting that the award of 6 percent should be reduced to zero. Based on Rodriquez, the employer therefore had the burden of proof. However, because we agree with the Referee that the record showed that any impairment exhibited by claimant was not due to the compensable injury, the employer successfully carried its burden of proving that claimant was not entitled to unscheduled permanent disability.

ORDER

The Referee's order dated June 20, 1994 is affirmed.

In the Matter of the Compensation of
KAREN M. MILLS, Claimant
WCB Case No. 94-03587
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Referee Lipton's order that: (1) set aside its denial of claimant's claim for a left knee injury; and (2) awarded a $2,900 assessed attorney fee under ORS 656.386(1). Claimant has moved for remand for the admission of additional evidence not presented at the hearing. On review, the issues are compensability, attorney fees and remand.

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

Compensability

Claimant, a bus driver, contended that she injured her left knee at work when she bumped the knee against the fare box on her bus. Claimant testified that, the morning of February 22, 1994, she started her bus, set it up, and then hit her knee as she got out of the seat. (Tr. 9). Since the knee was not hurting at that time, she did not think about the incident again until she noticed the bruise when she sought treatment at the urgent care clinic.

The Referee found claimant credible and concluded that the act of striking her left knee on the fare box was a material contibuting cause of the left knee contusion and strain. On review, the employer argues that claimant's reporting of her left knee injury is inconsistent because (based on contemporaneous medical reports) she did not immediately recall bumping her knee on the fare box. We disagree.

Claimant explained that she frequently bumped her knee on the fare box. She further explained that she did not associate the left knee pain with bumping her knee until she saw the bruise on her knee at the urgent care clinic.[1] Chart notes from the urgent care clinic indicate that claimant had "vague slightly ecchymotic swelling" near her left knee. (Ex. 2). Claimant was subsequently treated for the injury by Dr. Hermens, orthopedist. Dr. Hermens diagnosed a contusion/strain of the left knee which he causally related to the bumping incident reported by claimant. (Ex. 7-2). Specifically, Dr. Hermens opined that the major contributing cause of claimant's contusion/strain of the left knee was the incident in which claimant bumped her knee on February 22, 1994.

After reviewing the record, we are persuaded that claimant did, in fact, bump her left knee on the fare box on the morning of February 22, 1994 as she testified. Her testimony about the injury is consistent with the "vague slightly ecchymotic swelling" noted at the urgent care clinic and with Dr. Hermens' diagnosis and findings. In addition, claimant testified that her left knee was fine when she went to work the morning of February 22, 1994 and that she had not had any off work injuries to the knee. (Tr. 17). Under the circumstances, claimant has established compensability of her left knee contusion/strain injury.

Attorney Fee/Hearing Level

The Referee awarded claimant's attorney an assessed fee of $2,900 for services at hearing. The employer contends that this award is excessive. We disagree.

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[1] We acknowledge claimant's testimony that she told the doctor at the urgent care clinic that she bumped her knee on the bus. We further recognize that the chart notes do not reflect this history. However, based on this record, we determine that claimant was simply mistaken in this particular aspect of her medical history. Nevertheless, we consider this apparent confusion in her recollection of events to be minor and not so significant as to prompt us to discard the remaining portions of the record. Those remaining portions of the medical and lay evidence persuasively establish that claimant bumped her left knee while performing her work activities and that this injury was a material contributing cause of her need for medical treatment.

OAR 438-15-010(4) sets forth the following factors considered in determining a reasonable fee: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorney; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After reviewing the hearing record, and considering the above factors, we conclude that the Referee's attorney fee award is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's counsel's affidavit), the complexity of the issue, the value of the interest involved, and the risk that counsel's efforts might go uncompensated.

Remand

Claimant has moved for remand for admission of a chart note from Dr. Hermens. We find it unnecessary to address the motion for remand since claimant has prevailed on the present record.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $800, 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 claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

Claimant is not entitled to an attorney fee for defending against the attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Claimant is likewise entitled to no fee for services devoted to the remand issue.

ORDER

The Referee's order dated June 28, 1994 is affirmed. For services on Board review, claimant's attorney is awarded $800, payable by the employer.

In the Matter of the Compensation of
J. STARR WOLFE, Deceased, Claimant
WCB Case No. 91-18059
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The personal representative of decedent's estate requests review of Referee Menashe's order that dismissed decedent's request for hearing on the self-insured employer's "de facto" denial of her injury claim. On review, the issue is the propriety of the Referee's dismissal order.

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

This case was tried on the following stipulated facts. Decedent filed a hearing request on a "de facto" denial of her claim on December 20, 1991. She died on or about September 17, 1993. According to the employer, decedent died as a result of a one-car accident. At the time of her death, decedent had 3 children over 21 and not in school, she had no spouse and no dependents. The party seeking to be substituted for decedent is the personal representative of her estate, who is her oldest son.

Decedent died after filing a request for hearing. ORS 656.218(3) provides that if the worker has filed a request for hearing and death occurs prior to the final disposition of the request, the persons described in subsection (5) shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing. ORS 656.218(5) provides that the persons entitled to pursue the matter are those "who would have been entitled to receive death benefits if the injury causing the disability had been fatal." Based on the stipulated facts, there are no statutory beneficiaries available to pursue decedent's claim.

Furthermore, decedent's personal representative is not a statutory beneficiary entitled to continue the hearing request. In Trice v. Tektronix, Inc., 104 Or App 461 (1990), the claimant died after she had filed a request for hearing on the issue of temporary total disability benefits for her compensable stress claim. At the time of her death, she was unmarried and was not survived by any minor children. The employer filed a motion to dismiss on the ground that the claimant had left no statutory beneficiaries to pursue her request for hearing. The claimant's 28-year-old daughter, as the personal representative of her estate, moved for an order substituting her for the claimant.

The Trice court held that the right to pursue a deceased claimant's hearing request is limited under ORS 656.218 to those who are entitled to death benefits under ORS 656.204. 104 Or App at 465. The court noted that the claimant was unmarried when she died and had no minor children. The court concluded that the personal representative was not a statutory beneficiary entitled to pursue the hearing request. Id.

We recently distinguished Trice in Arturo Barron (Dcd), 46 Van Natta 2362 (1994). The primary difference between those two cases was that in Barron, unlike in Trice, the record contained an allegation that the decedent had statutory beneficiaries. In Barron, we found that the record was incompletely developed concerning whether there were statutory beneficiaries entitled to receive death benefits and we remanded to the Referee to determine whether statutory beneficiaries existed.

Here, as in Trice v. Tektronix, Inc., supra, the record establishes that there are no statutory beneficiaries. Since decedent's personal representative is not a statutory beneficiary entitled to pursue the hearing request, the Referee properly dismissed the hearing request.[1]

ORDER

The Referee's order dated April 12, 1994 is affirmed.

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[1] To the extent that decedent's personal representative's argument can be construed to include a claim for a burial allowance, we reject that claim. ORS 656.218(5) provides, in part: "In the absence of persons so entitled [to receive death benefits], a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204." Here, there is no unpaid award of benefits. Thus, the "unpaid award" is zero. The lesser of the unpaid award (zero) and the burial costs is zero. See ORS 656.218(5); Wilma F. Macaitis (Deceased), 42 Van Natta 2449 (1990). Therefore, decedent's personal representative is not entitled to a burial allowance pursuant to ORS 656.218(5).

In the Matter of the Compensation of
DANIEL C. GREER, Claimant
WCB Case No. 93-14805
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

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

The self-insured employer requests review of that portion of Referee Menashe's order which set aside its denial of claimant's back injury claim. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

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

Claimant, an employee of a group home for people with disabilities, agreed to transport a violent, developmentally disabled individual to a vocational training site for Multnomah County, the self-insured employer (hereafter the "County"). The County advised claimant that he could begin immediately on July 1, 1993, before execution of an employment contract. Claimant was to be paid approximately $478 per month regardless of the number of times he transported the individual. However, claimant would not be paid until he signed a "personal services agreement," which expressly provided that he was to be an "independent contractor." (Tr. 29).

Claimant signed a document entitled a "No Employees Certificate" on July 9, 1993, whereby he certified that he had no employees and that no employees of any employer would provide services in the performance of the yet to be executed contract with the County. It was both claimant's, and the transportation coordinator for the County's developmentally disabled program, Ms. McGuire's understanding that claimant could not hire any employees. (Trs. 27, 54). The "personal services agreement" was not fully executed until August 19, 1993, when claimant signed the agreement.

Apart from providing that claimant was to be considered an independent contractor, the personal services agreement stated that the duration of the contract was for one year from July 1, 1993 to June 30, 1994. (Ex. 2-5). However, at the March 11, 1994 hearing, Ms. McGuire remarked that the contract was in the process of being renewed. (Tr. 49). The agreement also contained a "hold harmless" clause protecting the County from any legal liability in connection with any legal proceeding arising from activities or services provided pursuant to the contract. (Ex. 2-7). The agreement also provided for termination of its provisions upon mutual consent or by either party with 30 days written notice. (Ex. 2-8).

The County provided no equipment to claimant, who used his own automobile, and he was not reimbursed for mileage or other expenses. (Tr. 35). Claimant received no benefits from the County and no deductions were taken from his paycheck. (Trs. 35, 43). The County required that claimant pick up the individual to be transported at 8 a.m. and return him home at 1:30 p.m.. (Tr. 25). The County also mandated that claimant provide "door to door" service and claimant was contacted on occasion regarding performance of his job. (Trs. 21, 28, 52). Claimant testified that he signed the employment contract in order to get paid and did not read it, although he did believe the personal services agreement was an employment contract. Claimant had not transported anyone for pay before contracting with the County. The County was the only entity for whom he did this kind of work. Claimant does not have an office, advertise or have business cards, belong to a trade association or own a business. (Tr. 15).

On October 29, 1993, claimant was involved in an automobile accident in which he suffered a back injury while transporting the individual for the County. The County denied the claim on the grounds that claimant was not a subject worker, but was rather an independent contractor.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the County's denial, reasoning that, since claimant did not satisfy the requirements of ORS 670.600, he did not qualify as an "independent contractor." Thus, the Referee concluded that claimant was an employee of the County and entitled to benefits for an injury that arose out of and in the course of his employment.

Subsequent to the Referee's order, the Supreme Court in S-W Floor Covering Shop v. National Council on Compensation Insurance, 318 Or 614 (1994), held that the definition of independent contractors in ORS 670.600, in and of itself, is not determinative with regard to workers' compensation coverage for independent contractors. Rather, the first decision to be made in subjectivity cases is whether claimant is a "worker" within the meaning of ORS 656.005(28). "The initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test." Id. at 630.

Right to Control

The factors to be considered under the traditional "right to control" test include: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Woody v. Waibel, 276 Or 189 (1976); Henn v. SAIF, 60 Or App 587, 591, (1982), rev den 294 Or 536 (1983); Castle Homes v. Whaite, 95 Or App 269, 272 (1989).

Applying the above factors to this case, we find that the third and fourth factors of the "right to control" test favor a finding that claimant was not a "worker." It is undisputed that the County did not furnish any equipment to claimant, who provided the most essential piece of equipment, his car, and was not reimbursed for his transportation expenses. In regard to the "right to the fire" factor, the "personal services agreement" provided that either party could terminate the contract after giving 30 days notice. That kind of provision tends to indicate an independent contractor, rather than an employer-employee, relationship. See McQuiggin v. Burr, 119 Or App 202, 207 (1993).

On the other hand, we find that the first two factors tend to support a finding of an employee-employer relationship. Claimant was paid a predetermined fee each month, regardless of the number of times he transported the individual for the County. This arrangement suggests that claimant was the equivalent of a salaried employee. Moreover, we note that, although the employment contract was for only a one-year period, Ms. McGuire testified that the contract was being renewed. We agree with claimant that his services were being provided for an indefinite period, which also evidences an employer-employee relationship, rather than one involving an independent contractor.

With regard to evidence of the right to, or the exercise of, control, the County set claimant's schedule (pick up at 8 a.m. and return individual at 1:30 p.m.) and required that he provide "door to door" service. Claimant had no flexibility in setting his own schedule, unlike the claimant in Burr, whom the court found to be an independent contractor. 119 Or App at 207. In addition, the County monitored claimant's job performance. Both claimant and the County believed that he had no authority to hire and fire employees. Under these circumstances, we find that there is sufficient evidence from which to conclude that the County had the right to, and had in fact exercised, control over the conduct of claimant's work.

In summary, we find the evidence evenly divided under the "right to control" test in determining whether claimant was a "worker" under ORS 656.005(28). The Supreme Court has held that where the evidence under the "right to control" test is insufficient to clarify the master-servant relationship, application of the "relative nature of the work" test is permissible. Woody v. Waibel, supra, 276 Or at 197. There is no indication in S-W Floor Covering Shop, supra, that the Court intended to restrict the determination of whether or not a claimant is a "worker" to the "right to control" test. Accordingly, we apply the "relative nature of the work" test to resolve the subjectivity issue.

Relative Nature of the Work

Under the "relative nature of the work" standard, several factors are considered. They include: (1) the character of the claimant's work; i.e., how skilled it is, how much of a separate calling it is and the extent to which it may be expected to carry its own accident burden; and (2) the relationship of claimant's work to the employer's business; i.e., how much it is a part of the employer's regular work,

whether it is continuous or intermittent and whether the duration is sufficient to amount to the hiring of continuing services, as distinguished from contracting for completion of a particular job. Woody v. Waibel, supra, 276 Or at 195.

Applying these factors to this claim, we find that the relationship between claimant and the County is one of employer and employee. Claimant's transportation services would not generally be considered skilled. Although they would be considered a separate calling, in that claimant performed these services during the time he was not otherwise engaged in his regular job at the group home, he did not provide transportation services to any other entity apart from the County. Given the nature of claimant's "business," it would not be reasonable to expect him to carry his own accident burden. Moreover, the County would be in a superior position to distribute the costs of an accident throughout society, a policy consideration the Waibel Court considered important in determining coverage under the workers' compensation system. Woody v. Waibel, supra, 276 Or at 194.

Finally, claimant's transportation of the individual in this case is an integral part of the County's regular work. Ms. McGuire's testimony that she was the transportation coordinator for the County's Developmental Disabilities Program establishes that transporting developmentally disabled individuals is part of the County's regular work. Claimant's transportation activities for the County were also continuous. Even though the "personal services agreement" was of limited duration, Ms. McGuire testified that claimant's contract was being renewed. We, therefore, find that claimant was providing continuing services for the County, rather than services for the completion of a particular job.

In conclusion, we find that, under the "relative nature of the work" test, claimant was an employee of the County. Therefore, we conclude that claimant was a "worker" under ORS 656.005(28).

We are mindful that the agreement between the County and claimant described claimant's status as that of an "independent contractor." However, that either or both of the parties considered the relation to be employer-independent contractor is not dispositive. Woody v. Waibel, supra, 276 Or at 198.

Moreover, there is no evidence that claimant and the County negotiated his employment status. In fact, the County does not dispute claimant's testimony that he signed the contract because he had to do so in order to be paid for his services. In light of these circumstances, we give the description of the employment relationship in the personal services agreement little weight in making our determination of the subjectivity issue.

Application of ORS 656.027

Having concluded that claimant is a "worker" for the purposes of workers' compensation law, we turn our attention to the issue of whether claimant is "nonsubject" under one of the exceptions listed in ORS 656.027. S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra, 318 Or at 631.

Sole proprietors, such as claimant, are excluded from coverage of workers' compensation law. ORS 656.027(7). However, when services are performed under contract, the sole proprietor must qualify as an "independent contractor." Id. The term "independent contractor" has the meaning provided in ORS 670.600. ORS 656.005(13).

The Referee determined that claimant did not meet the eight standards listed in ORS 670.600 and accordingly, did not qualify as an independent contractor. Thus, the Referee concluded that claimant was not excluded from coverage under ORS 656.027 and was a "subject worker."

On review, the County does not contest the Referee's determination. Moreover, we agree with the Referee's analysis of the subjectivity issue. Therefore, the Referee correctly found that claimant was a subject worker when he was injured in the October 29, 1993 motor vehicle accident in the course and scope of his employment.

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 is $1,000, to be paid by the County. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 22, 1994 is affirmed. Claimant's counsel is entitled to an assessed fee of $1,000 for services on review, payable by the County.

Board Chair Neidig dissenting.

The majority concludes that claimant was a subject worker when injured in the October 1993 automobile accident. I agree that, under S-W Floor Covering Shop v. National Council on Compensation Insurance, 318 Or 614 (1994), the first determination to be made in subjectivity cases is whether the claimant is a "worker" within the meaning of ORS 656.005(28). Where I part company with the majority is in their conclusion that the judicially created "right to control" test is inconclusive in determining whether claimant is a "worker." Because I would find that claimant is not a "worker" under the "right to control" test, I would not determine the subjectivity issue by applying the "relative nature of the work" standard.

Even the majority concedes that the third and fourth factors of the right to control test (i.e., furnishing of equipment and right to fire) favor a finding that claimant is not a "worker." The crucial issue then is whether one or more of the remaining factors (method of payment and direct evidence of the right to, or the exercise of, control) also support such a finding. I believe so.

With respect to the question of control, the County required that claimant deliver and pick-up claimant at certain times. However, every job has some requirements. Significantly, the County did not specify the kind of vehicle claimant had to use or the route of travel. Nor is there evidence that it prohibited claimant from making stops enroute. The County did not directly supervise claimant's work or require that claimant maintain regular contact. Claimant was required on at least three occasions, at his own expense, to make alternative arrangements for his client's transportation when he was unable to perform his duties under the employment contract. It would seem that, if claimant were merely an employee of the County, the County would have been responsible for making alternative transportation arrangements. I believe that the County was primarily interested in the result of claimant's work, rather than in the method and manner in which he accomplished it.

In summary, there is insufficient direct evidence of the County's right to, or exercise of, control over claimant's work. When combined with the other factors that favor a finding that claimant is not a "worker," the inescapable conclusion is that claimant was not a subject worker when injured in the automobile accident. Thus, I would reverse the Referee's order finding that claimant's claim is compensable.

For these reasons, I must respectfully dissent.

January 17, 1995 Cite as 47 Van Natta 51 (1995)

In the Matter of the Compensation of
RUBY HARRISON, Claimant
Own Motion No. 66-0400M
OWN MOTION ORDER OF DISMISSAL
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

On January 10, 1995, the SAIF Corporation submitted claimant's request for medical benefits relating to her December 22, 1963 industrial injury which resulted in permanent total disability. SAIF recommends that we dismiss the request for medical services, specifically, for a motorized wheelchair, as this claim does not fall within the Board's own motion jurisdiction.

ORS 656.245, the current statute which provides lifetime medical rights for compensable injuries, first became effective on January 1, 1966, and did not apply retroactively to injuries occurring before that date. See Or Laws 1965, ch 285 sec 23; William A. Newell, 35 Van Natta 629 (1983). Before that date, an injured worker was not entitled to medical services for a compensable injury unless the injury

occurred within the period from August 5, 1959, through December 31, 1965, and resulted in permanent total disability. Effective January 1, 1988, the legislature amended ORS 656.278 to grant the Board express own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. See Or Laws 1987, ch 884, 37. In addition, OAR 438-12-020(5) provides that "[a]n own motion claim for medical benefits does not include a claim for medical benefits relating to a compensable injury that occurred from August 5, 1959 through December 31, 1965 and resulted in an award of permanent total disability. Such claims shall be processed as a claim for medical services under ORS 656.245." Therefore, the Board, in its own motion authority, does not have jurisdiction over these claims.

Accordingly, we dismiss the request for medical benefits relating to claimant's 1963 industrial injury which resulted in permanent total disability.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH Q. QUIRK, Claimant
WCB Case No. 93-12514
ORDER ON REVIEW
Nancy FA Chapman, Claimant Attorney
Roberts, et al., Defense Attorneys

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

Claimant requests review of that portion of Referee Davis' order that upheld the insurer's partial denial of his left shoulder 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 had failed to establish compensability of his left shoulder condition as a consequence of his June 15, 1993 compensable right shoulder and thoracic injury. See ORS 656.005(7)(a)(A). We agree.

As the Referee noted, the only medical evidence in support of claimant's contention is Dr. Smith's "check-the-box" agreement with the statement that claimant's left shoulder condition was the "direct result" of the June 15, 1993 injury. Like the Referee, we find Dr. Smith's opinion unpersuasive because it is conclusory and lacking in explanation and medical analysis. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Accordingly, we agree with the Referee that claimant has failed to establish that his left shoulder condition is compensably related to his June 15, 1993 injury.

The insurer has moved to strike portions of claimant's reply brief on the grounds that claimant is arguing for the first time on review that he sustained a new compensable injury to his left shoulder on August 19, 1993. Because we conclude that claimant has failed to establish compensability of his left shoulder condition as a new injury occurring on August 19, 1993, we find it unnecessary to rule on the insurer's motion to strike.

At hearing, claimant contended that his left shoulder condition was a result of compensating for his right shoulder injury. On review, claimant continues to argue that his left shoulder condition is a compensable consequence of the June 15, 1993 injury, but alternatively contends his left shoulder condition, diagnosed as tendinitis, is the result of a new compensable injury sustained on August 19, 1993. Claimant further contends that this case presents an uncomplicated situation where medical evidence supporting causation is unnecessary. We disagree.

In Barnett v. SAIF, 122 Or App 279 (1993), the court reversed a Board order that upheld a back injury denial because no physician 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.

Here, we are not persuaded that the situation is uncomplicated. In this regard, claimant testified that he had symptoms in his left shoulder prior to August 19, 1993. (Tr. 30, 55). In addition, at hearing, claimant attributed his left shoulder condition to compensating for his compensable right shoulder condition rather than to an injury on August 19, 1993. (Tr. 66). Finally, claimant did not promptly report a left shoulder injury occurring on August 19, 1993 to his supervisor.

In light of such circumstances, we are not convinced that this is an uncomplicated situation. Accordingly, we conclude that medical evidence is necessary to establish that claimant's left shoulder condition is causally related to a discrete injury occurring on August 19, 1993. See Barnett v. SAIF, supra. Inasmuch as no medical evidence links claimant's left shoulder condition to an August 19, 1993 injury, we conclude that claimant has failed to establish compensability of this condition based on a new injury theory.

ORDER

The Referee's order dated April 4, 1994 is affirmed.

Board Member Hall dissenting.

I would agree that the causation of claimant's left shoulder condition presents a complex medical question. However, I would nonetheless find that claimant has presented medical evidence which establishes that his left shoulder condition is related to his June 15, 1993 compensable injury.

Dr. Smith has opined that claimant's left shoulder tendinitis is directly related to his June 15, 1993 compensable injury. (Exs. 9; 13). In an August 19, 1993 chart note, Dr. Smith indicated that claimant had a flare of tendinitis in the left shoulder secondary to trying to protect his compensable right upper extremity. In Exhibit 13, Dr. Smith opined that, to a reasonable medical probability, claimant's left shoulder tendinitis is the direct result of his June 15, 1993 compensable injury. Contrary to the majority's assessment of Exhibit 13 as an unexplained "check-the-box" agreement, it should be noted that the explanation for Dr. Smith's opinion is contained in the body of Exhibit 13 in accordance with our decision in Marta I. Gomez, 46 Van Natta 1654 (1994). In Gomez, we stated:

> "Whether referred to as a "check-the-box" report or a "concurrence," the persuasiveness of a medical expert's response depends on the explanation that corresponds to the expert's opinion. For very real and practical reasons (such as cost and time constraints), the explanation may have to be articulated or summarized by someone other than the doctor, or it may include citation to explanations and rationale already available elsewhere in the record, with the doctor then adopting that explanation * * *"

Claimant has the burden to establish compensability by a preponderance of the evidence. Here, Dr. Smith's opinion relating claimant's left shoulder condition to the June 15, 1993 injury, is unrebutted. Because this medical opinion is explained and stands unrebutted, I would find that claimant has satisfied his burden of proof. Therefore, I respectfully dissent.

In the Matter of the Compensation of
LELA M. KENFIELD, Claimant
WCB Case No. 91-08331
SECOND ORDER ON REMAND
Darris K. Rowell, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests abatement and reconsideration of our December 21, 1994 Order on Remand. In that order, on remand from the Court of Appeals, we found that, because no party had "wished" for Director review under ORS 656.327(1) of claimant's medical treatment claim, we had jurisdiction to determine whether the disputed medical services were palliative or curative. Based on the record as a whole, we further found that the medical treatment was palliative and not compensable under ORS 656.245(1)(b). Concluding that, therefore, the Director had exclusive jurisdiction of any possible further challenge to the denial of medical services, we also declined to address claimant's constitutional argument that finding her medical services not compensable deprived her of a "vested property interest", reasoning that, because there remained a possible procedure for Director review of the dispute, claimant's argument was premature.

Claimant first challenges our finding that the disputed medical treatment is palliative. Specifically, claimant contends that our order neglected to find that the treatment was rendered to only temporarily reduce her symptoms. Noting that Dr. Grant characterized claimant's treatment as "partially curative" and subsequently prescribed a home therapy program for "intermittent symptoms," claimant reasons that the disputed treatment was designed to reduce her symptoms indefinitely or permanently. Claimant further asserts that the treatments not only relieved her symptoms, but decreased her objective findings and increased her functional level.

In our prior order, we recognized Dr. Grant's retrospective description of claimant's treatment as "partially curative," as well as the references to decreased objective findings and increased functional level. We acknowledge that, standing alone, such statements could support a conclusion that the disputed treatment was rendered as a curative measure with permanent or indefinite consequences. Nevertheless, as explained in our previous order, in light of Dr. Grant's consistent conclusions regarding claimant's "medically stationary" status and physical restrictions, we are not persuaded that the treatment was rendered to permanently alleviate or eliminate claimant's low back condition. Instead, we continue to find that the treatment was rendered to temporarily reduce or moderate the intensity of claimant's otherwise stable low back condition. Consequently, we adhere to our prior conclusion that the treatment constitutes palliative care. See OAR 436-10-005(29).

Finally, claimant reasserts her constitutional argument that our order deprives her of "her vested right to palliative care." Specifically, claimant contends that, although ORS 656.245(1)(b) does provide a procedure for an attending physician to request approval of palliative care to enable the worker to continue working, claimant cannot avail herself of such an action because her attending physician "has not pursued this procedure" and claimant was not working. According to claimant, she "has in fact been denied a valuable property right because the Director has no authority to approve palliative care under the facts of this case" and, therefore, her constitutional argument is not premature and should be addressed by the Board. Claimant also adds that, if we find that the record is insufficiently developed with regard to this issue, she moves for remand to the Hearings Division or an acceptance by the Board of a stipulation to such "facts."

In effect, claimant requests us to determine the availability of a proceeding before the Director. We decline to do so. The statute clearly provides that "the attending physician may request approval from the Director" for the disputed medical treatment. Based on such language, we find that it is within the sole purview of the Director to decide that such an action cannot be sustained. In other words, if, in fact, claimant's attending physician chooses not to seek Director approval of the disputed medical

treatment, claimant's "constitutionality" challenge would become ripe for consideration by the Director.[1] Therefore, we continue to conclude that claimant's constitutional argument is premature.

We withdraw our December 21, 1994 order. On reconsideration, we adhere to and republish our December 21, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

It Is So Ordered.

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[1] Had we been inclined to consider claimant's "constitutional" challenge, we would have rejected such an argument. We would have based our conclusion on the following reasoning. The record, as presently developed, does not establish that claimant's attending physician has refused to comply with the Director approval procedure of ORS 656.245. Furthermore, since there has been no showing that such evidence regarding the attending physician was unobtainable with due diligence at teh time of the hearing, we would not find a compelling reason to remand the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

In the Matter of the Compensation of
ALVIN E. STRAESSLE, Claimant
WCB Case No. C4-03150
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bernt A. Hansen, Claimant Attorney
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On December 19, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition, with the following clarification.

The disposition states in part:

> "[C]laimant has applied for Preferred Worker Eligibility and was denied on November 17, 1994[. C]laimant wishes to preserve his right to seek Administrative Review of this denial of eligibility and exclude the CDA [sic] any prohibition against seeking director approval in the future. SAIF agrees that this CDA shall not bar claimant from making a claim against the Preferred Worker Program." (P. 2, Lns. 18-22).

Based on the aforementioned provision, it is apparent that claimant is presently ineligible for the Preferred Worker Program. Likewise, since claimant is currently seeking eligibility under the program, it is unlikely that claimant was employed by the SAIF Corporation's insured pursuant to the program. Under such circumstances, there would appear to be no reason for SAIF to seek prior approval of the CDA from the Director. In any event, should SAIF subsequently wish to seek reimbursement for some of the CDA proceeds from the Reemployment Assistance Reserve, such a request would be unsuccessful. See ORS 656.236(6).

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[1] Board Member Gunn expresses some confusion regarding the insertion of the "preferred worker eligibility" provision into the CDA. The funds, if any, derived from the "preferred worker" dispute resolution process are solely within the jurisdiction of the Director. Moreover, considering the lack of prior Director approval, the "preferred worker eligibility" provision seems oblique and unnecessary. In expressly addressing the provision, I wish to emphasize that our discussion of such a matter is dictum.

Accordingly, based on the aforementioned interpretation, we find that the parties' CDA is in accordance with the terms and conditions prescribed by the Director. Therefore, the CDA is approved. See ORS 656.236(1); OAR 438-15-052(1). An attorney fee of $2,500, payable to claimant's counsel, is approved.

In the event that our interpretation is inconsistent with the intentions of the parties, they may move for reconsideration. However, to be considered, the motion must be filed within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

January 20, 1995 Cite as 47 Van Natta 56 (1995)

In the Matter of the Compensation of
MARIE E. KENDALL, Claimant
WCB Case No. 93-10201
ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
James Thwing (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our December 29, 1994 order that: (1) concluded that SAIF had no authority to terminate claimant's temporary disability benefits; and (2) awarded a 25 percent penalty for SAIF's unreasonable termination of temporary disability benefits. SAIF contends that our order contradicts William J. Wilson, 43 Van Natta 288 (1991), rev'd on other grounds, Roseburg Forest Products v. Wilson, 110 Or App 72 (1991), on remand 44 Van Natta 724 (1992), and, in any event, the penalty was not warranted. Claimant's response, which objects to SAIF's request on procedural and substantive grounds, has also been received.

In order to further consider this matter, we withdraw our December 29, 1994 order. After completing our reconsideration, we shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THERESA J. LESTER, Deceased, Claimant
WCB Case No. TP-90061
THIRD PARTY DISTRIBUTION ORDER ON REMAND
Goldberg & Mechanic, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

This matter is before the Board on remand from the Court of Appeals. Urness v. Liberty Northwest Insurance Corporation, 130 Or App 454 (1994). The court reversed our prior order, Theresa J. Lester, 45 Van Natta 873 (1993), which in resolving a dispute concerning a "just and proper" distribution of third party settlement proceeds under ORS 656.593(3), found that a distribution in accordance with ORS 656.593(1), (the third party judgment distribution scheme) was "just and proper." Concluding that we erred in automatically applying the distribution scheme of ORS 656.593(1), the court has remanded for reconsideration.

The facts have been recited in our prior orders, as well as the court's previous decisions. Urness v. Liberty Northwest, supra; Liberty Northwest Ins. Corp. v. Golden, 116 Or App 64 (1992), rev den 315 Or 442 (1993); Theresa J. Lester, supra, Theresa J. Lester, 43 Van Natta 338 (1991). We incorporate those findings into this order. For background purposes, we offer the following summary.

Liberty Northwest accepted the deceased worker's claim and has provided benefits to the decedent's surviving husband and their two minor children. Claimant, the personal representative for the estate, initiated a third party action. Liberty Northwest did not object to a $300,000 third party settlement. However, it sought reimbursement of its claim costs for each beneficiary (the decedent's estranged husband and children) from the entire settlement. In addition to its actual claim costs incurred at the time of the third party settlement, Liberty Northwest's future lien costs are as follows: decedent's husband - $113,186; Sarah Lester - $13,903 and Jeromy Lester - $12,929.

Following a hearing, a probate court order apportioned the settlement proceeds. With the decedent's husband's concurrence, the probate court allocated 50 percent of the settlement to each child, with the estranged husband receiving nothing. (The decedent and her husband were separated at the time of her death, she had twice filed dissolution of marriage petitions, the children had solely resided with her, and the husband agreed "they suffered the most damages by losing their mother.")

In our initial order, we concluded that, since the claim costs for each specific beneficiary could be identified, it was "just and proper" that the lien for each beneficiary be recovered solely from that beneficiary's share of the third party settlement. Theresa J. Lester, 43 Van Natta 338 (1991). We reasoned that to do otherwise would permit a paying agency to receive reimbursement for claim expenditures related to a particular beneficiary (surviving spouse) from other beneficiaries' (children) portions of the settlement. Because none of the settlement proceeds were allocated by the probate court to the decedent's husband, we determined that it was "just and proper" for Liberty Northwest to recover reimbursement from the settlement proceeds for its actual and future claim costs related to decedent's children's benefits.

The court reversed our decision. Liberty Northwest v. Golden, supra. Reasoning that the probate court's order distributed only the amount of settlement proceeds remaining after satisfaction of the paying agency's share, the Golden court concluded that the probate court could not determine the distribution of settlement proceeds to the paying agency. Inasmuch as we used the wrong legal standard in determining a "just and proper" distribution of settlement proceeds under ORS 656.593(3), the court remanded for reconsideration.

On remand, we held that, "consistent with our longstanding policy of avoiding distributions on an ad hoc basis," we would apply the distribution scheme of ORS 656.593(1) for judgment proceeds in determining a "just and proper" distribution of settlement proceeds under ORS 656.593(3). Theresa J. Lester, 45 Van Natta 873 (1993). Consequently, after distribution of claimant's attorney fee, litigation expenses, and claimant's 1/3 share, we directed claimant's counsel to allocate the remaining balance of settlement proceeds to Liberty Northwest until it recovered reimbursement for its actual claim costs as of December 1, 1990 plus $140,018 (decedent's husband's "surviving spouse" projected costs of $113,186 + Sarah's projected costs of $13,903 + Jeromy's proposed costs of $12,929).

The court reversed our decision. Urness v. Liberty Northwest, supra. Reasoning that distributions on an "ad hoc" basis are exactly what ORS 656.593(3) contemplates in the distribution of settlement proceeds, the court held that each case should be judged on its own merits when determining a "just and proper" distribution. Although either one of our decisions might have been a "just and proper" resolution, the court determined that the method we had used in reaching our decisions was improper.

Consequently, the court has remanded for us to exercise our discretion to arrive at a "just and proper" distribution of settlement proceeds under ORS 656.593(3). Pursuant to the court's mandate, we proceed with our reconsideration.

As detailed in our prior orders, at the time of her death, the decedent had not lived with her husband for approximately one year. Moreover, the decedent had filed two separate marriage dissolution petitions, the most recent having been dismissed a few months before her death. Notwithstanding this dismissal, the decedent had intended to proceed with the dissolution of the marriage at the time of her death.

Since the couple's separation, the decedent's two minor children had resided only with her. She was actively involved in each of their personal lives. As a result of their mother's premature demise, the children's emotional and financial loss was profound.

Based on the couple's extensive history of marital discord and estrangement (including the decedent's active divorce plans), Mr. Chadsey (the third party insurer's attorney) determined that any jury award of damages resulting from the decedent's death would have been limited to the loss suffered from the minor children. The foundation for this opinion is further supported by reports which were developed for consideration at the probate court proceeding.

In light of the aforementioned evidence, we are persuaded that the entire $300,000 in settlement proceeds were designed to compensate the decedent's minor children for their losses. Consequently, we consider it "just and proper" for Liberty Northwest to recover its actual and future claim costs for the two children. See ORS 656.593(3). Likewise, because no portion of the third party settlement represented compensation to the decedent's estranged husband, we do not consider it "just and proper" for Liberty Northwest to receive any reimbursement for its "surviving spouse" claim costs. Id.

Accordingly, on reconsideration, we find the following distribution of third party settlement proceeds to Liberty Northwest to be "just and proper" under ORS 656.593(3). Liberty Northwest shall recover its actual claim costs for the two children incurred as of December 1, 1990. In addition, Liberty Northwest shall also recover projected claim costs for the children's benefits ($13,903 for Sarah and $12,929 for Jeromy). Claimant's attorney is directed to forward the aforementioned sums to Liberty Northwest. The remaining balance of settlement proceeds shall be distributed to the children in a manner consistent with the probate court's order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA A. COOPER, Claimant
WCB Case No. 93-04711
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Peterson's order that: (1) declined to assess a penalty pursuant to ORS 656.262(10) or an attorney fee pursuant to ORS 656.382(1) for the insurer's allegedly unreasonable claim processing regarding a medical bill; and (2) did not award an attorney fee under ORS 656.386(1) when the insurer finally paid the unpaid bill prior to the scheduled hearing. In its brief, the insurer contends that since the sole issue is a penalty under ORS 656.262(10), jurisdiction lies with the Director. On review, the issues are jurisdiction, penalties, and attorney fees. We reject the insurer's jurisdictional argument, and affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation. In March 1993, when the insurer received the resubmitted unpaid November 1992 medical bill, it again returned the bill to the physician. In doing so, the insurer explained that "no palliative care authorized." Thereafter, claimant requested a hearing.

In May 1993, the physician resubmitted the November 1992 bill and the insurer once again returned the bill accompanied by the insurer's written statement that "claim denied / copy of denial attached." (The reference to "denial" apparently pertains to the parties' November 1992 Disputed Claim Settlement for neck, upper back, shoulder, and psychological conditions.)

In August 1993, the physician again resubmitted the unpaid bill with a notation that it pertained to claimant's compensable low back condition. Shortly thereafter, prior to the parties' hearing, the bill was paid by the insurer.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant contended that she was entitled to an attorney fee award under ORS 656.386(1) for securing payment of the medical bill. In addition, she sought penalties and attorney fees for the insurer's allegedly unreasonable claim processing. Finding that the insurer's conduct was reasonable and appropriate, the Referee declined to award penalties or attorney fees.

On review, the insurer asserts that the Referee properly declined to award an attorney fee under ORS 656.386(1) because the disputed medical bill did not involve the "compensability" of claimant's medical services claim for her compensable low back condition. In support of its position, the insurer relies on the Court of Appeals decision in SAIF v. Allen, 124 Or App 183 (1993). Nevertheless, that decision has been reversed by the Supreme Court. See SAIF v. Allen, 320 Or 192 (1994).

After reviewing the text and context of ORS 656.386(1), the Court concluded that a claim for medical benefits is a "claim for compensation" under the statute. The Court further held that the Board had not erred in concluding that the carrier's conduct constituted a denial of the claim where the carrier had neither accepted, denied, nor paid the medical bills within 90 days and, in responding to claimant's hearing request, the carrier had replied that the bills had been timely paid. SAIF v. Allen, supra. Based on the carrier's conduct, the Allen Court determined the carrier's denial was not confined to the issue of the amount of compensation or extent of disability. Id.

Here, the insurer neither accepted, denied, nor paid the medical bill within 90 days. In fact, the insurer acknowledges that the bill was untimely paid. (Respondent's Brief, Page 2, Lines 16 - 17). Moreover, on two separate occasions, the insurer returned the medical bill with comments suggesting that the bill would not be paid. (In March 1993, stating no palliative care authorized and in May 1993, stating "claim denied / copy of denial attached.")

Under these circumstances, we conclude that the insurer's conduct constituted a denial of claimant's medical services claim not confined to the amount of compensation or extent of disability. Since the insurer paid this medical bill subsequent to claimant's April 1993 hearing request and prior to the December 1993 hearing, we find that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. Accordingly, claimant is entitled to an insurer-paid attorney fee award. 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 pre-hearing services concerning the insurer's payment of the $45 medical bill is $50, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the medical bill issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. In addition, the record indicates that the insurer eventually paid the disputed medical bill on its own initiative rather than as a result of claimant's attorney's efforts. We further note that claimant is not entitled to an attorney fee for services related to securing her attorney fee award at hearing. See Amador Mendez, 44 Van Natta 736 (1992).

Finally, considering the timing of the physician's medical bill (issuing shortly after the parties' disputed claim settlement which resolved the compensability of several conditions other than claimant's low back condition), as well as the physician's ongoing failures to expressly indicate that the bill was related to claimant's compensable low back condition, we do not find the insurer's conduct to have been unreasonable.[1] Consequently, we agree with, and adopt, the Referee's conclusion that claimant is not entitled to penalties under ORS 656.262(10) or an attorney fee award under ORS 656.382(1).[2]

ORDER

The Referee's order dated January 6, 1994 is reversed in part and affirmed in part. Claimant's attorney is awarded a $50 attorney fee under ORS 656.386(1), payable by the insurer. The remainder of the Referee's order is affirmed.

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[1] Member Gunn wishes to reiterate that better, or at least in this case some, communication between the claims examiner and claimant's attorney could have prevented the time and money spent on this matter.

[2] We reject the insurer's argument that jurisdiction rests with the Director because this dispute involves solely a penalty assessment. In addition to seeking a penalty under ORS 656.262(10), claimant requested attorney fee awards pursuant to ORS 656.382(1) and ORS 656.386(1). Because such attorney fee requests constitute a "question concerning a claim," the Hearings Division was the proper forum to resolve the disputes. James V. Johnston, 46 Van Natta 1813 (1994).

Board Member Haynes specially concurring.

Because I am bound by the Courts' interpretation and application of ORS 656.386(1) in SAIF v. Allen, 320 Or 192 (1994) and in SAIF v. Blackwell, 131 Or App 519 (December 7, 1994), I concur in the result reached by the majority. However, I write separately to address an incongruity between the above case law and the Director's rule, OAR 436-10-100(9).

OAR 436-10-100(9) provides that an insurer:

> "shall pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-10-090(6) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form may be returned to the medical provider for correction and resubmission. If an insurer returns such billings, it must do so within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing to the provider and the date the insurer receives the corrected billing, shall not apply toward the 45 days within which the insurer is required to make payment."

This rule provides an exception to the strict standard, of 90 day in which to accept or deny a claim, relied on by the Court in Allen, 320 Or at 211-212. In this case, the initial bill submitted by the physician was in accordance with OAR 436-10-090(6), but did not clearly show that the rendered treatment was related to the accepted condition. Pursuant to OAR 436-10-100(9), the insurer could defer the medical bill claim while seeking clarification of the bill without risking allegations of untimely claims processing. The insurer, then, paid the bill a week after it received the corrected bill. Thus, under the Director's rule, the insurer timely accepted the medical bill.

Although there is an apparent conflict between application of the Director's rule and the case law interpreting the attorney fee issue (in particular, ORS 656.262(6) and 656.386(1)), the statutes rather than the rule control. Forney v. Western States Plywood, 66 Or App 155 (1983). Given the case law precedent, and given the insurer's concession that it paid the medical bill late, claimant's attorney is entitled to a fee in this case.

January 23, 1995 Cite as 47 Van Natta 61 (1995)

In the Matter of the Compensation of
RICHARD L. ELSEA, Claimant
WCB Case Nos. 94-00503, 93-12428 & 93-13294
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Safeco Insurance Company requests review of those portions of Referee Hazelett's order that: (1) set aside its denial of claimant's injury / occupational disease claim for a left knee condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for the same condition. On review, the issues are compensability and responsibility.

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

During the 1970's, when claimant was in high school, he experienced some left knee pain. Claimant also has a compensable 1984 left knee injury claim. In December 1991, claimant fell at work and injured his right knee.

From 1985 through January 1993, claimant worked for Safeco's insured, Swan Island Sheet Metal Works. From March 1993 through April 9, 1993, claimant worked for Libery's insured, Helser Industries. On May 21, 1993, claimant sought treatment for left knee pain.

The Referee found claimant's left knee condition compensable and assigned responsibility to Safeco. On review, Safeco asserts that the medical evidence is insufficient to establish compensability and, under the last injurious exposure rule, Safeco is not liable for the left knee claim.

We first address the compensability issue. Medical evidence regarding causation is slight. Based on X-rays, claimant's treating orthopedic surgeon, Dr. Peterson, found degenerative changes in the left knee. (Exs. 18,22). According to Dr. Peterson, the degenerative changes were "due to chronic tear of the cartilage or chronic mild rotatory instability such as that associated with anterior cruciate ligament injury." (Ex. 25).

Examining physicians Dr. Kiest, orthopedic surgeon, and Dr. Gardner, neurologist, also found "degenerative change involving the medical compartment of his knee with some secondary degenerative changes in the patellar area." (Ex. 24-3). The panel termed the diagnosis "somewhat inadequate" since they lacked X-rays or MRI findings of the left knee. (Id.)

With regard to causation, the panel found that the "left knee problem is work related." Specifically, the panel explained that the condition was not due to a single injury but "an accumulative injury caused by the constant up and down work on various surfaces, particularly his kneeling activities." (Id.) The panel further stated that claimant had a "legitimate left knee problem probably basically degenerative in nature, historically aggravated in a major way by his work activities and is

more probably related to his 4+ year exposure at Swan Island than it is to his more recent 8 month exposure to other employers." (Id. at 4).

Dr. Peterson concurred with the report. (Ex. 27).

Safeco asserts that the report from Drs. Kiest and Gardner is entitled to little weight because the panel was not aware of claimant's left knee symptoms that he experienced in high school and the panel couched its opinion in terms of possibility rather than probability.

There was evidence that claimant related to Dr. Peterson that he had experienced intermittent left knee symptoms since high school. (Exs. 7-2, 7-4). The panel's report does not contain such a history. However, inasmuch as Dr. Peterson was aware of claimant's statement and nevertheless concurred with the panel's opinion that the left knee condition was work-related, we find the omission to be insignificant.

We are also persuaded that the panel's opinion regarding causation was in terms of probability. Although the panel noted that it could not "definitively answer all of these questions [posed by the carrier]" and "some [answers] are based on only supposition," when discussing causation, the panel stated that claimant's "left knee problem is work related," "his condition is related to work activities," and claimant "has a legitimate left knee problem basically degenerative in nature, historically aggravated in a major way by his work activities[.]" (Ex. 24-3, 24-4) (Emphasis added). In short, we find no indication that the panel's answers regarding causation were based on supposition. We find the report reliable and persuasive.

Based on the panel's description of claimant's left knee condition as "an accumulative injury" rather than due to a single injury, we further find that the condition is most appropriately analyzed as a claim for occupational disease. See Morrow v. Pacific University, 100 Or App 198, 202-03 (199); Valtinson v. SAIF, 56 Or App 184 (1982). Therefore, claimant must show that work activities were the major contributing cause of his left knee condition. See ORS 656.802(2). Based on the panel's report and Dr. Peterson's concurrence, claimant satisfied that burden.

Consequently, we agree with the Referee that claimant proved compensability of his left knee condition. However, we modify the Referee's order to clarify that claimant's claim is an occupational disease.

We turn to the responsibility issue. According to Safeco, responsibility should be determined pursuant to the last injurious exposure rule (LIER). Based on an application of that rule, Safeco asserts that responsibility would rest with a subsequent employer. We conclude that Safeco is responsible for the claim regardless of whether the rule is applicable. We base this conclusion on the following reasoning.

Where actual causation with respect to a specific identifiable employer is proven, it is not necessary to rely on judicially created rules of assignment pertaining to successive employments in determining responsibility. See Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade v. Starbuck, 296 Or 238, 244-45 (1984); Eva R. Billings, 45 Van Natta 2142, 2143 (1993). Here, because actual causation was established against a particular employer (Safeco's insured), we find that LIER does not apply.

The medical evidence concerning the relative contribution to claimant's left knee condition from his work at Swan Island and Helser Industries consists of the report from the panel of Dr. Kiest and Dr. Gardner. That report found that "it appears that this man has spent more time on his knees and working hard at Swan Island Sheet Metal than he has in the 8 months that he has been working for other employers[.]" (Ex. 24-3). The panel further stated that "the left knee condition is not materially affected by his heavy work at Helcer [sic] Industries as much as it has been by the previous 4+ year exposure at Swan Island" and the "left knee condition by his history was caused by his Swan Island Sheet Metal exposure." (Id.) This history was consistent with claimant's testimony that his work activities for Safeco's insured required more time on his knees as compared to his subsequent work activities and that he was experiencing continuous left knee complaints prior to leaving his work with Safeco's insured. (Tr. 8, 9 & 16). Finally, as noted above, Drs. Kiest and Gardner found that claimant's condition "is more probably related to his 4+ year exposure at Swan Island than it is to his recent 8 month exposure to other employers." (Id. at 4).

Based on this medical and lay evidence, we find that claimant's work activities at Swan Island (Safeco's insured) were the major contributing cause of his left knee condition. Because we conclude that claimant proved the actual cause of his left knee condition, we do not apply LIER. Eva R. Billings, supra. Accordingly, we conclude that Safeco is responsible for the claim. Id.

Alternatively, even if we applied LIER, we would continue to find Safeco responsible for the claim. Under LIER, the potentially causal employer at the time of disability is assigned initial liability for the disease. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not experience time loss due to the condition before seeking medical treatment, the date he first seeks medical treatment for the condition. Timm v. Maley, 125 Or App 396, 401 (1993). The dispositive date is the date claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Here, claimant first sought treatment for his left knee condition in May 1991. (Ex. 7-2). Although the appointment was scheduled as a follow-up examination for his right knee condition, claimant also registered left knee complaints (attributing them to a prior off-work injury). (Id.) Despite this lack of an initial diagnosis for claimant's left knee condition resulting from his work activities, Drs. Keist and Gardner subsequently found that the condition was "more probably related" to claimant's work activities for Safeco's insured rather than his subsequent work activities.

In light of such circumstances, we find that responsibility is initially assigned to Safeco because claimant first sought treatment for his left knee condition while he was working for Safeco's insured. Therefore, in order to shift responsibility to a later employer, Safeco must prove that claimant's later employment actually contributed to a worsening of his left knee condition. Timm v. Maley, supra; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Spurlock v. International Paper Co., 89 or App 461, 465 (1988).

As previously discussed, Drs. Keist and Gardner attributed claimant's left knee condition to his more arduous work activities for Safeco's insured. Moreover, these physicians concluded that claimant's condition was "not materially affected" by his subsequent work activities. Based on this opinion, we are not persuaded that claimant's left knee condition was actually worsened by his later employment exposure. Consequently, even if LIER was applicable, responsibility would remain with Safeco.

Claimant's attorney is entitled to an assessed fee for prevailing over Safeco's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 5, 1994 is affirmed, as modified. Safeco is directed to process claimant's left knee claim as an occupational disease. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by Safeco.

In the Matter of the Compensation of
TY M. HAWKINS, Claimant
WCB Case No. 93-02146
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Tooze, Shenker, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee Lipton's order that: (1) declined to award temporary disability compensation; (2) declined to assess penalties and attorney fees for an allegedly unreasonable aggravation denial; and (3) declined to assess penalties and attorney fees for an allegedly unreasonable "de facto" denial of an aggravation claim. On review, the issues are temporary disability compensation, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. At hearing, the insurer conceded that claimant had established a compensable aggravation as of the date claimant undergoes the surgery recommended by Dr. Franks, treating neurosurgeon. (Tr. 7-8). As of the date of the hearing, that surgery had not been performed. The insurer maintained its aggravation denial to the extent the aggravation was contingent on some event before surgery. (Tr. 8).

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Compensation

At hearing, the insurer conceded that claimant would have a compensable aggravation claim as of the date he undergoes the surgery recommended by Dr. Franks, treating neurosurgeon. (Tr. 7-8). This concession complies with the insurer's attorney's statement in an October 6, 1993 letter to claimant's attorney that the insurer agreed "to reopen the claim for aggravation as of the date [claimant] submits to surgery." (Ex. 103-1). As of the date of the hearing, that surgery had not been performed. The Referee noted that the parties agreed that claimant has suffered an aggravation; however, he declined to award temporary disability compensation on the ground claimant had not established that he was in the work force. While we agree that claimant is not entitled to the temporary disability benefits that he claims, we base our decision on the following reasoning.

In this case, in order to determine when claimant is entitled to temporary disability benefits, we must determine when claimant established a compensable aggravation claim. Every aggravation claim has two components: causation and worsening. Both must be established unless one is conceded. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992), aff'd by equally divided court Fitzpatrick v. Beaverton Welding, 127 Or App 560 (1994). Here, both components were conceded, at least as of a certain point in time; that is, the insurer conceded that claimant will have a compensable aggravation claim when he undergoes the recommended surgery.[1]

Therefore, the question presented here is whether claimant's condition worsened prior to the time that the insurer concedes that it will worsen. On this record, we conclude that it has not.

To prove a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsening of his low back condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396, 401 (1986). Thus, the worsening element is actually comprised of two components: a medical component (increased symptoms or a worsened underlying condition) and a legal component (diminished earning capacity). Finally, because claimant received a previous permanent disability award for his condition, he must establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

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[1] Even if the insurer did contest the causation component, we would find, based on the record, that claimant's current L5-S1 condition is caused by the work injury. (Exs. 85, 87).

The "base line" for determining whether the compensable condition has worsened is the evidence describing the claimant's "medically stationary" condition at or before the last award or arrangement of compensation (i.e., the last time the claimant was medically and legally determined to be medically stationary). Lindon E. Lewis, 46 Van Natta 237 (1994), aff'd mem Morgan Manufacturing/Nicolai Door v. Lewis, 131 Or App 267 (1994).

Claimant's claim was last closed by a March 26, 1992 Determination Order, which awarded only temporary disability compensation. Claimant was declared, by that order, to be medically stationary (as of January 29, 1992). (Ex. 12). Claimant requested reconsideration of that Determination Order and was subsequently awarded 17 percent unscheduled permanent disability and 5 percent scheduled permanent disability by a November 13, 1992 Order on Reconsideration. A prior referee's March 4, 1993 order affirmed the November 13, 1992 Order on Reconsideration. However, claimant's medically stationary date and status were neither challenged nor modified in the "extent" appeal process. Accordingly, per our rationale in Lewis, we conclude that the last award or arrangement of compensation (i.e., the last time claimant was legally and medically determined to be medically stationary) was the November 13, 1992 Order on Reconsideration. Thus, in order to establish a compensable aggravation claim, claimant must prove that his compensable low back condition worsened since the November 13, 1992 Order on Reconsideration. Lewis, supra; I. Albert Johnson, Sr., 46 Van Natta 974 (1994). Claimant alleges that his condition worsened in December 1992.

On May 26, 1993, Dr. Franks recommended decompression surgery on the right at L5-S1. (Ex. 91). Dr. Franks' recommendation came after he fully considered claimant's functional component and concluded that, notwithstanding this functional component, the diagnostic studies confirmed the need for the recommended surgery. (Exs. 84, 89A, 91, 92, 94, 97). Dr. Franks also recommended that Dr. Gripekoven, orthopedist, examine claimant and provide a second opinion regarding the need for surgery. After examining claimant and reviewing the records, Dr. Gripekoven opined that, despite claimant's functional problems, the recommended surgery was medically indicated. (Ex. 93).

The insurer requested Director review regarding whether the recommended surgery was reasonable and necessary. Dr. Purtzer, neurologist, performed a record review for the Director. (Ex. 100). By order dated October 1, 1993, the Director concluded that the proposed surgery was reasonable and necessary. (Ex. 102). That order was not appealed and has become final by operation of law.

The insurer concedes that, by virtue of claimant's need for the recommended surgery, he will have a compensable aggravation claim as of the date he actually undergoes the surgery. However, on review, the insurer focuses on whether claimant's condition pathologically worsened since the last arrangement of compensation and argues that it has not yet worsened, and will not "worsen" until surgery.

Given the insurer's concession that, at the time claimant undergoes surgery he will have a compensable aggravation claim, we do not find persuasive the insurer's argument regarding a lack of medical worsening. The L5-S1 condition that requires surgery will be the same at the time claimant undergoes the recommended surgery as it was at the time the surgery was recommended. The only change will be that the surgery is anticipated to improve claimant's condition. Under these circumstances, the only reasonable interpretation of the insurer's concession is that it establishes the medical worsening component of claimant's aggravation claim.

However, the question remains as to whether claimant has established the legal worsening component (diminished earning capacity) prior to the date he undergoes the recommended surgery. Claimant argues that the record as a whole establishes that he has diminished earning capacity and that he is entitled to temporary disability compensation from the date of Dr. Frank's December 1992 reports. We disagree.

At the time of the March 26, 1992 Determination Order, claimant was receiving both long term disability from the employer and Social Security disability for his low back condition. At that time, Dr. Harris, claimant's former treating physician, opined that claimant was capable of performing medium work with restrictions and agreed that claimant was capable of performing his at-injury job, which was considered light work. (Exs. 65, 67, 70).

Claimant requested reconsideration of the March 26, 1992 Determination Order. Dr. Bald, orthopedist, was appointed by the Director to serve as a medical arbiter for the reconsideration process. Following a November 3, 1992 examination, Dr. Bald determined that claimant was capable of performing light work, with limitations on stooping, twisting, climbing, and crawling. (Ex. 80-3). The November 13, 1992 Order on Reconsideration awarded claimant permanent partial disability (scheduled and unscheduled) based upon those impairment findings.

Claimant's condition did not change between the Determination Order, the arbiter's examination, and the Order on Reconsideration. His condition remained medically stationary throughout that period. Based on Dr. Bald's thorough and persuasive report, we find that, at the time of the last arrangement of compensation, claimant was ultimately adjudged to be capable of light work with restrictions. See Lindon Lewis, supra; J. Albert Johnson, supra.

On December 16, 1992, claimant began treating with Dr. Franks, on referral from Dr. Harris. (Ex. 84). Dr. Franks was aware that claimant was receiving Social Security disability for his low back condition. (Ex. 84-1). It is not apparent that Dr. Franks was aware that claimant had been determined capable of performing light work, with restrictions. Dr. Franks provides no opinion as to claimant's physical capacity to work.

In fact, Dr. Bald's November 3, 1992 report is the last medical evidence regarding claimant's physical capacity. Claimant continued to receive long term disability and Social Security disability at that time. Dr. Gripekoven stated that, given claimant's "significant functional problems," if claimant underwent the recommended surgery, his pain problem might be improved "but his work capacity would not be affected by repeat surgery. In other words, he would still be compromised for heavy physical labor." (Ex. 93-4). However, this statement does not support claimant's claim because Dr. Gripekoven does not give an opinion as to what claimant is capable of doing, he only notes that claimant still will not be capable of performing heavy labor after surgery. Again, claimant was only capable of performing light work with restrictions at the time of his last award.

Claimant argues that his testimony and his reports to Dr. Franks that he was unable to work or live with his pain support a finding that he has established a diminished earning capacity before the date of the proposed surgery. However, the medical record is replete with concerns about claimant's functional and motivational problems. (Exs. 89A, 91, 93, 94, 97, 100). Therefore, we do not find claimant's reports of his physical capabilities or inability to work persuasive.

Claimant asks us to infer that the surgery request itself establishes diminished earning capacity. However, we are unable to make such an inference on this record. While a request for surgery may, depending on the accompanying facts, evidence a change in earning capacity, a surgery request, in and of itself, does not necessarily establish diminished earning capacity sufficient to trigger payment of temporary disability benefits. For example, where surgery is requested but a worker continues working and earning full wages up until the date of the surgery, there would be no payment of temporary disability benefits until the worker undergoes the surgery.

Finally, Dr. Franks stated that, after the surgery and a reasonable recovery period, he would expect claimant to return to some type of work. (Exs. 94-2, 97). Claimant asks us to infer from this statement that claimant is unable to work prior to the recommended surgery. However, that inference does not necessarily follow from Dr. Franks' statement. Dr. Franks considered that claimant was retired and on Social Security disability because of his low back condition. (Ex. 84-1). However, there is no indication that he was aware that claimant was determined capable of performing light work with restrictions approximately six weeks before claimant first treated with him. (Exs. 80, 81, 84). Furthermore, Dr. Franks' statement was made in regard to concerns about claimant's functional problems, no reference was made to claimant's current capabilities. (Exs. 94-2, 97).

We realize that the fact claimant was not working at the time of the surgery recommendation does not preclude him from establishing a diminished earning capacity on the record as a whole. For example, a worker could be unemployed but the record might establish that he is less able to work than he or she was at the time of the last arrangement of compensation. However, here, the record as a whole does not meet claimant's burden of proof. Claimant has not established a diminished earning capacity prior to the time the insurer concedes he will have a compensable aggravation claim, i.e., when he undergoes the recommended surgery.

Penalties and Attorney Fees for Alleged "De Facto" Denial

The Referee found that the insurer did not "de facto" deny claimant's aggravation claim. We agree.

Under ORS 656.262(6), a carrier must accept or deny a claim within 90 days of notice of the claim. Claimant may make a claim for aggravation under ORS 656.273(2) or by the submission of a physician's report under ORS 656.273(3). When proceeding under the latter provision, the physician's report must contain prima facie evidence in the form of objective findings that claimant's compensable condition has worsened. Herman M. Carlson, 43 Van Natta 963, 964 (1991), aff'd Carlson v. Valley Mechanical, 115 Or App 371 (1992).

Claimant argues that Dr. Franks' reports dated December 16, 1992, and December 30, 1992, constitute an aggravation claim. We disagree. Although Dr. Franks' December 30, 1992 report related claimant's current condition to the work injury, neither report contained prima facie evidence that claimant's condition had medically worsened.

In a May 26, 1993 report, Dr. Franks acknowledged his concerns about claimant's motivation; however, he recommended decompression surgery on the right at L5-S1. (Ex. 91). We find that Dr. Franks' May 26, 1993 report is the first medical report containing prima facie evidence in the form of objective findings that claimant's condition had worsened (vis a vis the proposed surgery). Thus, this report constituted a claim for aggravation. In addition, claimant's attorney made an aggravation claim under ORS 656.273(2) with a letter dated June 28, 1993. (Ex. 92A).

On July 12, 1993, the insurer issued a denial of claimant's aggravation claim. Thus, the insurer denied the aggravation claim within 90 days of notice of the claim, whether that notice is calculated from Dr. Franks' May 1993 report or claimant's attorney's June 1993 letter. Therefore, the insurer did not "de facto" deny any aggravation claim and no penalties or attorney fees are due on that basis.

Penalties and Attorney Fees for Alleged Unreasonable Denial

The Referee did not find that the insurer's July 12, 1993 aggravation denial was unreasonable. We agree.

The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

On July 12, 1993, the insurer denied claimant's aggravation claim on the grounds that he had not shown a worsened condition, supported by objective evidence, that made him less able to work. (Ex. 95). Based on the available evidence, we find that the insurer had a legitimate doubt as to its liability for the aggravation claim.

In December 1992 reports, Dr. Franks compared radiographic tests from 1989, 1991, and 1992 and opined that the L5-S1 level looked about the same, with a persistent asymmetrical bulge at L5-S1 on the right. (Ex. 85). He also opined that claimant's current condition consisted of some "old" problems at L5-S1 and some "new" problems at L3-4, which he opined were not related to the work injury. Id. He recommended further diagnostic studies. (Ex. 87).

On May 26, 1993, although acknowledging concern about claimant's motivation, Dr. Franks recommended decompression surgery at L5-S1 on the right. (Ex. 91). In addition, Dr. Franks noted that he had earlier made a verbal communication to the insurer's attorney recommending against surgery. He explained that this change in opinion regarding the need for surgery was based on claimant's continuing radicular pain into the right lower extremity and Franks' reappraisal of the situation after a January 26, 1993 CT scan. (Ex. 91). This January 1993 CT scan had been evaluated three times, with only the third evaluation indicating the possibility of a bony spur impinging on the right nerve root at L5-S1. (Exs. 88, 88A, 88B).

In making this recommendation for surgery, Dr. Franks noted claimant's continuing right leg pain and indicated that once this surgery was performed, one could say that "all this [sic] is reasonable to be done has been done." (Ex. 91). On June 30, 1993, Dr. Franks opined that the 1993 neuroimaging studies were "strongly suggestive of ongoing nerve root compression[.]" (Ex. 94-2).

Dr. Franks did not opine that claimant's condition worsened. Although "magic words" are not necessary, we find that Dr. Franks' various opinions establish legitimate doubt as to whether claimant's condition had compensably worsened. This is especially true since Dr. Franks' comparison of pre-reconsideration order studies and post-reconsideration order studies indicate that the L5-S1 condition remained the same. In addition, Dr. Franks' reports speak in terms of "continuing" and "ongoing" problems, which would not indicate a worsened condition. Furthermore, although Dr. Franks eventually recommended surgery, he did not opine that the need for surgery was the result of a worsened condition rather than an ongoing condition.

Moreover, Dr. Franks never opined that claimant's condition had symptomatically worsened. Although Dr. Franks noted that claimant reported he could not live with his pain, Dr. Franks also expressed concern over claimant's functional component. (Exs. 91, 94). Given this, the insurer had legitimate doubt as to whether claimant's pain reports by themselves established a symptomatic worsening.

Dr. Gripekoven, examining orthopedist, opined that the major contributing cause of claimant's ongoing problems and need for surgery is the work injury. (Ex. 93-4). He noted that claimant reported consistent back and right leg pain since the work injury and that changes at the L5-S1 level were noted on the initial 1989 MRI. (Ex. 93-3, -4). He stated that if claimant's subjective complaints of increasing back and right leg pain were accurate, they would correlate with the diagnostic imaging changes and the proposed surgery would be medically appropriate. He was also concerned about claimant's functional component. Id. However, he did not opine that claimant's underlying condition had worsened. In addition, to the extent that he commented on claimant's increased symptoms, he did so in terms of a possibility, which is insufficient to carry claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981).

Given all of the above, we find that the insurer had legitimate doubt as to its liability. Therefore, we do not find the insurer's denial unreasonable. Accordingly, we do not assess penalties and attorney fees for that denial.

ORDER

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

In the Matter of the Compensation of
MARK R. JOHNSON, Claimant
WCB Case Nos. 93-05823, 92-13266, 93-03410 & 93-05822
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Baker's order that: (1) upheld Roof Life/Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for a low back condition; and (2) upheld Durametal/Argonaut Insurance Company's new injury claim for the same condition. Claimant contends that Roof Life/Liberty Northwest is precluded by the res judicata effect of the March 14, 1990 stipulation from denying claimant's current low back condition. In its brief, Skyline/CNA Insurance Companies (Skyline/CNA) requests dismissal of claimant's request for review. On review, the issues are dismissal, res judicata, compensability and responsibility. We deny the motion to dismiss and affirm the Referee's order.

FINDINGS OF FACT

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

In August 1991, claimant experienced an off-the-job motor vehicle accident that involved his neck and upper back and for which he received chiropractic treatment. (Exs. 47, 48, 50-1, 68-2, Tr. 33, 34).

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

In support of its motion to dismiss claimant's request for review, Skyline/CNA contends that dismissal is appropriate on the basis that claimant failed to dismiss it from his request for review.

By Opinion and Order dated February 1, 1994, the Referee upheld Skyline/CNA's denial and dismissed Skyline/CNA with prejudice as a party to the hearing pursuant to stipulation by the parties.

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). Inasmuch as claimant's request for Board review was mailed within 30 days of the issuance of the Referee's February 1, 1994 order, we conclude that the Referee's order has not become final and we have jurisdiction to consider this matter, including the dismissal of Skyline/CNA as a party. See ORS 656.289(3); Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986); Michael A. Ferdinand, 44 Van Natta 1167 (1992); Robert D. Billick, 40 Van Natta 1041 (1988). Accordingly, Skyline/CNA's motion is denied.

Moreover, were we to consider Skyline/CNA's motion as a request for it to be dismissed as a party to this proceeding based on the stipulations made at hearing, we would also deny the motion.

Although, as a practical matter, claimant is no longer pursuing a claim against Skyline/CNA, Skyline/CNA nevertheless remains a party to this proceeding under our de novo review authority. William E. Wood, 40 Van Natta 999, 1001 (1988) (A party seeking Board review cannot limit the scope of the Board's review to only those portions of the order directed to particular case numbers by seeking review of only select case numbers which are included with other case numbers in the same referee's order). Inasmuch as the Referee's decisions regarding WCB Case No. 92-13266, as well as the issues expressly raised on review, are contained in one final order, and because that order has been timely appealed, we retain de novo jurisdiction to consider all matters contained therein. Id. For these reasons, we conclude that Skyline/CNA shall remain a party on Board review. See Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992) (A party to a referee's order remains a party on Board review).

Res Judicata

Claimant argues that Roof Life/Liberty Northwest is precluded by the res judicata effect of the March 14, 1990 stipulation from denying claimant's current low back condition on the basis that it is unrelated to the 1988 industrial injury, unless that condition has changed since the time of stipulation. We disagree.

On March 30, 1988, claimant slipped off a roof to the ground, causing a low back strain. He was treated conservatively for relief of pain symptoms from the injury. Although a preexisting pars defect and sclerosis were noted at that time, there is no evidence that claimant's low back symptoms were related to either condition. (Ex. 24). The claim was closed without permanent disability. In June 1989, claimant sought treatment for low back complaints, which were characterized as a chronic lumbar strain related to the original injury. Neither claimant's treating chiropractor nor the medical examiners made note of claimant's preexisting conditions, much less attributed his symptoms to them. (Exs. 31 and 32). On September 19, 1989, Roof Life/Liberty denied claimant's aggravation claim on the basis that his low back condition had not materially worsened. Claimant requested a hearing; the parties settled the matter by means of a March 14, 1990 stipulation.

Essentially, a party may not relitigate any issue resolved by a stipulation or DCS, since a party is bound by such agreement. Safeway Stores v. Seney, 124 Or App (1993); Gilkey v. SAIF, 113 Or App 314, 316-17 (1992). See also Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993) (An employer is precluded from denying a claim by its prior stipulation that claimant's condition is compensable). Consequently, we look only to the terms of the agreement to determine whether a party is precluded from litigating a particular issue.

We find that the agreement here has no effect on the resolution of the claim for claimant's current low back condition. The parties stipulated that claimant made an aggravation claim which was denied by Liberty Northwest; that Liberty Northwest's aggravation denial was affirmed; that claimant's condition was a waxing and waning that was not considered at the time of the last closure; and that the permanent partial disability award granted by the stipulation (18.75 percent unscheduled permanent disability) was intended to compensate claimant for "all normal waxing and waning and increased symptomatology and resultant inability to work, if any, due to the effects of the industrial injury." Moreover, by the terms of the agreement, this latter provision was not to be interpreted to limit claimant's aggravation rights pursuant to ORS 656.273 in any way. (Ex. 37).

We conclude that the terms of the stipulation did nothing to resolve any claim for claimant's preexisting or allegedly resultant condition(s). As noted above, there is no evidence that claimant's 1988 low back symptoms were related to either the congenital or the arthritic condition. Moreover, in 1989, claimant's condition was characterized as a chronic lumbar strain related to the original injury. Consequently, we conclude that the stipulation (which pertained to a denied aggravation claim and a permanent disability award for claimant's compensable low back strain injury) does not operate as a judgment to establish that Liberty Northwest agreed to compensate claimant for his preexisting congenital pars defect or degenerative condition. Safeway Stores v. Seney, supra; Gilkey v. SAIF, supra. Accordingly, Roof Life/Liberty Northwest is not precluded from denying claimant's current low back condition. Fimbres v. Gibbons Supply Co., supra.

Compensability/Responsibility

We affirm and adopt the Referee's opinion on these issues, with the following supplementation.

In May 1992, claimant sustained a nondisabling injury to his thoracic spine while working at Durametal/Argonaut. His claim was accepted as a left thoracic strain. On August 11, 1992, claimant sought treatment for neck, upper back and low back complaints. He attributed his upper back complaints to a fall at work caused by his back "[giving] out," which in turn was caused by the residuals of a 1991 motor vehicle accident (MVA) that was unrelated to his work. Claimant attributed his low back complaints to an incident in March 1992 (Ex. 48-2); to lifting 50 pounds of steel bars on several occasions in August 1992, which resulted in "pulling" his low back (Ex. 50-1); and to lifting ten to fifteen pound risers used in brake drum fabrication, with the gradual onset of pain (Ex. 61-1). Durametal/Argonaut denied claimant's underlying back condition on the grounds that it arose from the MVA; and denied his August 1992 treatment for back pain as unrelated to his employment. On October 29, 1992, a claim was filed for a low back injury resulting from picking up risers early in July 1992. (Ex. 59). On December 29, 1992, Durametal/Argonaut denied compensability of and responsibility for claimant's low back condition. (Ex. 66).

Dr. McQueen, who treated claimant for the alleged July 1992 low back injury, reviewed his August 11, 1992 chart notes, and concluded that claimant's claim of a new on-the-job injury to his low back in July 1992 was medically unsubstantiated. (Exs. 59, 60 and 64-2). We agree. First, no report was made to claimant's employer regarding any of the alleged incidents. Second, claimant's varying attributions of the injury to his work are inconsistent. (Compare Exs. 47, 48-1, 48-3, 48-4, 50-1, 61-1, and 68-2). Consequently, claimant has failed to prove that he experienced a new injury involving his low back at Durametal/Argonaut.

Moreover, even if claimant did experience low back pain after lifting at work, he has failed to prove that the alleged lifting incident(s), rather than his preexisting pars defect or degenerative disc disease, is the major contributing cause of his current condition. See Exs. 64, 68-9 and 71-10. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 27 (1993).

ORDER

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

In the Matter of the Compensation of
LOIS J. SCHOCH, Claimant
WCB Case No. 92-09982
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Holtan's order that: (1) dismissed claimant's request for hearing of the Director's July 16, 1992 Order that found that proposed surgery for claimant's low back surgery was not appropriate; (2) found that the surgery dispute had been resolved pursuant to another referee's order; and (3) declined to award an assessed attorney fee. On review, the issues are dismissal and attorney fees. We reverse.

FINDINGS OF FACT

In January 1990, claimant suffered a compensable low back injury. Claimant's treating physician, Dr. Berkeley, diagnosed a nerve root entrapment syndrome at L4-5 and L5-S1. On February 14, 1992, Dr. Berkeley requested authorization for surgery. The insurer requested review of the proposed surgery by the Director pursuant to ORS 656.327(1).

On July 16, 1992, the Director found that the proposed surgery was not appropriate. On July 28, 1992, claimant requested a hearing. On December 10, 1992, applying the "substantial evidence" review standard of ORS 656.327(2), Referee Holtan affirmed the Director's order. Claimant sought review of that order. Relying on Jefferson v. Sam's Cafe, 123 Or App 464 (1993), we concluded that the Hearings Division, rather than the Director, had jurisdiction to resolve the dispute about proposed surgery. Lois J. Schoch, 45 Van Natta 2291 (1993), on recon 46 Van Natta 157 (1994). We remanded the matter to Referee Holtan in order for the parties to litigate the case under the proper standard.

While this case was being litigated, other claims involving the parties were also disputed. A September 17, 1992 Order on Reconsideration had rescinded a July 15, 1992 Determination Order as premature and returned the claim to open status. The insurer appealed the July 15, 1992 Order on Reconsideration. Referee McCullough found that claimant's low back claim had been prematurely closed by the July 15, 1992 Determination Order. On review, we affirmed Referee McCullough's order. (WCB Case No. 92-16273).

In the meantime, on May 25, 1993, Dr. Berkeley submitted a second request to proceed with a right L4-5 and L5-S1 microdecompression. On July 12, 1993, the insurer issued a partial denial for claimant's current need for medical treatment on the basis that her on-the-job injury was no longer the major contributing cause of the disability and need for treatment.

In a third proceeding, claimant filed a request for hearing, protesting the insurer's July 12, 1993 denial as well as the insurer's "de facto" denial of claimant's request for surgery. WCB Case No. 93-09584. In that case, on January 10, 1994, Referee Podnar found that claimant's request for surgery was reasonable and necessary. Referee Podnar also awarded an assessed attorney fee of $10,500 pursuant to ORS 656.382(1) and ORS 656.386(1). The insurer requested review of that portion of Referee Podnar's order that awarded the attorney fee. On September 8, 1994, we modified Referee Podnar's order, awarding a $5,750 assessed attorney fee under ORS 656.386(1) and a $2,000 assessed attorney fee under ORS 656.382(1). Lois J. Schoch, 46 Van Natta 1816 (1994).

On remand of this case to Referee Holtan, the insurer advised that it would not be appealing the merits of Referee Podnar's decision and that it was no longer contesting claimant's request for surgery. The insurer requested dismissal of the present case, arguing that Referee Podnar's decision about claimant's proposed surgery rendered the present case moot. Claimant disputed the insurer's contentions.

On April 25, 1994, Referee Holtan issued an order on remand. Referee Holtan concluded that the Director's July 16, 1992 order was invalid because the Director did not have jurisdiction over the proposed surgery. The Referee further found that the substance of the medical services dispute was decided in WCB case number 93-09584 before Referee Podnar and the decision in that case rendered this case moot. The Referee also denied claimant's request for an assessed attorney fee.

CONCLUSIONS OF LAW AND OPINION

Evidence

In the insurer's respondent's brief on review, it offers into evidence an April 12, 1994 report from Dr. Berkeley. The Board has no authority to consider newly discovered evidence. Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). However, we may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). We construe the insurer's request as a motion to remand. To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

We deny the insurer's motion to remand because the submitted evidence is not likely to affect the outcome of this case.

Director's July 16, 1992 Order

Claimant contends that she is entitled to an attorney fee pursuant to ORS 656.386(1) for litigating the Director's July 16, 1992 order. The insurer agrees with Referee Holtan that the issue of attorney fees was rendered moot by the proceeding before Referee Podnar.

A case is "moot" when a determination is sought on a matter which, when rendered, cannot have any practical effect on the existing controversy. Robert P. Holloway, Sr., 46 Van Natta 117 (1994) (citing Black's Law Dictionary 909 (5th ed. 1979)).

Although the issue of claimant's proposed back surgery was resolved in the proceeding before Referee Podnar, that proceeding did not resolve the entire controversy. The issues before Referee Podnar were the disputed proposed surgery, attorney fees and penalties. Referee Podnar concluded that the surgery was reasonable and necessary and awarded an attorney fee. Referee Podnar did not address the validity of the Director's July 16, 1992 order nor did he decide whether claimant was entitled to an attorney fee for efforts involved with her appeal of the Director's July 16, 1992 order.

In contrast, the issue before Referee Holtan in this case has been the validity of the Director's July 16, 1992 order. The insurer no longer argues that the Director's order is valid. The remaining issue is claimant's entitlement to an attorney fee for her counsel's efforts involved in litigating the Director's July 16, 1992 order. Resolution of that issue requires a final determination of the validity of the Director's order. We note that the insurer does not contend that claimant's counsel has not been instrumental in contesting the validity of the Director's order. Under these circumstances, we conclude that Referee Podnar's order did not render the issues before Referee Holtan moot.

It is now well-settled that jurisdiction over questions concerning proposed medical treatment resides exclusively with the Board. See Martin v. City of Albany, 320 Or 175, 188 (1994); Niccum v. Southcoast Lumber Co., 320 Or 189 (1994). In light of this, the Director lacked jurisdiction over the issue of the proposed surgery. Thus, the Director's July 16, 1992 order was null and void. See Roy R. Stoltenburg, 46 Van Natta 2386 (1994). Consequently, we vacate the Director's July 16, 1992 order. We proceed to address the issue of attorney fees.

There are three prerequisites for an attorney fee award under ORS 656.386(1). One, the claimant must initiate the appeal. Two, the appeal must be from an order or decision denying the claim for compensation. Three, the claimant must finally prevail on the issue of compensation. Shoulders v. SAIF, 300 Or 606, 611 (1986).

In the present case, claimant initiated the appeal by requesting a hearing on the Director's July 16, 1992 order. In SAIF v. Allen, 320 Or 192, 203 (1994), the Supreme Court held that a claim for medical benefits is a "claim for compensation" under ORS 656.386(1). We now consider whether the Director's order constituted an order denying the claim for compensation.

In Gwen A. Jackson, 46 Van Natta 822, 828 (1994), aff'd Liberty Northwest Insurance vs. Jackson, 132 Or App 134 (1994), we said that the insurer's characterization of the dispute as whether the proposed surgery was reasonable and necessary constituted a "decision denying the claim for compensation." See also Daniel K. Bevier, 46 Van Natta 909, 910 (1994).

In Sherry Y. Drobney, 46 Van Natta 964 (1994), Aff'd Liberty Northwest Insurance v. Jackson 132 Or App 134 (1994), unlike in Jackson, the case arose under the Director review procedures set forth in ORS 656.327. In Drobney, we found that the carrier's refusal to pay the claimant's surgery claim did not represent a decision denying a claim for compensation because the carrier was statutorily precluded from denying a medical services claim subject to the review procedures of ORS 656.327. Nevertheless, we found that the Director's order declaring the medical treatment not compensable and the referee's order affirming the Director's order constituted orders denying the claimant's medical services claim. Since the claimant had satisfied the statutory prerequisites by finally prevailing over those decisions on Board review, we held that she was entitled to an attorney fee award under ORS 656.386(1).[1]

Likewise, in this case, the Director's July 16, 1992 order declaring the medical treatment not compensable and Referee Holtan's December 10, 1992 order affirming the Director's order constituted orders denying claimant's claim for compensation. Thus, claimant has met the second requirement for prevailing on attorney fees under ORS 656.386(1).

The final requirement is that claimant must finally prevail on the issue of compensation. Shoulders v. SAIF, supra. In this case, we have concluded that the July 16, 1992 Director's order was null and void. See Martin v. City of Albany, supra. Furthermore, the insurer has acknowledged that it is no longer challenging claimant's surgery claim. Under such circumstances, we find that claimant, who has been contesting the validity of the Director's order from the beginning of this case, has "prevailed finally" from an order or decision denying a claim for compensation. Alternatively, considering the insurer's initial refusal to concede the propriety of the proposed surgery. We find that the insurer's conduct constitutes a decision denying the claim for compensation. Therefore, under either theory, she is entitled to an attorney fee pursuant to ORS 656.386(1).

Claimant has finally prevailed after remand with respect to the Director's July 16, 1992 order. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing, on Board review and on remand concerning the validity of the Director's July 16, 1992 order is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the 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 note that claimant is not entitled to an attorney fee for services rendered subsequent to the insurer's concession concerning the attorney fee issue. See Amador Mendez, 44 Van Natta 736 (1992).

Cross-appeal of September 17, 1992 Order on Reconsideration

Claimant also argues that she is entitled to an attorney fee for the insurer's withdrawal of its cross-appeal of the September 17, 1992 Order on Reconsideration. We briefly summarize the procedural history regarding this issue.

A Determination Order was issued on July 15, 1992, which awarded claimant temporary partial disability and 15 percent unscheduled permanent disability. The insurer requested reconsideration. The September 17, 1992 Order on Reconsideration rescinded the July 15, 1992 Determination Order and returned the claim to open status.

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[1] The insurer relies on Sherry A. Young, 45 Van Natta 2331 (1993), to argue that no attorney fee is permissible in this case. The insurer's reliance on Young is misplaced. In Sherry Y. Drobney, supra, we disavowed the reasoning in Sherry A. Young, supra, to the extent it was contrary to the holding of Gwen A. Jackson, supra. Sherry Y. Drobney, 46 Van Natta at 965 n.1. Furthermore, in Sherry A. Young, we relied on SAIF v. Allen, 124 Or App 183 (1993), to conclude that, even if we found the claimant's proposed surgery to be appropriate, the claimant would not be entitled to an attorney fee award under ORS 656.386(1). Subsequent to our order in Young, the Supreme Court reversed the Court of Appeals' decision in Allen. Thus, Sherry A. Young, supra, has little, if any, precedential value.

In the meantime, on July 28, 1992, claimant requested a hearing on the Director's July 16, 1992 order, which found that the proposed surgery for claimant's low back was not appropriate. In the insurer's October 21, 1992 response, it denied that claimant was entitled to additional permanent disability or further medical treatment. In addition, the insurer cross-appealed, disputing the the September 17, 1992 Order on Reconsideration and contending that the July 15, 1992 Determination Order should be affirmed.

At the November 4, 1992 hearing before Referee Holtan in this case, claimant argued that the insurer's "cross-appeal" was not a valid request for hearing. Although the insurer originally contended that it was a valid request for hearing, the insurer withdrew the issue without prejudice and preserved the issue for future hearing. Claimant argued that she was entitled to an attorney fee for the withdrawal of the alleged request for hearing. The insurer disagreed, arguing that claimant was not entitled to an attorney fee when the issue was withdrawn without prejudice. Neither Referee Holtan's December 10, 1992 order nor his April 25, 1994 order (in this case) awarded an assessed attorney fee.

On review, claimant argues that she is entitled to an attorney fee pursuant to ORS 656.382(2) for the insurer's withdrawal of its cross-appeal of the September 17, 1992 Order on Reconsideration. Claimant contends that, because the insurer withdrew the cross-appeal at hearing, the September 17, 1992 Order on Reconsideration was upheld and claimant prevailed, until the issue was raised again months later before Referee McCullough in WBC case number 92-16273.

The parties dispute whether the insurer "initiated" a hearing by cross-appealing the September 17, 1992 Order on Reconsideration. We need not resolve that issue because even if the insurer properly requested a hearing, we conclude that claimant is not entitled to an attorney fee pursuant to ORS 656.382(2).

In Terlouw v. Jesuit Seminary, 101 Or App 493, rev den 310 Or 282 (1990), the court declined to award a fee under ORS 656.382(2) because the Board had dismissed the carrier's appeal on the carrier's motion without a decision on the merits. Similarly, in Agripac, Inc. v. Kitchel, 73 Or App 132 (1985), the court held that, because the carrier's petition for judicial review had been dismissed on the claimant's motion without a finding "that the compensation to a claimant should not be disallowed or reduced," the claimant was not entitled to a fee under ORS 656.382(2).

Kitchel and Terlouw support the proposition that, when a request for hearing is dismissed without a decision on the merits, we are without authority to award attorney fees under ORS 656.382(2). Timothy L. Williams, 46 Van Natta 2274 (1994). Here, the insurer withdrew the cross-appeal of the September 17, 1992 Order on Reconsideration without prejudice. Therefore, there was no decision on the merits and no finding "that the compensation to a claimant should not be disallowed or reduced" under ORS 656.382(2). Consequently, claimant is not entitled to an attorney fee under ORS 656.382(2).

Claimant also argues that she is entitled to attorney fees under ORS 656.386(1) because she prevailed over the insurer's cross-appeal of the September 17, 1992 Order on Reconsideration. We disagree.

ORS 656.386(1) provides for an attorney fee where the claimant "prevails finally" from an order or decision denying the claim for compensation. The withdrawal of the insurer's cross-appeal did not result in claimant "obtaining" compensation without a hearing. See Robin L. Dean, 46 Van Natta 858 (1994) (Although the carrier's request for hearing concerning premature closure posed a "threat" of reduction of the claimant's temporary disability benefits, the carrier's withdrawal of the hearing request did not result in the claimant "obtaining" compensation without a hearing); see also Kim M. Harrison, 44 Van Natta 371 (1992). Moreover, the insurer's withdrawal in the proceeding before Referee Holtan was without prejudice. The insurer subsequently appealed the September 17, 1992 Order on Reconsideration in a separate proceeding before Referee McCullough. Therefore, claimant did not "prevail finally" in the hearing before Referee Holtan when the insurer withdrew its cross-appeal. Consequently, claimant is not entitled to an assessed attorney fee under ORS 656.386(1).

ORDER

The Referee's order dated April 25, 1994 is reversed. Claimant's hearing request is reinstated. The Director's July 16, 1992 order concerning claimant's proposed surgery is vacated. For services at hearing, on review, and on remand, claimant's attorney is awarded a $3,000 fee pursuant to ORS 656.386(1) for prevailing with respect to the Director's July 16, 1992 order, payable by the insurer.

January 23, 1995 Cite as 47 Van Natta 75 (1995)

In the Matter of the Compensation of
LINDA M. THOMAS, Claimant
WCB Case No. 94-00319
ORDER ON REVIEW
Olson Law Firm, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

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

Claimant requests review of that portion of Referee Garaventa's order which upheld the SAIF Corporation's denial of her current bilateral carpal tunnel condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In April 1993, SAIF accepted a nondisabling bilateral carpal tunnel syndrome resulting from claimant's employment as a secretary. Although claimant reported a three-year history of bilateral hand numbness, January 22, 1993 was selected as the date of injury. Though still symptomatic, claimant's condition was relatively stable before she returned to her attending physician, Dr. Humphrey, in September 1993, complaining of increased symptoms following one week's work re-roofing her house.

In November 1993, nerve conduction studies demonstrated a pathological worsening of claimant's carpal tunnel condition. Dr. Radecki, an examining physician, attributed the worsening of claimant's condition in major part to the roofing activities, rather than to claimant's original compensable carpal tunnel condition. (Ex. 13-5). Dr. Radecki also listed idiopathic factors such as heredity, hormonal and aging as other potential causes of claimant's condition. Dr. Radecki further commented that claimant did not really suffer an original injury in January 1993.

Dr. Radecki's report, plus Dr. Humphrey's "check-the-box" concurrence (Ex. 15), prompted SAIF to deny an aggravation of claimant's accepted carpal tunnel condition on December 8, 1993. SAIF later denied the compensability of claimant's current condition on February 11, 1994.

The Referee set aside the denial of aggravation as premature, reasoning that the "aggravation claim" was actually a request for reclassification of the claim to "disabling." Since no party contests that aspect of the Referee's order, we shall not disturb that conclusion. However, claimant asserts that the Referee erred in upholding the denial of her current carpal tunnel condition. For the following reasons, we agree with claimant.

In finding that claimant's current carpal tunnel condition was not compensable, the Referee relied on the medical opinion of Dr. Radecki, as well as Dr. Humphrey's concurrence. The Referee found Dr. Humphrey's subsequent opinion that claimant's compensable carpal tunnel syndrome was the major contributing cause of her current condition to be unpersuasive. We disagree with the Referee's interpretation of the medical evidence.

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, 814 (1983). Moreover, we afford greater weight to those opinions that are well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986). In this case, we find no persuasive reasons not to defer to Dr. Humphrey's opinion.

In response to an inquiry from SAIF, Dr. Humphrey initially opined that, while claimant's roofing activities pathologically worsened her carpal tunnel condition, the underlying cause of claimant's need for treatment remained the compensable carpal tunnel condition. (Ex. 12). As previously noted, Dr. Radecki opined that the roofing activity was the major factor in claimant's need for treatment. (Ex. 13-5). Following his "check-the-box" concurrence with Dr. Radecki, Dr. Humphrey explained his concurrence in a letter to claimant's counsel. (Ex. 19).

Dr. Humphrey wrote that claimant had carpal tunnel symptomatology prior to her roofing activities in September 1993. Although conceding that nerve conduction studies confirmed that roofing caused a pathological worsening of claimant's condition, Dr. Humphrey emphasized that the major contributing cause of claimant's need for treatment remained the compensable carpal tunnel condition. Dr. Humphrey opined that claimant's carpal tunnel symptoms would be present with or without the off-the-job activities because the underlying carpal tunnel pathology was present prior to the exacerbation. (Ex. 19).

SAIF attacks Dr. Humphrey's medical opinion, asserting that it is ambiguous and inconsistent. We disagree. Given the nature of his concurrence with Dr. Radecki's report, we find it reasonable for Dr. Humphrey to explain his opinion. We also do not find any ambiguity in Dr. Humphrey's opinion that the compensable condition remains the major causal factor in claimant's current overall carpal tunnel syndrome. Unlike the dissent, we consider Dr. Humphrey's report to have contained a sufficient explanation of his conclusion.

As for any alleged inconsistencies, we agree with claimant that the issue is not what caused the worsening of claimant's carpal tunnel condition. Aggravation is not at issue on appeal. Instead, the question is what is the major contributing cause of claimant's current condition. Dr. Humphrey cogently explains that it is the original compensable carpal tunnel condition.

Therefore, we find Dr. Humphrey's explanation of his concurrence with Dr. Radecki to be persuasive. Accordingly, Dr. Humphrey's opinion is sufficient to satisfy claimant's burden of proving medical causation. Moreover, we find that it is more convincing than Dr. Radecki's opinion, because the latter physician appears to question the compensability of claimant's original accepted carpal tunnel condition. Inasmuch as the compensability of claimant's original claim is not at issue, Dr. Radecki's opinion is of limited value in assessing the causation of claimant's carpal tunnel condition.

In conclusion, claimant has sustained her burden of proving that her accepted carpal tunnel condition is the major contributing cause of her current condition and need for treatment. Thus, we reverse the Referee's decision on this issue. Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated April 7, 1994 is reversed. SAIF's denial of claimant's current condition 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 $3,000, to be paid by SAIF.

Board Chair Neidig dissenting.

The majority concludes that Dr. Humphrey's opinion is not inconsistent and thus persuasive. Because I do not share the majority's view of Dr. Humphrey's opinion, I am compelled to dissent.

The majority's assessment of Dr. Humphrey's medical opinion is charitable to say the least. Dr. Humphrey gave an unconditional concurrence with Dr. Radecki's report, which reasonably concluded that claimant's off-the-job activity was the major contributing cause of claimant's current worsened condition. There is no question that Dr. Radecki and Dr. Humphrey believe that claimant's roofing activity worsened her underlying carpal tunnel pathology. What troubles me most about Dr. Humphrey's "explanation" of his concurrence with Dr. Radecki is his conclusion that, while the roofing activity worsened the underlying carpal tunnel activity, the original compensable condition remains the major contributing cause of claimant's current carpal tunnel condition.

Granted I am not a physician, but it seems to me that, without more explanation from Dr. Humphrey, these conclusions are inconsistent. If the roofing activity was sufficient to worsen the underlying pathology, it should be considered the major cause of claimant's current need for treatment. At the very least, the majority should have required a better explanation from Dr. Humphrey as to why it is not before finding his opinion to be the most persuasive.

Inasmuch as Dr. Humphrey does not harmonize the internal inconsistencies in his opinion, I would find that his medical opinion is not adequate to satisfy claimant's burden of proof. Consequently, I would affirm the Referee's order and uphold SAIF's denial of claimant's current carpal tunnel condition.

January 23, 1995 Cite as 47 Van Natta 77 (1995)

In the Matter of the Compensation of
HAROLD UNDERWOOD, Claimant
WCB Case Nos. 94-03147 & 94-01096
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
James D. Booth (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation, on behalf of Huffman & Wright Logging Company, requests review of those portions of Referee Spangler's order that: (1) awarded claimant temporary total disability benefits from August 26, 1993 through October 5, 1993 for an August 26, 1993 injury; and (2) assessed a penalty against SAIF/Huffman & Wright for an allegedly unreasonable failure to pay temporary disability. SAIF, on behalf of Northwest Timber Cutters, Incorporated, requests review of those portions of the order that: (1) directed it to calculate claimant's rate of temporary disability compensation for a November 23, 1993 injury based on his average earnings during two separate periods of employment; and (2) declined to authorize SAIF/Northwest Timber to calculate claimant's rate of temporary disability compensation based on his average earnings from October 12 through November 23, 1993. On review, the issues are entitlement to temporary disability, rate of temporary disability and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his third ultimate finding of fact, with the following supplementation and summary of the pertinent findings.

Claimant was incarcerated on May 15, 1993. He requested and was granted an outside work release. On October 12, 1993, Northwest Timber Cutters hired claimant to work for $140 for a six-hour day (less equipment rental), six days a week, weather and equipment availability permitting. The cutter job was ongoing, as long as work was available. At the time it hired claimant, Northwest Timber was logging under two contracts which were about to expire, but was seeking other contracts. Prior to the expiration of those contracts, Northwest Timber secured another logging contract.

At the time of hire, Northwest Timber was aware that claimant was on work release status and that his work release could be revoked at any time. After working for Northwest Timber for nine days, on October 21, 1993, claimant's work release was revoked and claimant was confined to jail. Claimant

did not quit his job with Northwest Timber and Northwest Timber did not fire claimant after his work release was revoked. Rather, Northwest Timber advised claimant that if work were available, he could return to his job upon release from jail. In order to assure that his job would be available when he was released, claimant arranged for two friends to replace him while he served the remainder of his sentence.

Claimant was released from jail on November 15, 1993. Between November 15 and November 21, 1993, claimant did not work but, instead, attended to family matters. On November 22, 1993, claimant resumed working for Northwest Timber. Claimant was injured on November 23, 1993.

SAIF accepted the claim on behalf of Northwest Timber. SAIF initially calculated claimant's temporary disability based on its understanding that, between October 12 and November 23, 1993, claimant earned $140 a day, five days a week. Upon receipt of additional payroll information, SAIF recalculated claimant's temporary disability by averaging his wage during November. At hearing, SAIF argued that claimant's rate of TTD should be calculated by averaging his wage during his entire period of employment with Northwest Timber.

Claimant was employed by Northwest Timber from October 12 through November 23, 1993. During that time: claimant worked nine days in October 1993; was incarcerated and unable to work from October 21 through November 15, 1993; chose not to work from November 15 through November 21, 1993; and worked November 22 through November 23, 1993.

Northwest Timber had work continuously available from October 12 through November 23, 1993.

CONCLUSIONS OF LAW AND OPINION

Entitlement to TTD/Penalty for Failure to Pay TTD

We adopt and affirm the Referee's opinion as it pertains to these claims against SAIF/Huffman & Wright.

Rate of TTD

Finding Northwest Timber "rehired" claimant on November 22, 1993, the Referee concluded that claimant worked for Northwest Timber during two separate periods: October 12 through October 21, 1993, and November 22 through November 23, 1993. The Referee further concluded, therefore, that claimant's temporary disability should be calculated based on his actual wages during solely those two periods of employment. On review, SAIF/Northwest Timber renews its argument that claimant's rate of TTD should be calculated based on his average wage from October 12 through November 23, 1993.

Former OAR/436-60-025(5)(a) (WCD Admin. Order 26-1990) provides:

> "(5) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section. * * * (a) For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. 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."

Claimant's earnings were irregular and his hours of work varied with the weather and availability of equipment. Thus, the rule is applicable. We infer that the Referee found the period of non-work from October 21 through November 21, 1993 constituted an "extended gap" for the purposes of former OAR/436-60-025(5)(a) that should not be included in determining claimant's average weekly earnings. We disagree.

Determining what is an "extended gap" includes not only consideration of the length of the break in work, but also whether the gap has caused a change in the work relationship between employer and employee. Steven B. Caldwell, 44 Van Natta 2566, 2567 (1992); see Craig E. Hobbs, 39 Van Natta 690 (1987). Such a determination is made on a case-by-case basis. Dena L. Barnett, 43 Van Natta 1776 (1991); Sally M. Turpin, 37 Van Natta 924, 926 (1985). An "extended gap" does not generally exist where the claimant's varying work schedule is within the reasonable expectations of the claimant and the employer. See Steven B. Caldwell, supra.

Here, when his work release was revoked in October 1993, claimant neither quit his job nor was fired. Claimant testified that "I had two guys replace me until I got out of jail. . . . It wasn't like I got fired from [Northwest Timber], and it wasn't like I quit [Northwest Timber]. It's just that I couldn't be there." Northwest Timber's agent Jacobs testified that he knew claimant was on work release when he hired claimant and that his work release could be revoked. Jacobs further testified that when claimant's release was revoked, Northwest Timber did not fire claimant. Instead, Jacobs advised claimant that if Northwest Timber had work available when he was released from jail, claimant would have a job.

In light of this testimony, we find that the four-week gap in employment (during which claimant was unable to or did not work) caused no change in the work relationship between claimant and his employer. On the contrary, the gap was well within the parties' reasonable expectations. See Steven B. Caldwell, supra.

Under these circumstances, we do not find that claimant's four-week period without earnings constituted an "extended gap" within the meaning of OAR 436-60-025(5)(a). Accordingly, we conclude that claimant's rate of temporary disability shall be calculated based upon the average weekly earnings for the approximately six-week period (from October 12 through November 23, 1993) that claimant worked for Northwest Timber.

Claimant's attorney is entitled to an assessed fee for prevailing against the SAIF Corporation/Huffman & Wright's request for review concerning claimant's entitlement to TTD benefits. 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 $750, payable by SAIF/Huffman & Wright. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Inasmuch as penalties are not considered compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to an attorney fee for prevailing against SAIF/Huffman & Wright's challenge to the Referee's penalty assessment. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The Referee's order dated May 25, 1994 is affirmed in part and modified in part. The SAIF Corporation, on behalf of Northwest Timber Cutters, Incorporated, is directed to calculate claimant's temporary disability compensation consistent with this order. Claimant's attorney's "out-of-compensation" fee as granted by the Referee's order is modified accordingly. The remainder of the order is affirmed. For services on review concerning claimant's entitlement to temporary disability benefits, claimant's counsel is awarded an assessed fee of $750, payable by SAIF/Huffman & Wright Logging Company.

In the Matter of the Compensation of
GEORGE L. GATES, Claimant
WCB Case Nos. 92-07879 & 92-01524
ORDER ON REMAND
Robert G. Dolton, Claimant Attorney
Schwabe, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Gates v. Liberty Northwest Insurance Corporation, 131 or App 164 (1994). The court has reversed our prior order which adopted and affirmed a Referee's order that had declined to award a carrier-paid attorney fee award under ORS 656.386(1) when Liberty Northwest withdrew the compensability portion of its denial at hearing. Reasoning that we are statutorily authorized to award an attorney fee, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" and "Ultimate Findings of Fact" contained in the Referee's order. We add the following findings.

On December 26, 1991, Liberty Northwest issued a denial of claimant's aggravation claim for his low back condition. (Ex. 19). Contending that it was unable to "substantiate a relationship between [claimant's] condition and [his] employment at [Liberty's insured]," Liberty denied claimant's "claim for compensation." In the event that claimant's "claim is later found compensable," Liberty further asserted that responsibility for his current condition would rest with a subsequent employer.

On January 31, 1992, claimant, through his attorney, requested a hearing contesting Liberty's aggravation denial. Claimant listed as issues compensability and responsibility. In response to claimant's hearing request, Liberty denied that claimant had suffered an aggravation or that it was responsible for the claim.

On May 15, 1992, Grocers Insurance Group issued a denial of claimant's "new injury" claim. (Ex. 17). "Without waiving a future defense of compensability," Grocers denied responsibility for the claim. Thereafter, claimant requested a hearing from Grocers' denial, which was consolidated with his hearing request regarding Liberty's denial.

At the hearing, the Referee clarified the issues for resolution. (Tr. 3). Since neither carrier was contesting compensability of the claim, the Referee announced (without objection) that "to the extent the written denials say that [compensability is denied], that's withdrawn."

CONCLUSIONS OF LAW AND OPINION

The Referee found Liberty responsible for claimant's condition. Turning to the attorney fee issue, the Referee reasoned that an award could not be granted because the sole issue at hearing was responsibility.

Claimant requested Board review, seeking an attorney fee award payable by Liberty. The Board affirmed the Referee's order, adopting the Referee's reliance on Multnomah County School District v. Tigner, 113 Or App 405 (1992).

The court has reversed our decision. Based on Safeway Stores, Inc. v. Hayes, 119 Or App 319, 322 (1993), and the legislative history regarding amended ORS 656.386(1), the court concluded that when the legislature authorized attorney fees where an attorney is instrumental in obtaining compensation for a claimant and a hearing is not held, the legislature meant that a hearing on compensability is not held. Consequently, the court held that if a carrier withdraws its denial of compensability before a hearing on that issue begins and the attorney was instrumental in obtaining that withdrawal, an attorney fee award under ORS 656.386(1) is authorized.

The court has remanded for reconsideration in light of its opinion. In accordance with the court's mandate, we proceed with our reconsideration.

Claimant's attorney filed a hearing request contesting Liberty's denial of claimant's aggravation claim. In addition, claimant's counsel attended the hearing, at which time Liberty's counsel concurred with the Referee's announcement that the compensability portion of its denial had been withdrawn. In light of such circumstances, we find that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. ORS 656.386(1); Gates v. Liberty Northwest, supra; Penny L. Hamrick, 46 Van Natta 14 (1994). Consquently, we conclude that claimant's attorney is entitled to a carrier-paid fee.

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 "pre-hearing" services concerning the withdrawal of the compensability portion of Liberty's denial is $1,000. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We further note that claimant is not entitled to an attorney fee for services rendered subsequent to the withdrawal of Liberty's compensability denial. See Amador Mendez, 44 Van Natta 736 (1992).

Accordingly, on reconsideration, we reverse that portion of the Referee's September 23, 1992 order, as reconsidered November 16, 1992, that declined to award an insurer-paid attorney fee under ORS 656.386(1). For "pre-hearing" services in securing the withdrawal of Liberty's compensability denial, claimant's attorney is awarded $1,000, to be paid by Liberty.

IT IS SO ORDERED.

In the Matter of the Compensation
MARCOS MONTOYA, Claimant
WCB Case No. C4-02709
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
H. Galaviz-Stoller, Claimant Attorney

Reviewed by Board Members Neidig and Gunn.

On October 27, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

The CDA contains the signatures of the SAIF Corporation's claims adjuster, SAIF's trial counsel and claimant's attorney, but does not include claimant's signature. On the line provided for claimant's signature, his attorney signed "for" claimant. In addition, claimant's attorney submitted a letter to the Board advising that claimant left for Mexico after authorizing settlement of the claim and that she has no way of contacting him there.

The Board's rules define a "claim disposition agreement" as a written agreement executed by all parties in which a claimant agrees to release rights or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim. OAR 438-09-001(1). In other words, the Board's rules require a CDA to be executed by all parties. See OAR 438-09-001(1); Catherine E. Evans, 45 Van Natta 1043 (1993); Edgar C. Sixberry, 43 Van Natta 335 (1991); Van L. Bloom, 46 Van Natta 2177 (1994).

Therefore, on November 4, 1994, by letter, the Board requested an addendum, providing claimant's original signature and an additional postcard. Claimant's original signature was not provided. Accordingly, because the original CDA does not contain claimant's original signature, it is not in compliance with the Director and Board rules. See OAR 436-60-145(1); OAR 438-09-001(1). Consequently, we disapprove the CDA as unreasonable as a matter of law, see ORS 656.236(1)(a), and return it to the parties. We consider this approach to be particularly appropriate where the record is devoid of a signature from claimant evidencing an understanding regarding the finality and significance of a CDA.

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

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
EDELMA R. NORIEGA, Claimant
WCB Case No. 94-06750
ORDER OF DISMISSAL
Gary D. Taylor, Claimant Attorney
Lundeen, et al., Defense Attorneys

Claimant, pro se, has requested Board review of the Referee's September 1, 1994 order. We have reviewed the request to determine whether we have jurisdiction to consider this appeal. Inasmuch as the record does not establish that the other parties received timely notice of claimant's appeal, we dismiss the request for review.

FINDINGS OF FACT

On September 1, 1994, the Referee issued an Order of Dismissal. Finding that claimant (then represented by an attorney) had withdrawn her hearing request, the Referee dismissed the request regarding a June 2, 1994 Order on Reconsideration. Parties to the Referee's order were claimant, the insurer, and its insured.

On October 3, 1994, the Board received claimant's handwritten letter requesting that her dismissed hearing be reinstated for another day. The request was mailed by certified mail to the Board on September 29, 1994. The request did not indicate that copies of the request had been provided to the other parties.

Rather than acknowledged as a request for Board review of the Referee's September 1, 1994 dismissal order, the letter was acknowledged (on October 12, 1994) as a request for a new hearing. (WCB Case No. 94-12021). After this oversight was brought to the Board's attention, claimant's letter was acknowledged as a request for review of the Referee's order on January 11, 1995.

CONCLUSIONS OF LAW AND OPINION

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

Here, the 30th day after the Referee's September 1, 1994 order was October 1, 1994, a Saturday. Consequently, the final day to perfect an appeal from the Referee's order was Monday, October 3, 1994. Anita L. Clifton, 43 Van Natta 1921 (1991). Assuming for the sake of argument that claimant's letter constitutes a request for Board review of the Referee's order, see Rochelle M. Gordon, 40 Van Natta 1808 (1988), the request was timely filed because it was mailed by certified mail to the Board on September 29, 1994. See OAR 438-05-046(1)(b).

Nevertheless, claimant must also establish that notice of her request for Board review was timely provided to the other parties. A review of this record does not support such a finding.

Claimant's letter does not indicate that any of the parties to the proceeding before the Referee were provided with either a copy, or received actual knowledge, of her letter within 30 days of the Referee's September 1, 1994 order. ORS 656.289(3); 656.295(2). Rather, the record suggests that the insurer's first notice of claimant's appeal occurred when it received the Board's January 11, 1995 acknowledgment letter.

Inasmuch as January 11, 1995 is more than 30 days from the date of the Referee's September 1, 1994 Order of Dismissal, we are persuaded that the other parties to this proceeding did not receive timely notice of claimant's request for Board review. Because the request is untimely, we lack authority to review the Referee's order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

Accordingly, claimant's request for Board review is dismissed.[1]

IT IS SO ORDERED.

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[1] In the event that claimant can establish that she provided notice of her request for Board review to the other parties within 30 days of the Referee's September 1, 1994 order, she may submit such written information for our review. However, to be considered, such written information must be received 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
STEPHEN K. RULE, Claimant
WCB Case No. 94-02872
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Crumme's order that affirmed an Order on Reconsideration which did not award any permanent disability for claimant's left carpal tunnel condition. Claimant seeks a scheduled permanent disability award or, alternatively, requests remand to the Referee for remand to the Department for a reasonable medical arbiter's examination. On review, the issues are remand and extent of scheduled permanent disability.

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

Claimant requested reconsideration of a Notice of Closure which awarded no permanent disability. A medical arbiter, Dr. Dineen, performed an examination of claimant's left forearm. (Ex. 10). As a result of Dr. Dineen's lack of impairment findings, the Order on Reconsideration affirmed the Notice of Closure. (Ex. 11).

Subsequent to the Order on Reconsideration, claimant, believing that Dr. Dineen's examination was inadequate, had an examination of his left arm performed by Dr. Rangitsch. At hearing, Claimant offered Dr. Rangitsch's report as evidence of impairment of the left forearm. The Referee declined to admit Dr. Rangitsch's report and concluded that claimant had failed to prove entitlement to scheduled permanent disability for the left carpal tunnel condition.

Claimant contends that, since Dr. Rangitsch was one of the surgeons involved in the operation on claimant's left arm and thereby an attending physician, claimant is entitled to an impairment rating based on Dr. Rangitsch's report.

We disagree with claimant's characterization of Dr. Rangitsch as his attending physician merely because he assisted at the left wrist surgery. Claimant's attending physician at the time of claim closure was Dr. Buehler, the physician primarily responsible for treating claimant's condition. Tr. 13; ORS 656.005(12)(b); ORS 656.245(3)(b)(B). Impairment findings from a physician other than the attending physician may be used only if those findings are ratified by the attending physician. OAR 436-35-007(8); Alex J. Como, 44 Van Natta 221 (1992). Dr. Buehler did not ratify Dr. Rangitsch's findings. Consequently, Dr. Rangitsch's impairment findings cannot be considered. Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994).

Alternatively, claimant requests remand to the Referee and then to the Department for another arbiter's examination to obtain valid measurements of his impairment.

We do not consider issues raised for the first time on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Because claimant did not raise his remand request at hearing, we decline to consider it on review. Moreover, even if we had considered this issue, we would deny the request.

Although we have the authority to remand to the Director for the adoption of temporary rules to address permanent impairment not covered by the disability standards, see Gallino v. Courtesy-Buick-GMC, 124 Or App 538 (1993), claimant makes no contention that the standards do not adequately address his permanent impairment. Moreover, we have previously held under similar circumstances that we will not remand a claim for a supplemental arbiter's examination. Beverly L. Cardin, 46 Van Natta 770 (1994); Enriqueta M. Restrepo, 45 Van Natta 752 (1993). As in Cardin and Restrepo, the Department in this case accepted the medical arbiter's report and relied on it to determine the extent of claimant's unscheduled permanent disability. The Department did not find the arbiter's report incomplete and did not direct the arbiter to perform a supplemental examination. Under these circumstances, there is no basis to remand. Beverly L. Cardin, supra; Enriqueta M. Restrepo, supra. See also Daniel L. Bourgo, 46 Van Natta 2505 (1994).

Consequently, we find that a preponderance of medical evidence does not support a finding of permanent impairment. We, therefore, affirm the Referee's order which declined to award claimant permanent disability.

ORDER

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

January 24, 1995 Cite as 47 Van Natta 84 (1995)

In the Matter of the Compensation of
ROBERT K. WARREN, Claimant
WCB Case No. 93-06052
ORDER DENYING MOTION TO DISMISS
Goldberg & Mechanic, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

The SAIF Corporation has moved the Board for an order dismissing claimant's request for review of a Referee's order. Specifically, SAIF contends that: (1) claimant neglected to serve a copy of the request on the Department; and (2) claimant's request was untimely filed. We deny the motion.

FINDINGS OF FACT

On November 25, 1994, the Referee issued an order which: (1) affirmed an Order on Reconsideration that awarded 10 percent scheduled permanent disability for loss of use or function of the leg, whereas a Notice of Closure (issued by SAIF as claim processor for the Department on behalf of the noncomplying employer) had awarded no permanent disability; (2) declined to award a penalty under ORS 656.268(4)(g); and (3) declined to direct SAIF to pay an attorney fee granted by a prior referee's order which arose from a noncomplying employer's appeal of a Director's noncomplying employer (NCE) order. Copies of the Referee's order were mailed to claimant, his attorney, SAIF (including its counsel), the NCE, and the Department.

On Tuesday, December 27, 1994, claimant mailed, by certified mail, a request for review of the Referee's order to the Board. The request included a Certificate of Service stating that a copy had been mailed to SAIF's counsel, the NCE, and claimant. On December 29, 1994, the Board mailed a computer-generated letter to claimant, SAIF, their respective counsels and the NCE acknowledging claimant's request.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

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). When the Board's adjudication includes review of a NCE order, the Department must be treated as a party entitled to be served with notice under ORS 656.295(2). Kelsey v. Drushella-Klohk NCE, supra.

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).

Noting that claimant neglected to serve a copy of his request for Board review on the Department, SAIF asserts that the appeal must be dismissed. We disagree.

Pursuant to the Kelsey holding, the Department is treated as a party when the Board's adjudication includes review of a NCE order. In contrast to Kelsey, this proceeding pertains to a subsequent hearing seeking "enforcement" of an earlier referee's "NCE" order. In other words, the prior referee's order involved a review of a NCE order; the present Referee's order arises from SAIF's processing of that "NCE" claim pursuant to the Department's referral of the claim under ORS 656.054.

In light of such circumstances, we are not inclined to consider the Department to be a party to this proceeding. Nevertheless, we need not resolve that question because, even if the Department was a party, SAIF (the entity statutorily authorized to process the claim pursuant to the Department's referral) received timely notice of claimant's request for Board review. We base this conclusion on the following reasoning.

Claimant's certificate of service by mail upon SAIF's counsel and the NCE is uncontested. Furthermore, no contention has been made that either the Department or SAIF 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 service by mail upon SAIF's counsel and the NCE 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).

Finally, SAIF notes that claimant's request was mailed on December 27, 1994, the 32nd day after the Referee's November 25, 1994 order. Consequently, SAIF contends that claimant's request for Board review was untimely filed. We disagree.

The 30th day after the Referee's November 25, 1994 order was December 25, 1994, a Sunday. Since Monday, December 26, 1994 was a federal holiday (and therefore no mail was delivered), the final day to perfect a timely appeal was Tuesday, December 27, 1994. See Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as claimant's request for review was mailed, by certified mail, to the Board on December 27, 1994, it was timely filed. See ORS 656.289(3); 656.295(2); OAR 438-05-046(1)(b).

Accordingly, SAIF's motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule implemented. Thereafter, this matter will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID WATTS, Claimant
WCB Case Nos. 94-02877 & 94-02363
ORDER ON RECONSIDERATION
Ernest M. Jenks, Claimant Attorney
Lundeen, et al., Defense Attorneys

Claimant has requested reconsideration of that portion of our December 30, 1994 Order on Review that declined to award claimant an assessed fee pursuant to ORS 656.386(1). Specifically, claimant contends that he advised the Referee that he intended to pursue this issue at hearing. For the following reasons, we adhere to our prior conclusion.

On review, claimant argued that he was entitled to an attorney fee under ORS 656.386(1) because the insurer conceded at hearing that claimant's proposed back surgery was causally related to the April 29, 1986 compensable injury. In our previous order, we found that claimant's attorney had not contended at hearing that he was entitled to an assessed fee because of the insurer's concession. Although we were not inclined to address the issue because claimant had not adequately preserved it, we proceeded to address the merits of claimant's argument.

On reconsideration, claimant contends that he specifically requested an attorney fee for the insurer's stipulation as to the causation issue. Although we are not convinced that claimant adequately raised this issue at hearing, we need not decide that issue. In our previous order, we merely pointed out that we were not inclined to address the issue. We concluded that, in any event, claimant was not entitled to an assessed fee for obtaining a concession that the proposed surgery was causally related to his compensable injury. Since claimant did not establish that the proposed surgery was reasonable and necessary, his claim for medical services was not found compensable. In other words, claimant did not "prevail finally" over an order or decision denying his claim for compensation pursuant to ORS 656.386(1). Consequently, he was not entitled to an assessed attorney fee. See Anthony J. Colistro, 43 Van Natta 1835 (1991) (Although "causation" portion of surgery denial rescinded at hearing, because the claimant did not establish that the surgery was reasonable and necessary, he was not entitled to an attorney fee pursuant to ORS 656.386(1)). We continue to adhere to that conclusion.

We withdraw our December 30, 1994 order. On reconsideration, as supplemented herein, we republish our December 30, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD C. WENDLER, Claimant
WCB Case Nos. 94-01803 & 93-11729
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Referee Peterson's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

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

We agree with the Referee that Dr. Flemming, treating physician, provides the most persuasive evidence regarding the cause of claimant's current low back condition.[1] We further agree that Dr. Flemming's opinion supports a conclusion that claimant's condition remains compensably related to his accepted 1989 injury claim.

In addition, we note that the Determination Order which closed the 1989 injury claim awarded 8 percent unscheduled permanent disability for bulging discs at L4-5 and L5-S1. (See Ex. 23-2). SAIF did not appeal that order. Because the uncontroverted evidence establishes that claimant's current problems arise from a bulging or herniated disc at the L4-5 level, SAIF is precluded from contending that claimant's L4-5 disc condition is not part of his compensable condition. See Messmer v. Deluxe Cabinet Works, 130 Or App 254, 258 (1994) ("[E]mployer's failure to challenge a [permanent disability] award on the basis that it included an award for a noncompensable condition preclude[d]] employer from contending later that condition is not part of the compensable claim.").

We further find that claimant has proven that his compensable low back condition worsened since the 1989 injury claim was closed; the worsening is established by medical evidence supported by objective findings; and the worsening resulted in diminished earning capacity (see Ex. 39). See ORS 656.273(1). SAIF does not dispute these elements of the claim.

Finally, we note that the parties' October 26, 1990 stipulated agreement, which awarded an additional 5 percent permanent disability (claimant's last arrangement of compensation), expressly provides that the award was made in contemplation of future waxing and waning of claimant's symptoms. (Ex. 24-2).

However, inasmuch as claimant has suffered a worsened condition (not just a symptomatic worsening), (see Exs. 35, 39, 40), he need not prove that this worsening is more than a waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8). Alternatively, even if claimant suffered a mere symptomatic worsening, we would find claimant's aggravation-related loss of three months' worktime indicative of "waxing symptoms" greater than those contemplated by the stipulated agreement.

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[1] In reaching this conclusion, we acknowledge SAIF's contention that Dr. Flemming's opinion should be discounted because it is inconsistent. Nonetheless, we disagree, based on the following reasoning.

It is true that Dr. Flemming once checked a box indicating concurrence with the one-time examiners' opinion that claimant's current condition results from an off-work lawn mowing incident. (See Exs. 42, 48). However, considering Dr. Flemming's opinion as a whole, we conclude that its reasoning (expressed in Dr. Flemming's own words) supports the claim. (See Exs. 35, 39, 40, 49, 52). See Beverly M. Brown, 46 Van Natta 2455 (1994) (We give little if any weight to conclusory opinions such as unexplained "check-the-box" reports, which lack persuasive foundation) (citing Marta I. Gomez, 46 Van Natta 1654 (1994)). Moreover, we agree with the Referee that the contrary opinion is unpersuasive because it is based on an inaccurate history regarding claimant's symptoms since 1989. See also, Kuhn v. SAIF, 73 Or App 768, 772 (1985) (Board erred in relying on medical evidence that condition resolved, when prior permanent disability award established the law of the case, i.e, that claimant had permanent disability).

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

ORDER

The Referee's order dated May 16, 1994 is affirmed. For services on review, claimant's counsel is awarded an $1,000 attorney fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
RONNI L. WYANT, Claimant
WCB Case Nos. 92-03740, 92-03739 & 91-10213
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Howell's order that: (1) upheld the SAIF Corporation's partial denial of her claim for thoracic outlet syndrome; and (2) upheld Liberty Northwest Insurance Corporation's partial denial of the same condition. On review, the issues are compensability and responsibility.

We adopt and affirm the Referee's order with the following supplementation. We change the findings of fact on page 3 to state that claimant began treating with Dr. Arbeene in February 1990 rather than February 1989.

Claimant compensably injured her left shoulder on November 17, 1987, while working for SAIF's insured. SAIF accepted a left shoulder strain. On August 20, 1991, claimant compensably injured her left shoulder while working for Liberty's insured. Liberty accepted the claim for costochondritis and contusion of the left shoulder and left back. At hearing, claimant asserted, among other things, that she suffers from left thoracic outlet syndrome. The Referee concluded that claimant did not meet her burden of proving that she has thoracic outlet syndrome.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Claimant argues that we should defer to the opinion of her treating physician, Dr. Kaye, a family practice physician. Dr. Kaye reported in December 1992 that claimant's symptoms were "compatible with thoracic outlet syndrome" and he referred her to Dr. Konowalchuk. (Ex. 40A). In a concurrence letter from claimant's attorney, Dr. Kaye subsequently agreed with Dr. Konowalchuk's diagnosis of thoracic outlet syndrome. (Ex. 42). We find that Dr. Kaye's opinions are not entitled to any particular deference because his opinions are conclusory.

Claimant also relies on the opinion of Dr. Konowalchuk, a plastic surgeon. Claimant refers to Dr. Konowalchuk as her "treating physician." We ordinarily defer to the attending physician's opinion because attending physicians generally have had a better opportunity to evaluate a claimant's condition than consulting physicians. See Weiland v. SAIF, supra. Here, however, the record indicates that Dr. Konowalchuk saw claimant on two occasions. Given his limited opportunity to evaluate claimant's condition, we decline to give Dr. Konowalchuk's opinion the greater weight ordinarily given to attending physicians' opinions.

In contrast, Dr. Arbeene, an orthopedist, treated claimant for a period of two years, from February 1990 to February 1992. Dr. Arbeene reported that claimant's "history is confusing and vague and complicated by medical differences of opinion, medically contradictory results (NCS), and functional factors." (Ex. 64). Dr. Arbeene did not believe that claimant's symptoms were explained by the diagnosis of thoracic outlet syndrome. (Id). Dr. Arbeene's conclusion is supported by the opinions of Dr. Mertens, a neurologist, Dr. Porter, a professor of vascular surgery, Dr. Brooks, a neurologist, and Dr. Donahoo, an orthopedic surgeon, all of whom reported that claimant did not have thoracic outlet syndrome. (Exs. 48, 49 & 63). We agree with the Referee's reasoning and conclusion that claimant has not met her burden of proving that she suffers from thoracic outlet syndrome.

ORDER

The Referee's order dated March 4, 1994 is affirmed.

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

On October 28, 1994, we withdrew our October 6, 1994 Order on Remand which: (1) affirmed a Referee's order that had set aside the self-insured employer's denial of claimant's myocardial infarction claim; and (2) in accordance with the Supreme Court's appellate judgment, awarded claimant a $23,250 carrier-paid attorney fee. We took this action in response to the employer's representation that the Supreme Court was considering the employer's motion to recall the appellate judgment.

Since issuance of our abatement order, we have received copies of the Court's October 26, 1994 Order Recalling Appellate Judgment and its December 9, 1994 Amended Appellate Judgment. Pursuant to those rulings, the Supreme Court has recalled that portion of its prior appellate judgment which directed us to award a specific attorney fee award in the event that we found the claim compensable. Instead, the Court has mandated that claimant is entitled to recovery of $441.50 in appellate costs, contingent on his ultimately prevailing on the compensability issue.

After receiving copies of the aforementioned Supreme Court rulings, we implemented a supplemental briefing schedule. Having received the parties' respective positions, we proceed with our reconsideration of claimant's attorney fee award.[1]

Since claimant has finally prevailed concerning the employer's denial of his myocardial infarction, claimant is entitled to a carrier-paid attorney fee award for services rendered before every prior forum. ORS 656.388(1). In determining a reasonable attorney fee award, 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.

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[1] Noting that the employer has not sought reconsideration of our compensability finding, claimant has moved for bifurcation of the compensability and attorney fee issues. Reasoning that consideration of the attorney fee issue will delay the processing of his compensable claim, claimant requests issuance of separate orders concerning the two issues. In light of our prompt decision regarding the attorney fee issue, claimant's motion for bifurcation has become moot.

The Referee previously awarded a $5,300 fee for services at hearing and we initially granted a $1,000 fee for services on review. Those awards have not been challenged by the employer. After considering the factors set forth in the aforementioned rule, we find those awards to be reasonable. Consequently, those awards are reinstated. We turn to an evaluation of the record for the purposes of determining a reasonable attorney fee award for claimant's counsel's services on reconsideration of our initial Board order, before the Court of Appeals, and before the Supreme Court.

As demonstrated by the number of appellate decisions (culminating in a Supreme Court opinion), the compensability issue presented a complex legal and medical question. The value of the interest, as well as the benefit secured, to claimant were substantial. The appellate briefs from each of the parties establishes that their respective arguments were presented in an articulate and skillful manner.

Claimant does not challenge the attorney fee awards previously granted by the Referee's order and our initial order ($6,300). Instead, he seeks an additional award for his counsel's services before the Board on reconsideration, as well as before the appellate courts. Claimant's counsel has submitted an affidavit listing the amount of time expended before those forums. Setting forth 155 hours of services, claimant seeks an additional attorney fee totalling $23,250.

The employer challenges claimant's request. Contending that claimant's counsel was already familiar with the case due to his prior services at hearing and on Board review, the employer asserts that claimant's counsel's alloted time was excessive. The employer further notes that claimant's counsel is seeking an attorney fee award for services involving an amicus curiae brief prepared / submitted by another attorney, as well as other services pertaining to another case which was consolidated by the Supreme Court for consideration in tandem with the present case.

In reply, claimant asserts that the time expended by his counsel was not excessive. He explains that substantial research and reasoning was necessary to distinguish this case from developing case law and to convince the Supreme Court that the lower court's analysis had been incorrect. Claimant further notes that new theories were advanced by the employer at nearly every appellate level. Finally, in light of the case's consolidation with another case at the Supreme Court level, as well as the submission of an amicus brief, claimant reasons that it was necessary for his counsel to become familiar with these matters in preparation for oral argument.

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 before the Board on reconsideration and before the appellate courts is $17,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the nature of the proceedings, the complexity of the issue, the benefit secured by claimant, the time devoted to the compensability issue (as represented by the record, claimant's appellate briefs and claimant's counsel's affidavit of services regarding this case, as well as after consideration of the employer's objections), and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our October 6, 1994 order. For services at hearing and on Board review, claimant's attorney is awarded a fee of $6,300, to be paid by the employer. For services before the Board on reconsideration and before the appellate courts, claimant's attorney is awarded $17,500, also payable by the employer.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD J. DEMILLE, Claimant
WCB Case Nos. 94-04493 & 94-01197
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Bostwick, et al., Defense Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation (on behalf of Venetian Blind Company, and hereafter referred to as SAIF/VBC) requests review of those portions of Referee Schultz' order that: (1) awarded claimant's counsel a carrier-paid attorney fee under ORS 656.386(1) for finally prevailing over SAIF/VBC's denial of claimant's current low back condition; and (2) assessed a penalty for the late payment of medical bills. Claimant initially cross-requested review of the Referee's order, but withdrew that request in his respondent's brief. Claimant moves to strike SAIF/VBC's reply brief. On review, the issues are evidence, penalties 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 exception of the fourth Finding of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike SAIF/VBC's Reply Brief

Contending that SAIF/VBC's reply brief raises a responsibility issue which had not been previously addressed on review, claimant moves to strike the brief. One of the issues raised in SAIF/VBC's appellant's brief was claimant's entitlement to a ".386(1)" attorney fee. Consistent with that argument, SAIF/VBC has argued in its reply brief that claimant is not entitled to an attorney fee award because its denial was not set aside. We do not interpret that contention as a challenge to the Referee's responsibility decision, but rather as an argument concerning the Referee's attorney fee award. Based on that interpretation, we deny claimant's motion to strike.

Attorney Fees

As a result of claimant's compensable May 1991 low back injury, SAIF/VBC accepted a low back strain and L4-5 herniated disc. Claimant has received 15 percent unscheduled permanent disability.

In October 1993, claimant began to experience renewed low back symptoms in addition to pain radiating into his right leg and right foot weakness. (Ex. 60). Claimant's treating physician, Dr. Aversano, D.O., opined that the major contributing cause of claimant's increased symptoms was his accepted May 1991 injury. (Ex. 71).

On March 4, 1994, SAIF/VBC sent a letter informing claimant that it was investigating his "aggravation claim" for a low back condition. (Ex. 65E-1). The letter stated: "[t]his is not a denial of your claim;" however, the letter also stated that it believed another of its insureds (hereafter referred to as SAIF/McGee) was the responsible employer. Id. (emphasis in original). The March 4th letter concluded by informing claimant: "[w]e have not requested the appointment of a paying agent pursuant to ORS 656.307, because the compensability of your claim has not been determined." (Ex. 65E-2).

In a second letter sent to claimant on March 18, 1994, SAIF/VBC denied claimant's aggravation claim for his May 1991 low back injury. (Ex. 67A). Specifically, that March 18th letter stated: "Information in your file indicates that your condition has not worsened since the last award or arrangement for compensation. Therefore, we must deny your request to reopen the claim." Id. The letter ended with a statement of claimant's hearing rights consistent with ORS 656.262(8). Id. SAIF/VBC made no further mention of requesting a paying agent under ORS 656.307, nor was there any other discussion regarding responsibility for the claim. Finally, the denial did not indicate that SAIF/VBC would pay claimant's medical bills or had conceded the compensability of his current low back condition.

SAIF/VBC sent a third letter to claimant on April 25, 1994. (Ex. 70). The relevant portion of the April 25th denial provided:

> "On March 18, 1994 a denial of your aggravation was issued based on information in your file indicating that your condition had not worsened since the last award of arrangement for compensation. If it is determined that your condition has worsened, it is SAIF's contention that this alleged worsening is due to your current employment at [SAIF/McGee]. Therefore, SAIF Corporation denies responsibility for the worsening of your current condition." Id.

Once again, the denial letter did not indicate whether SAIF/VBC would pay for claimant's medical bills or whether it had conceded the compensability of claimant's current low back condition. The letter also did not mention whether SAIF/VBC would be requesting a paying agent.

In clarifying the issues to be litigated at hearing, the parties had the following discourse:

> [SAIF/McGee's counsel]: "I'm going to concede that this is a work related condition. I'm not going to concede whether or not there's . . . a worsening under the aggravation statutes or not, but I will state that any medical treatment is causally connected to the original claim."
>
> [SAIF/VBC's counsel]: My position is the same as [SAIF/McGee's counsel]. There's no -- we're conceding that [claimant] has a herniated L4-5 disk and has a lumbar strain that been accepted and continues to necessitate palliative care from time to time, but we're denying that there's been a compensable aggravation sufficient to reopen the claim." (Tr. 11).

The Referee found that claimant's current low back condition and need for treatment was attributable to his May 1991 injury and L4-5 disc herniation, as accepted by SAIF/VBC. However, the Referee concluded that claimant had failed to prove that his compensable condition had worsened under ORS 656.273(1). Thus, the Referee upheld SAIF/VBC's denial of claimant's aggravation claim, but set aside its denial of claimant's low back strain and L4-5 herniated disc condition and remanded the claim to SAIF/VBC for "continuing acceptance." The Referee awarded claimant's counsel a $2,500 carrier-paid attorney fee.

SAIF/VBC challenges the Referee's attorney fee award. It argues that it never denied compensability for anything other than claimant's aggravation claim and, therefore, should not be responsible for payment of an assessed attorney fee. We conclude that claimant is entitled to an attorney fee award under ORS 656.386(1) for obtaining the SAIF/VBC's concession of compensability of claimant's current low back condition. We base this conclusion on the following reasoning.

In James McGougan, 46 Van Natta 1639 (1994), we found that the claimant's counsel was not entitled to a carrier-paid fee under ORS 656.386(1) where the insurer had only denied responsibility and not compensability. In McGougan, the insurer's denial letter expressly stated that the claimant's claim was compensable, that it was only denying responsibility, and that a paying agent would be requested pursuant to ORS 656.307. Reasoning that compensability was not at issue, we held that ORS 656.386(1) was not applicable.

Here, neither of SAIF/VBC's denials contained express language notifying claimant that the compensability of his current condition was not at issue, nor did SAIF/VBC assert that it was only denying responsibility or requesting a paying agent. Therefore, we find claimant's circumstances to be distinguishable from the case of James McGougan, supra. Instead, we find this case to be analogous to Linda K. Ennis, 46 Van Natta 1142 (1994), where we held that an attorney fee award under ORS 656.386(1) was appropriate.

In Ennis, the responsibility disclaimer/denial letter did not expressly concede or address compensability, did not request the designation of a paying agent, contained "notice of hearing" provisions consistent with a denial of compensation, and denied the claimant's claim for benefits. Id. Under such circumstances, the insurer argued that it had never denied the compensability of the claimant's condition, only responsibility for that condition. We disagreed. Reasoning that the insurer had not expressly conceded compensability of the disputed condition, we held that the claimant was entitled to a ".386(1)" attorney fee award.

Here, the first letter SAIF/VBC sent claimant expressly placed him on notice that both compensability and responsibility were at issue. Moreover, SAIF/VBC informed claimant that it had not requested a paying agent pending its determination regarding the compensability of his claim. The subsequent March 18th letter denied "[claimant's] request to reopen the claim." The denial neither indicated that claimant's medical bills would be paid nor was the compensability of claimant's low back condition conceded or addressed. In addition, the April 25th letter repeated SAIF/VBC's denial regarding any worsening of claimant's current condition, but added that, if "it is determined that your condition has worsened," then "SAIF Corporation denies responsibility for the worsening of your current condition." (Ex. 70). As with the previous denial, compensability was neither mentioned nor conceded. Furthermore, the letter did not indicate that SAIF/VBC would be paying claimant's medical bills.

Claimant contends that it was not until he appeared at hearing that SAIF/VBC expressly admitted the compensability of his current low back condition. We agree.

As previously discussed, none of the letters issued by SAIF/VBC indicated that it would pay for claimant's medical bills. Moreover, SAIF/VBC neither mentioned nor conceded the compensability of claimant's current low back condition in any of its pre-hearing correspondence. Inasmuch as SAIF/VBC's position regarding the compensability of claimant's current condition was not clarified until the time of hearing, we hold that claimant is entitled to an attorney fee award under ORS 656.386(1) for securing this concession. See Linda K. Ennis, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the Referee's $2,500 attorney fee award constitutes a reasonable fee for claimant's counsel's pre-hearing services in obtaining SAIF/VBC's concession of the compensability of claimant's current low back conditions. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant is not entitled to an attorney fee for services on review regarding the Referee's attorney fee award. State of Oregon v. Hendershott, 108 Or App 584 (1991); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Penalties

The Referee assessed a penalty, finding that SAIF/VBC untimely paid two medical bills: (1) a December 20, 1993 bill from Dr. Aversano, (Exhibits 64B and 69); and (2) a January 28, 1994 bill from Eastmoreland Radiology (Exhibits 65A and 65B). SAIF/VBC contends that claimant failed to establish when or if SAIF/VBC received the two bills. Consequently, SAIF/VBC asserts that a penalty for untimely payment of the bills is not warranted. We reverse in part, affirm in part, and modify in part.

A January 28, 1994 billing from Eastmoreland Radiology is represented by two documents. The first is a "statement of account" indicating a balance due of $156.75. (Ex. 65A). The second document is an unsigned letter dated February 8, 1994 from claimant's counsel directing SAIF's attention to an enclosed copy of the "Eastmoreland Radiology statement of $156.75 dated 1/28/94." (Ex. 65B). However, neither document indicates when, or if, they were either mailed to or received by SAIF.

Inasmuch as the record does not establish when the Eastmoreland Radiology billing was mailed to SAIF (e.g., certificate of service, postal receipt), and since SAIF disputes its receipt of that billing, claimant cannot rely upon the presumption of receipt under ORS 40.135(1)(q). See Carol M. Cote-Williams, 44 Van Natta 367, 369 (1992); Shari Hallberg, 42 Van Natta 2750 (1990). Consequently, the record does not establish when SAIF/VBC received the Eastmoreland Radiology billing. See Bruce Hardee, 46 Van Natta 2261 (1994); Carol M. Cote-Williams, supra.

Accordingly, no penalty can be assessed for SAIF's alleged failure to timely process that billing. Shari Hallberg, supra. Therefore, we reverse that portion of the Referee's order that awarded a penalty for the insurer's allegedly untimely payment for medical services rendered by Eastmoreland Radiology.

Next, a December 20, 1993 billing from Dr. Aversano is also represented by two documents. The first document is a "health insurance claim form" (dated December 20, 1993) addressed to SAIF, which reflects a balance due of $115 for services rendered on that date. (Ex. 64B). The second document is a note sent from Dr. Aversano's office to claimant's counsel on April 13, 1994. (Ex. 69). The note indicated that the "outstanding bill/chartnote" of December 20 had been "billed to SAIF no later than the 23rd of December." Id. Furthermore, at the May 16, 1994 hearing, claimant represented (without contradiction) that Dr. Aversano's December 1993 bill had not been paid. (Tr. 22).

Inasmuch as the "health insurance claim form" was addressed to SAIF, we interpret Dr. Aversano's subsequent reference to having "billed" SAIF to constitute a representation that the bill was mailed to SAIF by December 23, 1993. Since Dr. Aversano's April 13, 1994 note and claimant's testimony confirmed that the bill was not paid within 90 days of its mailing, we are persuaded that SAIF/VBC failed to timely pay Dr. Aversano's December 20, 1993 bill.[1] Accordingly, we affirm the Referee's order assessing a penalty for the late payment of that medical bill. ORS 656.262(10)(a).

However, we modify the calculation of that penalty. Based upon Exhibit 69, we find that the amount of the unpaid bill was $115, rather than $150, as listed in the Referee's order. Consequently, claimant is awarded a penalty equal to 25 percent of the $115 medical bill. This penalty shall be shared equally by claimant and his attorney.

Claimant's counsel is not entitled to an assessed fee for defending against the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated May 25, 1994 is reversed in part, modified in part and affirmed in part. That portion of the Referee's order that assessed a penalty for the untimely payment of $156.75 to Eastmoreland Radiology is reversed. The Referee's penalty award for untimely payment of $150 to Dr. Aversano is modified to $115. Claimant's and his attorney's 50 percent shares of this penalty shall be likewise modified. The remainder of the Referee's order is affirmed.

[1] In contrast to the Eastmoreland Radiology billing, the record contains evidence from the medical service provider (Dr. Aversano) establishing that the medical charge was "billed," which we have interpreted under these circumstances to mean "mailed" to SAIF and not reimbursed within 90 days.

In the Matter of the Compensation of
PATRICIA FISHER, Claimant
WCB Case No. 92-13625
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Referee Peterson's order that set aside its denial of claimant's aggravation claim for a right wrist condition. Claimant cross-requests review of the Referee's $2,500 attorney fee award. On review, the issues are aggravation and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable right wrist injury on July 5, 1986. The claim was processed by SAIF on behalf of the noncomplying employer. Claimant underwent surgery on November 19, 1987 for a "hypermobile scaphoid" in her right wrist. (Ex. 17). A Determination Order issued on April 19, 1988, awarding claimant 15 percent scheduled permanent disability for weakness and lost range of motion in her right wrist/forearm.

While working for an "out-of-state" employer in June 1992, claimant began to experience renewed symptoms in her right wrist. On October 8, 1992, SAIF disclaimed/denied responsibility and compensability regarding claimant's aggravation claim for "right wrist extensor tendinitis." (Ex. 34). Claimant requested a hearing and the Referee set aside SAIF's denial. Relying upon the medical opinion of claimant's treating physician and surgeon, Dr. Keck (orthopedist specializing in hand surgery), as well as the opinion of Dr. Powell (orthopedist), the Referee reasoned that the preponderance of evidence indicated that claimant's worsened right wrist condition was due to her accepted July 1986 injury.

SAIF argues that claimant's current right wrist condition is due to a preexisting "lax ligament" condition. (App. Br. at 3). Specifically, SAIF relies on the March 20, 1987 opinion of Dr. German (orthopedic surgeon): "It is my suspicion this patient does have lax ligaments of both wrists as well as generalized laxity." (Ex. 10). Conversely, Dr. Powell opined that claimant's right wrist condition was "directly related" to her 1986 injury. (Ex. 37A-5). Dr. Powell also stated that there was "no basis" to conclude that claimant's "laxity" preexisted her 1986 injury. (Ex. 44).

The medical evidence does not establish that claimant has a preexisting "lax ligament" condition. In the face of contradictory evidence, Dr. German's "suspicion" by itself is too speculative to prove a preexisting ligament condition. See generally Gormley v. SAIF, 52 Or App 1055, 1059 (1981). Therefore, in order to establish a compensable aggravation claim for her right wrist condition, claimant has the burden of proving that her worsened condition is materially related to her original injury. See Jocelyn v. Liberty Northwest Ins. Corp., 132 Or App 165 (December 28, 1994). Taylor v. SAIF, 75 Or App 583 (1985). We agree with the Referee that the preponderance of medical evidence indicates that claimant's current right wrist condition is an aggravation of her accepted July 1986 injury. See ORS 656.273(1); Smith v. SAIF, 302 Or 396, 399 (1986).

Alternatively, SAIF argues that claimant's worsened condition is not compensable, because it is the result of the "out-of-state" work exposure. In order to prevail, SAIF must prove that the major contributing cause of claimant's worsened condition was that "out-of-state" work exposure. See ORS 656.273(1); John I. Jett, 46 Van Natta 33 (1994); see also Fernandez v. M & M Reforestation, 124 Or App 38 (1993).

We find no persuasive medical evidence that claimant suffered a new injury or occupational disease as a result of her "out-of-state" work exposure. Specifically, claimant's treating physician (Dr. Keck) opined that claimant's work activities with the "out-of-state" employer caused her right wrist condition to become symptomatic in 1992, but claimant's 1986 injury was the ultimate cause of her "underlying problem." (Ex. 43-2). Dr. Keck defined that "underlying problem" as scapholunate laxity. (Ex. 45-17). Furthermore, Dr. Keck stated that it was "more probable than not" that claimant's current condition involved the same ligament that was injured in her 1986 injury. (Ex. 45-11). Dr. Powell agreed that claimant's "underlying condition dates back to her injury of 1986."

Finding no reason to do otherwise, we afford Dr. Keck's medical opinion the deference due a treating physician. Weiland v. SAIF, 64 Or App 810(1983). In addition, we rely upon the complete and well-reasoned opinions of both Dr. Keck and Dr. Powell. See Somers v. SAIF, supra. Therefore, we conclude that SAIF has not met its burden of proving that an "out-of-state" work exposure in 1992 was the major contributing cause of claimant's worsened condition. Accordingly, we conclude that claimant's aggravation claim is compensable. ORS 656.273(1); see John I. Jett, supra.

Lastly, claimant cross-requests review of the Referee's attorney fee award. (Resp. Br. at 9). For services at the hearing level, the Referee awarded a $2,500 attorney fee under ORS 656.386(1). Claimant contends that the award should be increased to $6,000. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $2,500 is a reasonable attorney fee for claimant's counsel's services at the hearing level concerning the employer's aggravation denial. 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.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and

applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the aggravation issue is $1,800, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee award for services devoted to the attorney fee issue.

ORDER

The Referee's order dated April 21, 1994 is affirmed. Claimant's counsel is awarded an assessed fee of $1,800, payable by the SAIF Corporation.

In the Matter of the Compensation of
EULALIO M. GARCIA, Claimant
WCB Case No. 94-01916
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Referee Howell's order that: (1) awarded claimant additional temporary total disability (TTD) at a higher rate; (2) declined to modify claimant's TTD award to temporary partial disability (TPD) based on his receipt of unemployment compensation; and (3) assessed penalties for allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Exhibit 11A is a March 18, 1994 letter addressed to Dr. Aptecker from SAIF's claims examiner. This letter asks several questions and contains handwritten responses to those questions. Those responses are unsigned and undated.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability

Claimant was compensably injured on December 1, 1993. Dr. Bhasin, chiropractor, began treating claimant on December 2, 1993, and indicated that claimant was not released to regular work. SAIF paid TTD from December 5, 1993 to December 17, 1993, making the final payment on January 6, 1994. (Ex. 12).

The Referee concluded that SAIF was not entitled to unilaterally terminate claimant's TTD benefits as of December 17, 1993. Specifically, the Referee concluded that, as of December 17, 1993, claimant had not returned to regular work, nor had he been released to regular work, nor offered modified work consistent with Dr. Bhasin's restrictions. On review, SAIF does not dispute the Referee's decision regarding its unilateral termination of TTD in relation to Dr. Bhasin's authorization for time loss.

SAIF enrolled claimant in a managed care organization (MCO). (Ex. 9-2, -3). On February 1, 1994, claimant began treating with Dr. Aptecker, a chiropractor who was on the list of MCO providers that SAIF gave to claimant. (Tr. 11-12, Exs. 9, 10). Dr. Aptecker eventually authorized time loss for claimant beginning February 1, 1994, the first day he treated claimant. (Exs. 10, 11). SAIF paid claimant TTD from February 1, 1994 to April 2, 1994. Based on a release to regular work from Dr. Aptecker, SAIF terminated claimant's TTD benefits as of April 2, 1994.

The Referee ordered SAIF to pay unpaid TTD from the date of the compensable injury through "the present." As discussed above, the Referee did not find SAIF entitled to unilaterally terminate TTD regarding Dr. Bhasin's time loss authorization. In addition, the Referee reasoned that Dr. Aptecker, as a chiropractor, was not qualified to serve as claimant's attending physician under ORS 656.005(12)(b)(B) at the time he issued the release to regular work. Thus, because there was no release to regular work from a qualified attending physician, the Referee determined that SAIF was not entitled to unilaterally terminate TTD payments pursuant to ORS 656.268(3)(b).

On review, SAIF contends that its termination of benefits was authorized under ORS 656.268(3)(b) because Dr. Aptecker was qualified to serve as claimant's attending physician. Specifically, SAIF argues that the MCO contract authorized a chiropractor who was a member of the MCO, such as Dr. Aptecker, to serve as an attending physician.[1] We agree with the Referee's conclusion that SAIF was not entitled to unilaterally terminate claimant's TTD. However, we base our decision on the following reasoning.

Under the facts of this case, there is no need to resolve the issue of whether Dr. Aptecker, as a chiropractor under contract with a MCO, was qualified to serve as claimant's attending physician at the time he released claimant to regular work. Even assuming that Dr. Aptecker was so qualified, the requirements of ORS 656.268(3)(b) that would enable SAIF to unilaterally terminate claimant's TTD compensation were not met.

ORS 656.268(3)(b) allows an insurer to unilaterally terminate TTD payments when "[t]he attending physician gives the worker a written release to return to regular employment." The requirements of ORS 656.268(3)(b) are clear, unambiguous and specific in what is required before an insurer may unilaterally terminate TTD benefits. Those requirements were not met here.

Specifically, even assuming Dr. Aptecker was claimant's attending physician, there is no evidence that claimant received the document in question.[2] (Ex. 11A). Claimant testified that Dr. Aptecker never informed him that he was released to work and never sent him any documents. (Tr. 12-13, 16). Consequently a written release to regular work was not given to claimant as expressly required by ORS 656.268(3)(b). Cameron v. Norco Contract Service, 128 Or App 422 (1994); Trevor E. Shaw, 46 Van Natta 1821 (1994). Accordingly, we conclude that SAIF improperly terminated claimant's TTD benefits.

Temporary Partial Disability

On review, SAIF argues that claimant's TTD benefits should be reduced to TPD benefits by offsetting the unemployment benefits claimant received beginning in February 1994. Claimant argues that we should not address the issue of TPD benefits because that issue was not raised at hearing. We disagree with claimant and find that the issue of TPD benefits was both raised at hearing and addressed by the Referee's order.

Claimant raised the issue of TPD benefits in his request for hearing. This, in itself, raised the issue at hearing. Liberty Northwest Ins. Corp. v. Alonso, 105 Or App 458 (1991). In addition, claimant agreed to the Referee's summary of the points that the parties agreed to, including the statement that "claimant is entitled to some temporary disability compensation, either temporary total or temporary partial disability." (Tr. 2). Finally, claimant's attorney attempted to develop testimony at hearing regarding TPD. (Tr. 9-11). On this record, we find that the issue of TPD benefits was raised at hearing.

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[1] SAIF contends that the MCO contract contains a provision that allows member chiropractors to serve as attending physicians. However, the record contains no evidence regarding that MCO contract. Inasmuch as the aforementioned "chiropractor" provision has not been conceded, we would have been unable to resolve this "attending physician" question based on the record before us. In any event, as subsequently discussed, it is not necessary to resolve the issue of whether Dr. Aptecker was qualified to serve as claimant's attending physician at the time he was released to regular work.

[2] We note that Exhibit 11A is a March 18, 1994 letter addressed to Dr. Aptecker from SAIF's claims examiner. The letter asks several questions and contains handwritten responses to those questions. However, those responses are undated and unsigned. For that reason, we give Exhibit 11A little probative weight.

The Referee found that SAIF could not reduce claimant's TTD to TPD because none of the conditions for terminating temporary total disability under ORS 656.268(3) were met. SAIF requested reconsideration of the Referee's order, arguing that, since claimant testified that he had been receiving unemployment benefits beginning in February 1994, claimant was only entitled to TPD. The Referee denied SAIF's request for reconsideration, finding that the reasoning in Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987), had been disavowed by Stone v. Whittier Wood Products, 124 Or App 117 (1993). We disagree that Stone disavowed Wells.

Subsequent to the Referee's order, we issued our decision in Timothy O. Logsdon, 46 Van Natta 1602 (1994). There, we concluded that Stone had not overruled Wells and that the two decisions were not inconsistent. In reaching this conclusion, we found that:

> "Stone sets forth the manner in which to calculate a worker's TPD rate and concludes that post-injury wages do not, in and of themselves, establish whether a worker has a diminished 'earning power at any kind of work' pursuant to ORS 656.212. Wells holds that the representations made by a worker in obtaining unemployment compensation take the worker out of the realm of total disability and that unemployment benefits may be treated as receipt of post-injury wages and offset against TPD. Thus, the TPD calculated under the court's guidance in Stone is subject to an offset of unemployment benefits pursuant to Wells." 46 Van Natta at 1603.

Applying that reasoning in Logsdon, we determined that the claimant was entitled to TPD (not TTD) during the period he received unemployment benefits. Id. The same reasoning applies here. Claimant is entitled to TPD (not TTD) during the period he received unemployment benefits. Wells, supra.

Consequently, we conclude that claimant is entitled to TPD for the period during which he received unemployment benefits. Thus, SAIF is directed to calculate claimant's temporary disability under the court's guidance in Stone, considering the amount of unemployment benefits he received during the relevant period pursuant to Wells. Logsdon, supra.

Penalties

The Referee found that SAIF had unreasonably failed to pay claimant compensation by its impermissible unilateral termination of TTD. Consequently, the Referee assessed a penalty of 25 percent of the additional temporary disability compensation payable as a result of his order. SAIF does not argue that the penalty should be reversed. Instead, SAIF argues that, if we reduce the amount of compensation due claimant, the penalty assessed by the Referee should be reduced accordingly. We agree.

Pursuant to the above reasoning, claimant is entitled to TTD from the date of injury until he began receiving unemployment benefits. While he received unemployment benefits, he was entitled to TPD based on his receipt of unemployment benefits as if those benefits were wages as analyzed under Stone and Wells. Timothy O. Logsdon, supra. The assessed penalty is modified to 25 percent of unpaid TTD and TPD benefits payable from the effective date of SAIF's unilateral termination (December 17, 1993) through the date of the May 10, 1994 hearing. One half of the penalty is to be paid directly to claimant and the other half is to be paid directly to claimant's attorney. ORS 656.262(10)(a).

ORDER

The Referee's order dated June 6, 1994 is affirmed in part and modified in part. The Referee's temporary total disability award is modified to award claimant temporary partial disability benefits during the period that he received unemployment benefits. In lieu of the Referee's penalty assessment, SAIF is assessed a penalty of 25 percent of claimant's temporary total and temporary partial disability awards payable from the effective date of SAIF's unilateral termination (December 17, 1993) to the date of the May 10, 1994 hearing. Such penalty shall be paid one-half each directly to claimant and claimant's attorney. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CHRISTOPHER R. GARZA, Claimant
WCB Case No. 93-05268
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Garaventa's order which affirmed an Order on Reconsideration that awarded no unscheduled permanent disability benefits for a low back injury. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant contends that he is entitled to an unscheduled permanent disability award based on lost range of motion and a chronic condition limiting repetitive use. We disagree.

Because claimant's condition became medically stationary after July 1, 1990, and his claim was closed before December 14, 1993, we apply the disability rating standards in effect at the time of the June 15, 1993 Determination Order. See OAR 436-35-003(2). Those standards are set forth in WCD Admin. Order 6-1992.

We find no persuasive evidence of lost range of motion. Dr. Stringham made range of motion findings, but opined that they were an "underestimate" of claimant's true ability. (Ex. 28). Accordingly, we find no permanent impairment based on lost range of motion.

A worker may be entitled to an unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use an unscheduled body part due to a chronic and permanent medical condition. Former OAR 436-35-320(5). This rule requires medical evidence of, at least, a partial loss of ability to repetitively use the body part. See Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

Here, we find no persuasive medical evidence of a partial loss of ability to repetitively use the low back. Dr. Stringham, claimant's attending physician, reported that claimant has low back pain which is "limiting in his activity to some extent," and that there is an "increased risk of recurrent injury." (Ex. 28). Neither of these statements establishes a partial loss of ability to repetitively use the low back.

Furthermore, although a physical capacities evaluator recommended that claimant avoid bending and twisting, (Ex. 20-2), that recommendation does not establish that he is unable to bend and/or twist repetitively. See Rae L. Holzapfel, 45 Van Natta 1748 (1993). In any event, we may not consider the physical capacities evaluation for the purpose of making impairment findings because it was not ratified by Dr. Stringham. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). Finally, claimant points to his own lay testimony as evidence of a chronic condition impairment; however, such lay testimony alone is insufficient to establish impairment under the standards. Former OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991). Accordingly, claimant is not entitled to a permanent disability award.

ORDER

The Referee's order dated May 2, 1994 is affirmed.

In the Matter of the Compensation of
KEVIN S. LARSEN, Claimant
WCB Case No. 94-01591
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Charles L. Lisle, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Hazelett's order that upheld the self-insured employer's denial of claimant's aggravation claim for a left knee condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's current anterior cruciate (AC) ligament condition did not arise out of and in the course of his employment. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). The Referee further concluded that claimant failed to establish the compensability of his current left knee condition and need for treatment as either a resultant or consequential condition. See ORS 656.005(7)(a)(A); ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 27 (1993).

On review, claimant contends that this case should have been analyzed as an aggravation claim under the material contributing cause standard of ORS 656.273(1). The employer does not dispute the posture of the case.[1] However, the employer argues that, because claimant had a preexisting AC ligament condition, the proper statutory analysis for determining the compensability of claimant's present left knee condition as an aggravation claim is the major contributing cause standard under ORS 656.005(7)(a)(B).

Claimant sustained an off-work left knee strain in January 1989, at which time he "stretched" the AC ligament. Claimant then injured his left knee at work in August 1989. During arthroscopic surgery, Dr. Dahlin, claimant's treating orthopedic surgeon, repaired a torn medial meniscus, and discovered a chronic AC ligament deficiency. The employer accepted a left medial meniscus tear.

In a December 18, 1989 closing examination, Dr. Dahlin concluded that claimant was medically stationary without impairment, and released him for unrestricted activities. Thereafter, a Determination Order awarded claimant 5 percent permanent disability for surgery. Although claimant experienced occasional locking and "popping" of the left knee, after April 1990, he did not seek treatment again until December 1993.

Dr. Dahlin performed repeat arthroscopic surgery in February 1994. Dr. Dahlin found no disruption of the AC ligament, chondromalacia of the medial femoral condyle at the site of the 1989 medial meniscus surgery (but no further tear to the medial meniscus), and loose medial femoral condyle cartilage bodies which he removed from the knee joint.

In order to establish a compensable aggravation of a scheduled condition, claimant must prove, by medical evidence supported by objective findings, a worsened condition resulting from the compensable condition. ORS 656.273(1) and (3); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that he is more disabled, i.e., has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993); International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988). Because claimant received a previous

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[1] The present case arose from the employer's denial of claimant's "recent left knee problems" as not representing a "compensable result, consequence or worsening" of the accepted left knee condition.

permanent disability award for his condition, he must also establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).[2]

Claimant contends that he has established a compensable aggravation claim under the material contributing cause standard of ORS 656.273(1). The employer asserts that the major contributing cause standard under ORS 656.005(7)(a)(B) applies. The Referee did not specifically address the aggravation issue.[3] Inasmuch as the present case arose from the employer's denial of, inter alia, a "worsening" of the accepted left knee condition, we do so now.

The pivotal issue on review concerns the applicable standard of proof of causation to be applied to aggravation claims under ORS 656.273. Subsequent to the filing of briefs in this case, the Court of Appeals issued its decision in Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994). There, the employer accepted a claim that had been diagnosed as a low back strain, superimposed on a preexisting, non-work related degenerative lumbar disc condition (unchanged by the work injury). The claim was closed by Determination Order. After a CT scan revealed increasing disc derangement and herniation, the claimant's physician recommended a diskectomy and fusion. The claimant filed an aggravation claim for his worsened low back condition, which the employer denied. The claimant appealed.

We affirmed a referee's order that held that, because the claimant's current condition was caused by a combination of his compensable injury and his preexisting disc condition, he was required to show, pursuant to ORS 656.005(7)(a)(B), that the compensable injury was the major contributing cause of the worsened condition. The Court of Appeals disagreed. In deciding whether the major contributing cause standard for conditions resulting from the combination of a compensable condition and a preexisting condition was intended to change the legal standard that applies to a claim for aggravation under ORS 656.273(1), the court first looked to the text and context of the statute.

Finding that the phrase "resulting from" in the aggravation statute has long been interpreted to require a claimant to prove only that the original compensable injury of occupational disease was a material contributing cause of the worsened condition, the court reasoned that the legislature's failure to change that language precluded a conclusion that the legislature intended a change in its meaning. The court found further support for its conclusion that there was no intent to change the standard for aggravations claims (except those involving off-the-job injuries), in the legislative history. Examining the proposed changes to ORS 656.273, the court found no mention of the major contributing cause standard of ORS 656.005(7)(a)(B) or suggestion that the legislature intended ORS 656.005(7)(a)(B) to apply in the aggravation context. The court concluded, therefore, that the legislature did not intend to affect the standard of proof for aggravation claims.

Applying that analysis to the facts, the Jocelyn court held that 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, even if the claimant had a condition that preexisted the compensable injury. Id.

Thus, in order to establish a compensable aggravation of his accepted knee condition, claimant need only establish that his accepted condition materially contributed to his current need for medical services.[4] ORS 656.273(1); Jocelyn v. Wampler Werth Farms, supra. We turn to an application of the Jocelyn rationale.

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[2] On this record, however, we find no contemporaneous medical report establishing that the Determination Order contemplated future waxing and waning of claimant's left knee symptoms. Consequently, it is unnecessary to determine whether claimant's current symptoms exceeded any contemplated fluctuating symptoms. See Daniel C. Reddekopp, 46 Van Natta 1536 (1994).

[3] The Referee analyzed the compensability of claimant's current knee condition as a primary, resultant, and consequential condition. Because he found that claimant's current condition was not compensable, the Referee did not separately address aggravation.

[4] The major contributing cause standard does not apply in an aggravation context absent an assertion by the carrier that an off-work injury caused the current condition. That contention does not apply to this case.

The employer accepted a left medial meniscus tear. Claimant's current left knee condition encompasses both chronic AC ligament deficiency/laxity and medial femoral condyle chondromalacia with loose medial femoral condyle cartilage bodies. Dr. Dahlin reported that, currently, claimant's AC ligament is intact and that the degree of ligament instability remains unchanged from 1989. Dr. Dahlin noted, however, that claimant now has post-meniscectomy changes in the knee joint, viz., medial femoral condyle chondromalacia with loose cartilage bodies. Neither examining physician Dr. Thompson nor reviewing physician Dr. Hunt disputes that claimant has post-meniscectomy medial femoral condyle chondromalacia.

Dr. Dahlin, who performed both the 1989 and 1994 arthroscopic surgeries, opined that the medial meniscus injury with meniscectomy is the primary cause of claimant's current left knee condition. Dr. Hunt opined that both the meniscectomy and the chronic AC ligament instability are contributing causes of claimant current condition. Dr. Thompson commented, that, because it is rather unusual for this type of articular degeneration to occur in five years following a meniscectomy, it was his "feeling" that the medial femoral condyle changes more likely are due to the AC instability rather than the torn meniscus.

We conclude that claimant has established that his compensable injury is a material contributing cause of his worsened left knee condition (medial femoral condyle chondromalacia with loose cartilage bodies). In reaching this conclusion, we rely on the opinion of Dr. Dahlin. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). Further, we interpret Dr. Hunt's opinion to support the conclusion that the compensable injury is at least a material contributing cause of claimant's worsened knee condition. See Jocelyn v. Wampler Werth Farms, supra; McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

Accordingly, we reverse the Referee's decision upholding the employer's denial of claimant's left knee condition, insofar as that denial pertains to claimant's aggravation claim for the medial femoral condyle chondromalacia condition. We do not disturb the Referee's decision insofar as it upheld the employer's denial of claimant's AC ligament condition.

Claimant's counsel is entitled to an attorney fee for services at hearing and on review concerning the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services is $2,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated June 10, 1994 is reversed in part and affirmed in part. The self-insured employer's denial, insofar as it denied claimant's aggravation claim for the medial femoral condyle chondromalacia condition, is set aside and the claim is remanded to the employer for processing in accordance with the law. The remainder of the Referee's order is affirmed. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $2,500, to be paid by the employer.

In the Matter of the Compensation of
STEVEN R. LYONS, Claimant
WCB Case No. 93-12406
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of that portion of Referee Brazeau's order that set aside its partial denial of claimant's current low back condition and need for medical services. Claimant cross-requests review of that portion of the order that upheld the employer's October 19, 1993 denial of claimant's aggravation claim for the same condition. On review, the issues are aggravation and medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On October 12, 1993, the employer denied claimant's aggravation claim on the basis that claimant's condition and need for treatment did not arise out of the scope and course of his employment with the employer. (Ex. 50). On October 19, 1993, the employer issued an amended denial of claimant's current condition and need for medical treatment on the same basis. (Ex. 55).

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt and affirm the Referee's analysis regarding this issue, with the following supplementation.

To prove a compensable aggravation, a claimant must establish that his or her compensable injury materially contributed to his worsened condition. Jocelyn v. Liberty Northwest Ins. Corp., 132 Or App 165 (1994); Fernandez v. M & M Reforestation, 124 Or App 38, 42 (1993). A carrier may defeat an otherwise compensable aggravation claim by establishing that the major contributing cause of an alleged aggravation was an off-work injury. Id.; see ORS 656.273(1).

No one contests that claimant has met his initial burden of proof. Rather, the dispute focuses on whether the employer has established that claimant's 1993 off-work lifting incident was the major contributing cause of his alleged aggravation.[1] Claimant asserts that, because the evidence regarding that issue is in equipoise, the employer has failed to defeat the compensability of his aggravation claim. We disagree.

Dr. Buza, treating neurosurgeon, opined that both the 1993 off-work lifting incident and the 1989 compensable injury contributed to claimant's current disc herniation. He further concluded that, based on claimant's history, the 1993 injury caused greater than 51 percent of claimant's current disc condition. The reports of Dr. Stanford, examining physician, support Dr. Buza's conclusion.

In contrast, Dr. Rollings, treating physician, opined that the major contributing cause of claimant's current condition and need for treatment was the 1989 back injury, in that the 1993 lifting incident worsened his prior disc condition, making it symptomatic.

Dr. Rollings' opinion does not render the evidence in equipoise, as claimant contends. Rollings merely opined that the 1989 injury was the major cause of claimant's condition without offering an explanation for that conclusion. Moreover, he did not address a one-year hiatus in claimant's medical treatment. Consequently, we are more persuaded by Drs. Buza's and Stanford's opinions. E.g., Kassahn v. Publisher's Paper Co., 76 Or App 105 (1985).

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[1] In Jocelyn v. Liberty Northwest Ins. Corp., supra, the court held that ORS 656.005(7)(a)(B)'s major contributing cause standard does not apply to aggravation cases under ORS 656.273 where the issue concerns the degree to which a claimant's original injury was the cause of the worsened condition. Here, the issue concerns the degree to which an off-work injury contributed to claimant's worsened condition. Jocelyn is, therefore, inapposite.

For these reasons, we conclude that the major contributing cause of claimant's worsened condition was the 1993 off-work lifting incident. Accordingly, we affirm the Referee's conclusion that the employer has defeated claimant's aggravation claim.

Medical Services

The Referee concluded that, under Sam D. Ferguson, 44 Van Natta 274 (1992), aff'd Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993), claimant need only establish that his compensable injury is a material contributing cause of the need for medical services. Concluding that claimant had met that burden, the Referee set aside the employer's October 19, 1993 denial of claimant's current condition and need for medical treatment. The employer argues that neither ORS 656.245(1) nor Ferguson applies to this case. We agree.

The primary issue presented here is whether the parties litigated this matter as an aggravation claim or as a medical services claim. If it is the latter, claimant need only establish that his accepted condition materially contributed to his current need for medical services. ORS 656.245(1); Roseburg Forest Products v. Ferguson, supra; Beck v. James River Corp., 124 Or App 484 (1993).

Claimant sustained a compensable low back injury in 1989. The claim was closed in April 1991 with a 23 percent permanent disability award. In September 1993, claimant's back symptoms increased following an off-work lifting incident. Dr. Rollings took claimant off work and submitted an aggravation claim to the employer on October 6, 1993. (Ex. 44). On October 12, 1993, the employer denied claimant's aggravation claim on the basis that claimant's condition and need for treatment did not arise out of the scope and course of his employment with the employer. (Ex. 50). On October 19, 1993, the employer issued an amended denial of claimant's current condition and need for medical treatment on the ground that the condition did not represent a worsening of claimant's compensable injury. (Ex. 55). At hearing, the parties agreed that the issue was two denials of compensability and responsibility for claimant's current condition and need for treatment. (Tr. 2).

On the basis of this evidence, we conclude that the parties' disagreement concerned the compensability of claimant's current low back condition as an aggravation of his 1989 compensable injury, not the compensability of continuing medical treatment related to the 1989 injury. Consequently, we conclude that the parties were litigating this matter as an aggravation claim rather than as a medical services claim.[2] See Joseph Parry, 46 Van Natta 2318 (1994) (Beck v. James River Corporation, supra, held inapplicable to case litigated as resultant condition claim, not medical services claim). In view of this conclusion, and claimant's failure to establish a compensable aggravation, we reverse that portion of the Referee's order setting aside the employer's October 19, 1993 denial.

ORDER

The Referee's order dated January 26, 1994, as reconsidered February 9, 1994, is affirmed in part and reversed in part. That portion of the order setting aside the employer's October 19, 1993 denial is reversed. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

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[2] The Court of Appeals has held that carriers are bound by the express language of their denials. Tattoo v. Barrett Business Services, 118 Or App 348, 351 (1993). The employer's denials are both couched in the terms of ORS 656.273(1). Therefore, we conclude that, in the absence of a concession by the employer redefining the issue at stake as a medical services claim related to claimant's accepted condition, the employer's amended denial of claimant's aggravation claim to include his current condition and need for medical services does not serve to convert the issue being litigated from an aggravation claim to an ORS 656.245(1) medical services claim. Moreover, there is nothing in the hearing transcript to indicate that claimant specified that medical treatment for his original injury was at issue. See Joseph Parry, supra, 46 Van Natta at 2319, n 3; cf. Larry D. Johnson, 46 Van Natta 440 (1994) (Board unable to determine whether parties litigating matter as medical services or consequential or resultant condition claim).

In the Matter of the Compensation of
PATRICIA A. MALONE, Claimant
WCB Case Nos. 93-12519 & 93-09091
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Roberts, et al., Defense Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Sedgwick James & Co., on behalf of Hillhaven Corporation (Hillhaven), requested, and claimant and Crawford & Company, on behalf of Plantation Care Center (Plantation), cross-requested, review of Referee Daughtry's order that: (1) found that Hillhaven had untimely disclaimed responsibility for claimant's neck condition; (2) set aside Hillhaven's denial/disclaimer of claimant's neck condition; (3) upheld Plantation's denial of claimant's claim for the neck condition; (4) set aside Plantation's denial/disclaimer of claimant's right shoulder condition; (5) upheld Hillhaven's denial of claimant's right shoulder condition; (6) awarded a $3,000 carrier-paid attorney fee under ORS 656.386(1) payable by Hillhaven for finally prevailing over its denial of claimant's neck condition; and (7) awarded a $1,000 carrier-paid attorney fee under ORS 656.382(1) payable by Plantation for an allegedly unreasonable resistance to the payment of compensation.

Pursuant to a Disputed Claim Settlement, claimant and Hillhaven have resolved all issues between them. By interim order dated October 25, 1994, we approved the settlement, thereby resolving the disputes pending between claimant and Hillhaven. Inasmuch as the issues involving claimant and Plantation were unaffected by the settlement, we retained jurisdiction to consider those issues. Accordingly, we proceed to address the issues remaining between claimant and Plantation.

Claimant requests review of that portion of Referee Daughtry's order that did not award an attorney fee pursuant to ORS 656.386(1) against Plantation for its denial of claimant's right shoulder condition. Plantation cross-requests review of that portion of the Referee's order that awarded claimant's counsel a $1,000 attorney fee for Plantation's allegedly unreasonable denial. In her brief, claimant also seeks correction of a typographical error in the Referee's order. 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 filed a claim with Plantation for a September 9, 1992 right shoulder injury. Plantation denied that injury claim on October 9, 1992 and claimant requested a hearing. In an order dated July 14, 1993, Referee Howell set aside Plantation's October 9, 1992 denial of claimant's right shoulder injury claim. Plantation requested Board review of Referee Howell's order.

On October 18, 1993, claimant filed a claim for an aggravation of her September 10, 1992 injury and/or requested that Plantation formally accept claimant's current need for treatment. (Ex. 22B). Plantation denied the October 18, 1993 claim on October 19, 1993, stating: "It is our position that your right shoulder issue [sic] is not compensable and currently this issue is in front of the Board." (Ex. 22C).

Claimant requested a hearing on Plantation's October 19, 1993 denial which resulted in the current litigation. At the hearing, Plantation took the position that the right shoulder condition was not compensable. In the alternative, assuming that the condition was compensable, Plantation argued that another carrier was responsible. (Tr. 5-6).

The Referee found claimant's right shoulder condition compensable and Plantation responsible for that condition. However, reasoning that an ORS 656.386(1) fee had already been assessed against Plantation in the litigation before Referee Howell, the present Referee declined to award an ORS 656.386(1) attorney fee payable by Plantation. After the date of hearing, but before the Referee issued his "Opinion and Order on Reconsideration," the Board affirmed Referee Howell's order.

On review, claimant contends that Plantation's denial of compensability put her right to continuing benefits for her compensable right shoulder/scapula condition at issue. On this basis, claimant seeks an attorney fee pursuant to ORS 656.386(1) for her counsel's efforts in setting aside that denial. Plantation contends that its October 19, 1993 denial is consistent with its original position that the right shoulder/scapula condition was not compensable. It argues that since the compensability of the right shoulder/scapula condition was already on appeal in another proceeding, its October 19, 1993 denial was not a separate denial which could also give rise to a fee. We disagree with Plantation's reasoning.

Plantation denied claimant's October 18, 1993, "claim for compensation." This claim, for an aggravation and/or for claimant's medical treatment in April through June of 1993, is separate from claimant's claim for an initial injury on September 9, 1992. Inasmuch as Plantation's denial of that aggravation/medical services claim has been set aside, claimant is entitled to an attorney fee pursuant to ORS 656.386(1). SAIF v. Allen, 320 Or 192 (1994).

Our decision is supported by the court's recent decision in Karl v. Construction Equipment Co., 132 Or App 293 (1995). In Karl, the insurer had denied compensability of an aggravation claim for the left knee. While the issue of compensability of the aggravation claim was on appeal, the claimant requested a second hearing seeking payment of medical bills related to the left knee. Finding that it was unclear whether he had jurisdiction over the medical services dispute, the referee dismissed the claimant's hearing request and the claimant requested Board review. In the meantime, the Board issued its order finding the aggravation claim compensable.

On Board review of the medical services dispute, we held that the earlier aggravation litigation had established a causal connection between the claimant's current need for treatment of his left knee and the compensable injury. Thus, we held that the insurer was precluded from asserting that the medical bills for the left knee were not related to the compensable injury. We initially awarded an additional attorney fee pursuant to ORS 656.386(1) to the claimant's attorney for prevailing on the compensability of the medical treatment. Hartmut Karl, 45 Van Natta 2137 (1994). However, on reconsideration, we withdrew our attorney fee award in reliance on SAIF v. Allen, 124 Or App 183 (1993). 45 Van Natta 2381 (1993).

Finding that there was no indication that the insurer's denial of medical bills was limited to the amount of compensation due, the court reversed and remanded for the award of an attorney fee under ORS 656.386(1). The court based its conclusion on the Supreme Court's decision in SAIF v. Allen, supra.

Here, we likewise conclude that there is no indication that Plantation's denial of medical treatment was limited to the amount of compensation due. Accordingly, an attorney fee under ORS 656.386(1) is appropriate. Karl v. Construction Equipment Co., supra.

Plantation also argues that, as a result of the Board's order affirming Referee Howell's order, the compensability issue in this case became moot. However, this situation is analogous to one where an insurer withdraws or rescinds a compensability denial. Even under those circumstances, claimant's attorney would still be entitled to an attorney fee for his efforts in obtaining compensation without a hearing. See Gates v. Liberty Northwest Ins. Corp., 131 Or App 164 (1994); Penny L. Hamrick, 46 Van Natta 14 on recon 46 Van Natta 410 (1994).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the compensability issue is $2,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), 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 a fee for services on review regarding the attorney fee issue. See Carolyn Brown, 46 Van Natta 1653 (1994); Amador Mendez, 44 Van Natta 736 (1992).

Plantation seeks reversal of the Referee's award, pursuant to ORS 656.382(1), of a $1,000 attorney fee. The Referee awarded the fee because he found that Plantation's denial required claimant to "unnecessarily re-prepare and re-present his compensability case." On this basis, the Referee concluded that the denial amounted to unreasonable resistance to the payment of compensation. We disagree.

Plantation issued its denial in order to be consistent with its earlier appeal of Referee Howell's order finding the September 9, 1992 right shoulder injury compensable. Since the second claim stemmed from the September 9, 1992 injury claim which was under litigation, it was not unreasonable for Plantation to deny the second claim. Thus, Plantation's denial, which was consistent with its earlier position, does not amount to an unreasonable resistance to the payment of compensation. However, as discussed above, Plantation's position does result in its responsibility for an attorney fee award under ORS 656.386(1) for claimant's counsel's services in setting aside Plantation's compensability denial. Accordingly, under these circumstances, no penalty-related attorney fee is warranted.

Finally, claimant seeks correction of a typographical error. The third paragraph of the Referee's June 7, 1994 "Opinion and Order on Reconsideration" is corrected to read as follows:

> "Based on my observation at hearing, I conclude claimant was a cautious, sometimes precise, sometimes vague, but was not a lying witness."

In reaching this conclusion, we note that the Referee attempted to correct this typographical error in a June 23, 1994 amended order. However, because a request for Board review had already been filed, that amended order was a nullity. See Ramey S. Johnson, 40 Van Natta 370 (1988).

ORDER

By this reference, we incorporate our October 25, 1994 Interim Order of Dismissal into this final appealable order. The Referee's order dated March 29, 1994, as reconsidered on June 7, 1994, is reversed in part. The Referee's award of a $1,000 penalty-related attorney fee is reversed. For services at hearing concerning the right shoulder compensability issue, claimant's attorney is awarded $2,000, payable by Plantation.

January 26, 1995 Cite as 47 Van Natta 107 (1995)

In the Matter of the Compensation of
MELVIN L. MARTIN, Claimant
WCB Case No. 90-20361
ORDER ON REMAND
Welch, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. Martin v. City of Albany, 320 Or 175 (1994). The Court affirmed the Court of Appeals decision, Martin v. City of Albany, 124 Or App 434 (1993), which reversed our order that held that the Hearings Division lacked jurisdiction under ORS 656.327 to consider a medical treatment dispute concerning a proposed back surgery. Melvin L. Martin, 44 Van Natta 258 (1992). Reasoning that jurisdiction over proposed medical treatment lies with the Hearings Division, the Court has remanded for further proceedings.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following substitution. We substitute the following for the fourth paragraph in the Referee's findings of fact.

Dr. Hennings, Ph.D., clinical psychologist, evaluated claimant on August 30, 1990. (Ex. 46). Dr. Hennings concluded that "[a]lthough [claimant] would not appear to be a good candidate for spinal cord stimulation interventions, there is a possibility that such an intervention may be successful; whereas, increasing maladjustment is quite likely without such interventions." (Ex. 46-6). Dr. Hennings also concluded that Dr. Collada's plan to emphasize physical conditioning after the spinal cord stimulation implant appeared to be the most appropriate psychological approach. Id.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on September 20, 1972. As a result of this injury, claimant eventually had three surgical procedures on his lumbar spine. In 1984, claimant underwent a laminectomy with L4-5 and L5-S1 fusion. In 1988, he underwent L3 through S1 fusion with Lukey plates. In 1989, the L3 through S1 fusion was repeated with tightening of the screws and placement of

more bone graft. These surgeries did not resolve claimant's pain. Following the last surgery, claimant had increasing, severe low back pain that radiated into the lower extremities.

Dr. Tiley, treating orthopedic surgeon, referred claimant to Dr. Burchiel, neurosurgeon and head of the Neurosurgery Division at the Oregon Health Sciences University, for consideration of a spinal cord stimulation implant. (Ex. 38). Claimant was also referred to Dr. Collada, Jr., neurosurgeon, who subsequently became claimant's attending physician. (Ex. 45). Both Drs. Burchiel and Collada recommended at least a trial of spinal cord stimulation to treat claimant's pain. (Exs. 39, 42, 43, 45, 47, 56). On October 22, 1990, the SAIF Corporation requested Director review of the reasonableness and necessity of the proposed treatment. On November 1, 1990, claimant requested a hearing, challenging SAIF's "de facto" denial of the proposed implant surgery.

As of the date of hearing, the Director had begun processing the medical review, but had not issued an order. At hearing, the Referee concluded that the Hearings Division had jurisdiction over the issue of the reasonableness and necessity of the proposed treatment. Relying on the opinions of Drs. Burchiel and Collada, the Referee concluded that the proposed spinal cord stimulation was reasonable and necessary treatment for claimant's compensable low back injury.

On review, we found that the Referee lacked jurisdiction over the issue of the reasonableness and necessity of the proposed treatment. Relying on Stanley Meyers, 43 Van Natta 2643 (1991), and Kevin S. Keller, 44 Van Natta 225 (1992), we concluded that the medical services dispute was not a matter concerning a claim over which the Hearings Division had jurisdiction.

On appeal, the Court of Appeals reversed our decision (per curiam), citing Jefferson v. Sam's Cafe, 123 Or App 646 (1993). In Jefferson, the court held that ORS 656.327 is inapplicable to disputes regarding proposed medical treatment and that the Board and its Hearings Division have exclusive jurisdiction to resolve disputes concerning proposed medical treatment. The Supreme Court affirmed the Court of Appeals. Martin V. City of Albany, supra. Reasoning that the Board was authorized to consider a dispute regarding a proposed medical treatment, the Court has remanded for reconsideration. In accordance with the Court's mandate, we proceed with our reconsideration.

Claimant carries the burden of proving by a preponderance of the evidence that the proposed treatment is reasonable and necessary. West v. SAIF, 74 Or App 317 (1985). The issue of whether the proposed treatment is reasonable and necessary for the compensable low back injury presents a complex medical question, the resolution of which turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

In June 1990, Dr. Burchiel examined claimant. He opined that claimant had a failed back syndrome with continuing back and leg pain from the multiple fusion procedures and the instrumentation claimant had undergone. (Ex. 39-2). He stated that claimant would be a reasonably good candidate for spinal cord stimulation, assuming he was able to "pass muster in the Pain Clinic and with the psychological screening." Id. After reviewing a repeat myelogram/CT of claimant's low back, Dr. Burchiel continued to believe that claimant "would be a good candidate for at least a trial of spinal cord stimulation given his current pain symptoms." (Ex. 42).

Dr. Collada examined claimant on August 21, 1990, and September 14, 1990. (Exs. 43, 47). He opined that claimant had chronic back and leg pain following the repeated surgical procedures and found that claimant's radiologic studies suggested adhesive arachnoiditis. (Ex. 43-3). He recommended psychological screening and opined that claimant should have a trial of spinal cord stimulation, if that screening showed no contraindications. Id. He also stated that claimant needed to gain some conditioning but that his pain would have to be brought under some degree of control before "pushing conditioning." Id.

Dr. Hennings, clinical psychologist, performed a psychological examination of claimant. Dr. Hennings opined that "[a]lthough [claimant] would not appear to be a good candidate for spinal cord stimulation interventions, there is a possibility that such an intervention may be successful; whereas, increasing maladjustment is quite likely without such interventions." (Ex. 46-6). Dr. Hennings also concluded that Dr. Collada's plan to emphasize physical conditioning after the spinal cord stimulation implant appeared to be the most appropriate psychological approach. Id.

Dr. Collada reviewed Dr. Hennings' report and concluded that, although the psychological evaluation documented claimant as having a lot of dependency problems, it "also found features that would not contraindicate the performance of a trial of spinal cord stimulation." (Ex. 47). Dr. Collada decided to proceed with a trial of spinal cord stimulation and, depending on the results, determine whether claimant was a candidate for permanent spinal cord stimulation implant. Id.

Dr. Norton, M.D., SAIF's medical advisor, performed a record review regarding Dr. Collada's recommendation for implantation of a spinal cord stimulator for claimant's chronic pain. (Ex. 51). Dr. Norton opined that the proposed surgery was not appropriate, given SAIF's experience with other workers who had undergone the procedure and had experienced a high complication rate. He also opined that claimant's psychological profile predicted a poor result.

We find the opinions of Drs. Burchiel and Collada most persuasive. These physicians are experienced in performing spinal cord stimulation procedures. Because of Drs. Burchiel's and Collada's greater expertise in performing this procedure, we defer to their evaluation of the appropriateness of the procedure. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Furthermore, Dr. Collada addressed Dr. Norton's concerns about potential complications by explaining that advances in technology and surgical technique had minimized complications. (Ex. 56-1). Finally, Dr. Collada reviewed claimant's psychological evaluation and explained that, while claimant was not the ideal surgical candidate psychologically, there were no contraindications for a trial spinal cord stimulation. (Ex. 47).

Accordingly, claimant has established that a trial spinal cord stimulation is reasonable and necessary treatment for his compensable low back injury. Consequently, SAIF's "de facto" denial shall be set aside.

Claimant has finally prevailed after remand regarding the reasonableness and necessity of the proposed trial spinal cord stimulation. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991).

After considering the factors set forth in OAR 438-15-010(4), we agree that the Referee's award of an assessed attorney fee of $1,500 for services at hearing is a reasonable fee. Furthermore, after considering those same factors, we find that a reasonable assessed attorney fee for claimant's counsel's services at the Board, Court of Appeals, and Supreme Court is $3,500. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, the Referee's order dated April 30, 1991 is affirmed. For services rendered on Board review and the appellate court levels, claimant's attorney is awarded a $3,500 attorney fee, payable by the SAIF Corporation.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUSSELL E. NELSON, Claimant
WCB Case No. 93-05114
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Turner-Christian.

Claimant requests review of that portion of Referee Hazelett's order that upheld the insurer's denial of claimant's occupational disease claim for a gastrointestinal condition and a mental disorder. 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 two exceptions. Claimant began having problems with nausea and vomiting in November 1991, rather than in 1992. (Tr. 59, Exs. 3 & 14). Also, we do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee analyzed claimant's claim as a mental disorder condition. Applying SAIF v. Hukari, 113 Or App 475, rev den 314 Or 391 (1992), the Referee found that claimant failed to establish, by clear and convincing proof, that the cause of his condition arose out of and in the course of employment. In Hukari, the court held that any claim that a condition is independently compensable because it was caused by on-the-job stress must be treated as a mental disorder claim under ORS 656.802(3).

Subsequent to the Referee's order, the Supreme Court issued Mathel v. Josephine County, 319 Or 235 (1994). In Mathel, the Court considered whether the claimant's claim for a heart attack properly was analyzed as an accidental injury or occupational disease. The Court noted that, generally, workers make claims for accidental injuries or occupational diseases and not for their causes. Id. at 242. The Court further found that ORS 656.005(7) referred to "events" and ORS 656.802 referred to "ongoing conditions or states of the body or mind." Finding that a heart attack was an "event," the Court held that, whether caused by physical exertion, on-the-job stress, or both, a heart attack was an accidental injury within the meaning of ORS 656.005(7)(a) rather than a mental disorder under ORS 656.802(3). Id. at 242-43.

In DiBrito v. SAIF, 319 Or 244 (1994), another decision issued subsequent to the Referee's order, the Court expanded on its Mathel holding. In DiBrito, the claimant sought compensation for an episode of colitis and a personality disorder. The Court agreed with the Board's application of ORS 656.802 to the claim for the personality disorder. Id. at 249. However, citing Mathel, the Court further held that the Board erred in not analyzing separately the claim for colitis under ORS 656.005(7), explaining that, whether caused by physical factors, by job stress, or by both, the episode of colitis was an "event" constituting an accidental injury. Id. at 248-49.

In the present case, claimant characterizes his claim as a "mental disorder/irritable bowel syndrome claim." He contends that his mental disorder is "adjustment reaction of adult life." We construe claimant's claim as encompassing both his irritable bowel syndrome and his mental disorder. Pursuant to Mathel and DiBrito, we must analyze each claim separately.

Irritable Bowel Syndrome

Based on Mathel and DiBrito, in determining the appropriate standard for analyzing compensability, we focus on whether claimant's irritable bowel syndrome (IBS) was an "event" under ORS 656.005(7) or an "ongoing condition or state of the body or mind" under ORS 656.802; the cause of claimant's condition is not material to this inquiry. The record shows that claimant's gastrointestinal symptoms were gradual in onset. (Exs. 3 & 14). Therefore, we find that claimant's condition was not an "event" and more similar to a "state of the body," constituting an occupational disease. Accordingly, to carry his burden on his IBS claim, claimant must establish that his work exposure was the major contributing cause of his IBS or its worsening. ORS 656.802(2).

Claimant relies on the opinions of Drs. Schlippert and Arcelay. Claimant began treating with Dr. Arcelay, an internist, in November 1992. In May 1993, Dr. Arcelay diagnosed claimant with IBS and stated that "the stress that [claimant] has undergone while working at [the employer] is the major cause of his problems." (Ex. 26a). Dr. Arcelay reported to the insurer that claimant's gastrointestinal distress had almost completely resolved by May 1993 (Ex. 26). At that time, claimant was working at different employment and had not had any gastrointestinal distress in over a month, except on two occasions when he was involved in a custody battle with his former wife. (Id). Dr. Arcelay concluded that claimant's gastrointestinal problems were "strongly, if not directly, related to the conditions and stresses that he was subjected to while working for [the employer] in the recent past." (Id).

In November 1992, Dr. Arcelay referred claimant to Dr. Schlippert, an internist specializing in gastrointestinal disease. Dr. Schlippert treated claimant for approximately a one-month period. In May 1993, Dr. Schlippert reported to claimant's attorney that claimant's symptoms were due to "psychophysiologic gastrointestinal reaction, primarily stress induced." (Ex. 25A). Dr. Schlippert recalled that claimant had told him he felt great stress related to his work. Dr. Schlippert stated that there was no other apparent identifiable cause of psychological stress in claimant's life. Dr. Schlippert noted that the discovery of Helicobacter species was a "coincidental finding." (Id). Dr. Schlippert concluded that "the most likely cause of this disorder of gastrointestinal function is that of a stress induced condition which in my opinion was most likely at the time related to his work situation." (Id). Dr. Arcelay concurred with Dr. Schlippert's report. (Ex. 27).

The only contrary evidence is from Dr. Ramsthal, an internist, who examined claimant on behalf of the insurer. Dr. Ramsthal did not feel that there was any major contributing cause for claimant's condition. Nevertheless, he reported that claimant's work conditions "could have aggravated or perhaps precipitated his symptoms initially." (Ex. 22). Dr. Ramsthal did not explain what else he thought could have caused claimant's IBS. Dr. Ramsthal mentioned that claimant's "pre-existing medical conditions might be that he uses some alcohol, uses some caffeinated beverages and that he smokes." (Id). However, Dr. Ramsthal stated that those would all be contributing causes for "peptic disease although he has very little if any of that which we can determine. In short, there probably are none." (Id.; emphasis added).

Although Dr. Ramsthal mentioned claimant's helicobacter gastritis, he stated claimant had "irritable bowel syndrome and incidentally has a biopsy consistent with Helicobacter gastritis." (Id). Dr. Ramsthal did not state that the helicobacter gastritis was related to claimant's IBS. On the other hand, Drs. Arcelay and Schlippert opined that the helicobacter gastritis and the IBS were not causally related. (Exs. 25A, 28 & 29).

We conclude that the opinions of Drs. Arcelay and Schlippert persuasively establish that claimant's work activities at the employer were the major contributing cause of his irritable bowel syndrome. Therefore, claimant proved compensability. See ORS 656.802(2).

Claimant is entitled to an assessed attorney fee for prevailing on the irritable bowel syndrome 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 irritable bowel syndrome issue is $5,000, to be paid by insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs, claimant's counsel's statement of services and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Mental Disorder

As discussed previously, we must analyze claimant's irritable bowel syndrome and mental disorder separately. Since claimant is trying to establish the independent compensability of a mental disorder (adjustment reaction to adult life), it must be analyzed as an occupational disease under ORS 656.802. See Fuls v. SAIF, 129 Or App 255 (1994).

In order to establish compensability of a stress-related mental disorder, the worker must prove that the employment conditions were the major contributing cause of the mental disorder and establish

its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, pursuant to ORS 656.802(3)(a) - (d), the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment.

Claimant contends that he has a mental disorder recognized in the medical or psychological community, i.e., "adjustment reaction of adult life." The causation of claimant's mental disorder 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).

There are two medical opinions that discuss claimant's "adjustment reaction of adult life." Dr. Klein and Dr. Gwinnell each saw claimant on one occasion for examinations on behalf of the insurer. There is nothing in the record to indicate that claimant has ever been treated for his mental disorder. Neither Dr. Klein nor Dr. Gwinnell discussed the onset of claimant's "reaction of adult life." Moreover, neither Dr. Klein nor Dr. Gwinnell indicated that claimant's work exposure was the major contributing cause of his mental disorder or its worsening. To the contrary, Dr. Klein indicated that, at the time she wrote her report, non-work stressors were causing more of claimant's problems than work stressors. (Ex. 23).

Dr. Gwinnell, a psychiatrist, interviewed claimant and his wife to assess the level of work stress at the employer and the relationship of the stress to claimant's adjustment reaction. Although Dr. Gwinnell discussed claimant's work activities in detail, she did not discuss the connection between claimant's mental disorder and his work activities. Rather, she reported that claimant's gastrointestinal symptoms were a direct result of the severe and unusual work stress that claimant experienced while working at the employer. (Ex. 30).

We conclude that claimant has not established that his work activities were the major contributing cause of his mental disorder or its worsening. Therefore, his independent claim for a mental disorder is not compensable.

Constitutionality of ORS 656.802

Claimant contends that, if the Board denies benefits under the limiting provisions of ORS 656.802(3)(a) - (d), he has been deprived of his constitutional rights guaranteed by Article I, Section 10 of the Oregon Constitution because he has been deprived of his sole and exclusive remedy for injury done to his person.

We need not address the constitutional argument with respect to claimant's IBS claim because we found that claim compensable. Although we concluded that claimant's mental disorder claim is not compensable, we did not rely on the provisions of ORS 656.802(3)(a) - (d), in doing so. Rather, we concluded that claimant failed to prove that his employment conditions were the major contributing cause of his mental disorder. See ORS 656.802(1), (2). Since we did not rely on ORS 656.802(3)(a) - (d), it is not necessary to address claimant's argument that those sections of the statute violate the Oregon Constitution.

ORDER

The Referee's order dated March 3, 1994 is reversed in part and affirmed in part. The insurer's denial of claimant's irritable bowel syndrome claim is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the irritable bowel syndrome claim, claimant's attorney is awarded $5,000, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JOHN J. RICE, Claimant
WCB Case Nos. 90-14069 & 90-12474
SECOND ORDER ON REMAND
Philip Schuster II, Claimant Attorney
Beers, et al., Defense Attorneys

The insurer requests reconsideration of our December 30, 1994 Order on Remand, contending that we improperly found that claimant suffered an April 1989 pratfall at work, mistakenly concluded that claimant's L5-S1 condition is compensable, and exceeded the scope of the court's remand.

The insurer misreads our order. First, we did not find claimant's condition compensable "on the basis" of a single pratfall. Instead, we concluded that claimant's November 26, 1990 L5-S1 surgery is compensably related to the accepted low back condition, because the condition causing the need for surgery resulted from years of trauma at work (including multiple injuries, traumatic work activities, and the accepted back strain condition). We based this conclusion on our interpretation of Dr. Nash's opinion.

The insurer challenges our reliance on Dr. Nash, noting that the attending surgeon referred to a 1989 pratfall, which it contends is "inconsistent" with a prior Arbitrator's finding that no specific work incident occurred. Asserting that the Arbitrator's finding precludes a conclusion that claimant's current condition is related to a 1989 pratfall, the insurer argues that its denial must be reinstated.

We disagree with the insurer's reasoning. In discussing the relationship between claimant's work and his current L5-S1 condition, Dr. Nash does specifically refer to a 1989 pratfall. Nevertheless, that reference must be evaluated within the context of Dr. Nash's opinion and the issue presented. The issue for resolution was whether claimant's current L5-S1 condition (including resulting surgery) was related to his accepted condition for which the insurer had previously been found responsible.

In relating claimant's L5-S1 surgery to work trauma, Dr. Nash specifically referred to a 1989 pratfall, as well as to claimant's injuries dating from 1980. As explained in our prior decision, we interpret Dr. Nash's opinion to be that claimant's current L5-S1 condition is related to his work-related condition. Since, as a result of claimant's employment exposure during its coverage, the insurer has previously been found responsible for that condition, it likewise follows that the insurer is responsible for claimant's current L5-S1 condition and resulting surgery. Such a conclusion is consistent with the premise of Dr. Nash's opinion, as well as the prior Arbitrator's findings.

Second, we acknowledge that the court instructed us to explain our disposition of claimant's "law of the case" and "issue preclusion" arguments. We did so, stating that we do not interpret these arguments as new issues which were raised by claimant for the first time on reconsideration of our initial Order on Review. Rather, as we stated in our first Order on Remand, claimant's essential argument has remained constant; i.e., the November 26, 1990 L5-S1 surgery is compensable because it is related to claimant's compensable back condition. (Order on Remand, page 3).

Under these circumstances, we "disposed" of claimant's "law of the case" argument by finding that the law of the prior Arbitrator's decision is simply that claimant's low back condition was compensable as of April 1990, when the Arbitrator's order issued. (See Order on Remand, note 3). We further "dispose" of claimant's issue preclusion argument as follows. Because the Arbitrator's order actually and necessarily determined only that claimant's then-current condition was compensable (as an occupational disease), no other issues are precluded by that order. Thus, we have carried out the court's explicit instructions on remand.

In addition, because the court reversed our prior order and remanded it for reconsideration, we reconsidered our prior conclusions regarding the disposition of claimant's claim and found them to be in error. As we explained in our Order on Remand, this error occurred because we (not claimant) mistakenly narrowed claimant's theory of his case. Under these circumstances, we have acted within our authority on remand.

Finally, we acknowledge an apparent typographic error in Dr. Nash's May 6, 1991 report. (Exhibit 93, see Order on Remand, p. 3). Because we agree with the insurer that Dr. Nash's opinion as a whole indicates that he meant to refer to "claimant's injuries since 1980" instead of claimant's "injuries since 1990" in this report, we now insert "[sic]" after 1990 within the quotation set out in the second sentence of the fourth paragraph on page 4 of our Order on Remand. (See Ex. 89).

Accordingly, our December 30, 1994 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 30, 1994 order, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAWRENCE RUNNINGHAWK, Claimant
WCB Nos. 93-09177 & 93-06876
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
John B. Motley (Saif), Defense Attorney
Werst, et al., Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of Referee Garaventa's order that: (1) found SAIF responsible for claimant's March 15, 1993 "new injury" claim for a herniated disc condition; (2) set aside SAIF's denial of claimant's condition under an accepted 1992 claim; and (3) upheld Kemper Insurance Company's denial of responsibility for the same condition. On review, SAIF contends that the Referee improperly addressed a "new injury" claim.

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

SAIF contends that the Referee did not have jurisdiction to adjudicate compensability of a March 15, 1993 injury at SAIF's insured's because claimant never filed a claim for that particular injury. According to SAIF, the issue of responsibility must be adjudicated based on only two claims, the claim filed against Kemper for claimant's 1985 accepted injury and the claim against SAIF for his 1992 accepted injury. We disagree.

On March 15, 1993, claimant suffered acute low back and left leg pain when he was installing a water meter while employed by SAIF's insured. On March 29, 1992, Dr. Ferguson referred claimant to Dr. Lax after claimant's CT scan showed an extruded disc fragment. (Ex. 35). Dr. Lax examined claimant and proposed an interlaminar laminotomy and discectomy at L4-5. (Ex. 39B). Dr. Lax's April 16, 1993 letter proposing surgery included a copy of his original consultation with claimant, which reported that claimant had injured his back in September 1992 and in early March he had recurrent pain. (Ex. 36).

Under these circumstances, we are inclined to find that SAIF had notice of a claim for compensation regarding a March 15, 1993 injury. 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). Our inclination is further supported by SAIF'S June 16, 1993 letter. At that time, SAIF asked Dr. Lax whether claimant's recent incidents on August 29, 1992 and March 14, 1993 had caused a pathological worsening of his condition. (Ex. 45A).

We need not resolve this pre-hearing "claim" issue because we find that SAIF raised no objection to consideration of the March 1993 claim at hearing. Following post-hearing depositions, claimant argued that there had been a new injury in March 1993. (Exs. 49-33, 49-38 & 39). Kemper asserted that claimant had a new condition caused by the 1992 and 1993 incidents. (Ex. 49-35). SAIF argued that Dr. Ferguson's post-hearing deposition indicated that SAIF's August 1992 injury was a separate and distinct injury that had resolved, which left the 1985 and 1993 injuries to be litigated. (Ex. 49-37).

Under these circumstances, SAIF's failure to object to litigation of the March 1993 injury claim constituted a "denial of the claim and a valid waiver of all procedural errors relating to litigation of the claim." Thomas v. SAIF, 64 Or App 193 (1983). We conclude that the Referee had jurisdiction to litigate the compensability of claimant's March 15, 1993 injury.

We agree with and adopt the Referee's reasoning which held that the March 1993 injury constitutes a "new injury" for which SAIF is responsible. See ORS 656.308(1). However, we modify those portions of the Referee's order which appeared to direct SAIF to process the injury under the 1992 claim.

The Referee set aside SAIF's July 30, 1993 denial of responsibility for claimant's current treatment and remanded the claim to SAIF for processing according to law. Although SAIF denied responsibility for claimant's current condition on July 30, 1993, the denial letter referred to the claim for the August 29, 1992 injury. (Ex. 46). Inasmuch as we agree with the Referee's finding that SAIF is responsible for claimant's condition under the March 1993 "new injury" claim, it follows that SAIF's denial of claimant's current condition as related to the August 1992 claim is upheld. Likewise, it follows that SAIF must process claimant's March 15, 1993 injury under a "new injury" claim (including its responsibility for the Referee's attorney fee award).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and SAIF's objections thereto), the complexity of the the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 10, 1994 is affirmed as modified. SAIF's denial of claimant's current condition as related to the August 1992 claim is reinstated and upheld. The Referee's order is modified to direct SAIF to process claimant's March 15, 1993 injury under a new claim. SAIF is also responsible for the Referee's $2,400 attorney fee award under the new claim. For services on review, claimant's attorney is awarded $1,500, payable by the SAIF Corporation under the March 1993 new injury claim.

January 26, 1995 Cite as 47 Van Natta 115 (1995)

In the Matter of the Compensation of
CARRIE L. SMITH, Claimant
WCB Case No. 94-03505, 93-04132, 94-03504 & 93-12527
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation, on behalf of Oregon Coast Seafoods, Inc., (Oregon Coast), requests review of Arbitrator Garaventa's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral wrist and left elbow conditions; and (2) upheld Liberty Northwest's denial of claimant's occupational disease claim for the same conditions on behalf of Depoe Bay Fish Co. (Depoe Bay). Depoe Bay moves to strike Oregon Coast's appellant's brief for a failure to timely serve Depoe Bay with a copy of Oregon Coast's brief. On review, the issues are the procedural motion and responsibility.

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

Preliminary matters

Motion to strike

OAR 438-11-020(2) provides that the party requesting Board review shall file its appellant's brief with the Board within 21 days after the date of mailing of the transcript of record to the parties. Additionally, OAR 438-05-046(2)(a) provides that a true copy of anything filed under the Board's rules shall be simultaneously served to each other party, or to their attorneys.

Here, Oregon Coast concedes that it failed to timely serve a copy of its appellant's brief on Depoe Bay. However, noting that it subsequently provided a copy to Depoe Bay (who has filed its respondent's brief), Oregon Coast opposes Depoe Bay's motion to strike. Inasmuch as no party has been aggrieved by Oregon Coast's untimely compliance with the briefing schedule, we decline to strike Oregon Coast's brief. See Robert E. Peterson, 44 Van Natta 2275 (1992).

Scope of review

ORS 656.307(2) provides that we review decisions rendered by an arbitrator on referral from the Director for questions of law except in one circumstance: "If the claimant can establish, on the arbitration record, that the determination [of the responsibility issue] resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator by the board and the Court of Appeals shall be as provided for matters concerning a claim." Thus, the statute provides for de novo review, where claimant contends that the arbitrator erred and a different assignment of responsibility will affect his rate of temporary disability compensation. See John L. Riggs, III, 42 Van Natta 2816, 2817 (1990); compare Jack W. Sanford, 45 Van Natta 52 (1993).

Here, claimant argues that the Arbitrator's assignment of responsibility should be reversed. In addition, the arbitration record reveals that the temporary disability rate will be affected by the assignment of responsibility. (Ex. 28). On these facts, we find that claimant has invoked his right to de novo review under ORS 656.307(2). See Brenda K. Passmore, 43 Van Natta 1457, 1458 (1991).

Responsibility

Oregon Coast and claimant argue that the Arbitrator erred in applying the last injurious exposure rule, because "actual causation" is proven in this case. 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. See Martin J. Stuehr, 46 Van Natta 1877 (1994); Maria Gonzales, 45 Van Natta 466 (1993).

Here, although there is evidence that claimant's work activities with Depoe Bay were the major contributing cause of her upper extremity conditions, (Exs. 18-1-2, 24-1-2, 25, 32-11), there is also evidence that her later work for Oregon Coast actually contributed to these conditions (Exs. 15-4, 33-6-7; see Ex. 32-11-13,). Under these circumstances, we are not persuaded that "actual causation" is proven with respect to Depoe Bay. Accordingly, we agree with the Arbitrator that the last injurious exposure rule is applicable. See Bonnie A. Stafford, 46 Van Natta 1452, 1453 (1994) (citing Runft v. SAIF, 303 Or 493, 501-02 (1987)(The employer may use the rule of assignment of responsibility defensively where the evidence establishes that subsequent employment contributed to the claimant's disease).

We further agree that responsibility is properly assigned with Oregon Coast, because claimant was working for Oregon Coast when she first sought treatment for her compensable upper extremity conditions. See Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994) (If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning responsibility for the claim.); see also SAIF v. Kelly, 130 Or App 185 (1994).

In addition, because Oregon Coast has not established that prior work exposure (with Depoe Bay) was the sole cause of claimant's wrist and elbow conditions or that it was impossible for claimant's work exposure with Oregon Coast to cause these conditions, responsibility remains with Oregon Coast. See FMC Corporation v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (1985). Finally, even if claimant initially sought treatment while working for Depoe Bay, the result would be the same because work activities for Oregon Coast actually contributed to the compensable conditions. Spurlock v. International Paper Co., 89 Or App 461, 465 (1988).

Claimant is not entitled to an assessed attorney fee on Board review. Oregon Coast, not claimant, requested Board review. Moreover, the request for review was from an order allowing the claim. Under such circumstances, a fee cannot be awarded under ORS 656.386(1). See Shoulders v. SAIF, 300 Or 606 (1986).

Claimant's right to compensation was not at risk of disallowance, because a ".307 order" issued prior to hearing. Nor was claimant's right to compensation at risk of reduction. The Arbitrator assigned responsibility to Oregon Coast and it had the lower rate of temporary disability compensation. (See Ex. 28). Thus, there was no risk that the amount of compensation would be decreased on review; if anything, the amount would be increased. Consequently, under these circumstances, claimant is not entitled to an assessed attorney fee under ORS 656.382(2). See Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). Finally, claimant is not entitled to an attorney fee under ORS 656.307(5). See Lynda C. Prociw, 46 Van Natta 1875 (1994); Ernest C. Blinkhorn, 42 Van Natta 2597 (1990).

ORDER

The Arbitrator's order dated July 14, 1994 is affirmed.

January 26, 1995 Cite as 47 Van Natta 117 (1995)

In the Matter of the Compensation of
DONNA J. SPENCER, Claimant
WCB Case No. 93-13708
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

The SAIF Corporation requests review of that portion of Referee Lipton's order that awarded claimant's counsel an assessed fee under ORS 656.382(2). 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

On April 7, 1993, claimant filed an occupational disease claim for a right wrist condition. The Department of Consumer and Business Services[1] declared the employer to be in noncompliance and SAIF was directed to process the claim on behalf of the noncomplying employer (hereafter referred to as the NCE). On September 14, 1993, SAIF accepted claimant's occupational disease claim as "DeQuervain's synovitis, right wrist."

The NCE objected to SAIF's acceptance and requested a hearing. However, the NCE withdrew its request on February 9, 1994, the day before the hearing was scheduled to commence. Claimant requested a determination regarding her entitlement to attorney fees. The Referee dismissed the NCE's hearing request and awarded an assessed fee to claimant's counsel.

ORS 656.382(2)

The relevant portion of ORS 656.382(2) provides for an attorney fee award if an employer requests a hearing and the Referee subsequently "finds the compensation awarded to a claimant should not be disallowed or reduced." The Referee held that, due to the NCE's withdrawal of its request for hearing, claimant's compensation was neither disallowed or reduced. Furthermore, relying on Eileen A. Edge, 45 Van Natta 2051 (1993), the Referee reasoned that:

> "the withdrawal of a request for hearing protesting SAIF's acceptance of a claim resulting in a dismissal of that request for hearing and consequently no disallowance or reduction of compensation amounts to a 'finding.'" (Opinion and Order at 3) (Emphasis supplied).

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[1] Formerly the Department of Insurance and Finance.

The Referee concluded that the abovementioned "finding" satisfied the "actually litigated" requirement for issue preclusion and, although not a finding of contested fact, was sufficient to satisfy the requirement for assessing an attorney fee under ORS 656.382(2). Id.

In Eileen A. Edge, supra, we held that a carrier was precluded from denying a knee condition because the carrier had previously accepted the same condition pursuant to a stipulation. Citing International Paper Company v. Pearson, 106 Or App 121 (1991), we reasoned that issues resolved by stipulation are considered to be actually litigated and determined by a valid and final judgment. However, as there has been no stipulation nor any actual litigation of compensability, we find that Eileen A. Edge is distinguishable.

SAIF asserts that, inasmuch as the NCE's request for hearing was withdrawn without a decision on the merits, claimant is not entitled to a "382(2)" fee. We agree.

We have previously addressed this issue in Kenneth J. Short, 45 Van Natta 342 (1993). There, the NCE withdrew its request for hearing and its denial of compensability. We held that, since the NCE had withdrawn the issue of compensability prior to hearing, the Referee's "finding" that the claimant's award of compensation was not disallowed or reduced was not a finding "on the merits" of the claim. Id. at 343. Consequently, absent a decision on the merits, the Referee was without authority to award attorney fees under ORS 656.382(2). Id.

Accordingly, we find that claimant is not entitled to an attorney fee award under ORS 656.382(2). Kenneth J. Short, supra.

ORS 656.386(1)

As an alternative argument, claimant asserts entitlement to an attorney fee award under ORS 656.386(1). We disagree.

A claimant is entitled to an attorney fee under ORS 656.386(1) only in an appeal from an order or decision denying the claim for compensation. See O'Neal v. Tewell, 119 Or App 329 (1993) (assessed fees under ORS 656.386(1) are only available for prevailing over a denied claim).

Here, claimant's circumstances are analogous to O'Neal. Specifically, SAIF had already accepted claimant's occupational disease claim when the NCE requested the hearing. Thus, there was no further compensation to be obtained at hearing. Rather, the NCE's subsequent withdrawal of its request for hearing merely removed the threat that claimant's benefits might be reduced. We have previously held that where the withdrawal of a request for hearing does not result in the claimant's obtaining compensation, ORS 656.386(1) is not applicable. See Kim M. Harrison, 44 Van Natta 371 (1992).

ORDER

The Referee's order dated May 5, 1994 is reversed in part and affirmed in part. That portion of the order that awarded claimant's counsel an assessed fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOSEPH E. STEELE, Claimant
WCB Case No. 93-14470
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Daughtry's order that affirmed an order on Reconsideration which did not award any additional permanent disability. Claimant seeks remand for the appointment of a medical examiner and the consideration of that examiner's future report. On review, the issues are remand and extent of scheduled and unscheduled permanent disability.

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

Claimant sustained compensable cervical, lumbar and bilateral arm conditions. His claim was first closed by Determination Order in August 1987, with an award of 30 percent permanent disability (PPD). By a March 1988 Stipulated Order, claimant was awarded an additional 30 percent PPD.

Claimant's low back condition worsened, and in June 1992, claimant underwent repeat fusion at L4-5. In July 1993, Dr. Newby, claimant's attending physician, declared claimant medically stationary without additional impairment. Claimant's claim was reclosed by an August 12, 1993 Determination Order which awarded no additional PPD.

On August 30, 1993, claimant requested reconsideration of the Determination Order and also requested a medical arbiter examination. In his report, the medical arbiter addressed only claimant's lumbar condition. An Order on Reconsideration issued on November 19, 1993. The reconsideration order (and the Department's evaluation worksheet) recited that claimant's accepted compensable conditions consisted of his cervical and lumbar strains, and affirmed that portion of the August 1993 Determination Order which awarded no additional PPD. Claimant did not request that the Appellate Unit rescind the Order on Reconsideration and issue a corrected order. Rather, on December 7, 1993, claimant requested a hearing on the Order on Reconsideration.

At hearing, the parties agreed that the rating by the Department was incomplete. The Referee found, however, that the Hearings Division lacked authority to remand the claim to the Department for appointment of another medical arbiter. The Referee further found that while he could appoint a medical examiner, he could not consider that examiner's report to rate impairment. Turning to the merits of the PPD issue, the Referee affirmed the Order on Reconsideration which did not award any additional PPD.

On review, claimant agrees that the Referee could not remand the case to the Department for the appointment of another medical arbiter. See Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). Instead, claimant requests that the Board remand this case to the Referee to appoint the medical arbiter to serve as a "post-reconsideration" medical examiner pursuant to OAR 438-07-005(5) to conduct a complete medical examination to fully determine the extent of his disability. We decline to grant claimant's request.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

We find no compelling reason for remanding this case to the Referee. As the Referee observed, 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 Determination Order. Hence,

although the Referee generally has discretionary authority to appoint a medical examiner under OAR 438-07-005(5), the Referee is statutorily prohibited from considering any medical evidence of impairment generated subsequent to the medical arbiter's report.[1] We conclude that prohibition applies to findings made by an examiner appointed by the Referee.

Claimant argues, however, that if the Referee had appointed the medical arbiter (Dr. Fry) as the medical examiner, Dr. Fry's report would have been admissible under ORS 656.268(6)(a), which provides, in pertinent part: "Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." We disagree.

We have held that the above-quoted provision was added to ORS 656.268(6)(a) to permit admission of an initial medical arbiter report that was requested, but not completed, before expiration of the statutory time limit for the Department's reconsideration. Daniel L. Bourgo, 46 Van Natta 2505 (1994). We have also held that an initial medical arbiter's report was incomplete, and therefore allowed admission of a supplemental arbiter's report at hearing, where the arbiter indicated, prior to issuance of the reconsideration order, that the report was incomplete and would not be finished until further testing data was available. Ryan F. Johnson, 46 Van Natta 844 (1994). In Johnson, we considered the "post-reconsideration order" report to represent completion of the arbiter's self-described "incomplete" report. See Daniel L. Bourgo, supra (modifying the holding in Johnson).

In Anne M. Younger, 45 Van Natta 68 (1993), we found that an initial medical arbiter's report was "incomplete" where the Department advised, after issuance of its reconsideration order, that the medical arbiter's examination was incomplete, and instructed the arbiter to perform a supplemental exam. In Younger, we remanded the case to the Referee for receipt of the arbiter's supplemental report.

Here, the initial medical arbiter report was completed, and it was considered by the Department, prior to the expiration of the statutory time limit for reconsideration. Neither the medical arbiter nor the Department had indicated that the arbiter's report was incomplete. See Beverly L. Cardin, 46 Van Natta 770 (1994); Enriqueta M. Restrepo, 45 Van Natta 752 (1993). Rather, claimant asserts (and SAIF does not dispute) that the arbiter's examination was incomplete. Under such circumstances, he requests a supplemental arbiter's examination and report. As we discussed in Bourgo, however, the implementation of the medical arbiter process during the 1990 legislative session was intended as a significant step toward providing a nonlitigious, less costly administrative forum for resolving extent of disability issues. To permit the parties to solicit supplemental opinions from the medical arbiter would tend to further the very same "dueling doctors" and litigious system the legislature was attempting to avoid. Id.

Because neither the medical arbiter nor the Department indicated the medical arbiter's report was incomplete, we conclude that ORS 656.268(6)(a) does not apply to the facts of this case. In any event, it is questionable whether the arbiter's examination (even without an examination of the arms) was incomplete. Claimant's attending physician, Dr. Newby, who has been treating the arm condition (thoracic outlet syndrome), did not mention the arms in his closing examination report. Moreover, Dr. Newby reported no additional PPD. (Ex. 18).

Finally, as a practical matter, claimant had an available remedy through the Department's reconsideration process. Under its administrative rules, the Department is required to rescind its order and issue a new one at the request of either party for the correction of inadvertent errors or omissions brought to the Department's attention before a hearing is requested. OAR 436-30-008(1).[2] Insofar as claimant is alleging an inadvertent error or omission, that contention could have been submitted to the

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[1] Claimant interprets Pacheco-Gonzalez as prohibiting post-reconsideration evidence of "a condition existing after the time of reconsideration," and urges the admission of post-reconsideration evidence that relates back to claimant's condition at the time of reconsideration. Claimant misreads Pacheco-Gonzalez; it construed ORS 656.268(7) to prohibit the admission of evidence developed after the medical arbiter's report. 123 Or App at 316.

[2] OAR 436-30-008(1) provides, in relevant part, that: "the Appellate Unit may change or cancel any order it issues if it has made an inadvertent error or omission which affects the order. . . .The Appellate Unit will act within the remainder of the [180-day] appeals period after the reconsideration order being changed or cancelled is mailed only if a hearing has not been requested." (Emphasis added). Here, claimant requested a hearing with more than 140 days remaining in the 180-day appeal period (excluding the time period for the Department's reconsideration).

Department after claimant received his copy of either the medical arbiter's report or the Department's Order on Reconsideration.[3] Claimant failed to do so.[4]

For the foregoing reasons, claimant is not entitled to a supplemental examination by the medical arbiter. Under the facts of this case, therefore, a remand to the Referee is not reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., supra. We base this conclusion on the following reasoning.

With the exception of a medical arbiter, only the attending physician at the time of claim closure can make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). Here, the attending physician, Dr. Newby, has opined that claimant sustained no additional permanent disability, beyond that for which claimant has already been awarded 60 percent unscheduled permanent disability. Absent a compelling reason for remanding this case to the Referee, claimant's motion to remand is denied.

We turn to the merits of the permanent disability issue. At hearing, claimant agreed that the record does not support an increased disability award. We therefore adopt the Referee's conclusion that claimant has not established entitlement to an increased permanent disability award.

ORDER

The Referee's order dated March 29, 1994 is affirmed.

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[3] The report from such an examination would not be a prohibited "post-reconsideration" report. Instead, because the Department would have rescinded the initial Order on Reconsideration, that supplemental medical arbiter's report would also constitute the "findings of a medical arbiter" upon which the Department could rely in issuing a corrected Order on Reconsideration. See Pacheco-Gonzalez v. SAIF, supra (ORS 656.268(7) prohibits admission of evidence developed after the medical arbiter's report, not the medical arbiter's report itself); Anne M. Younger, supra.

[4] Claimant contends that this case should be remanded to the Referee for further evidence taking, to fulfill his statutory right to prove the disability standards were not correctly applied. We sympathize with claimant's plight. However, it was claimant who elected not to exercise his right to have the Order on Reconsideration reconsidered again by the Department. Claimant "cannot now ask for a second 'bite of the apple' to remedy the very situation that resulted from his choice of strategy." See Benzinger v. Department of Insurance and Finance, 129 Or App 264 (1994).

January 26, 1995 Cite as 47 Van Natta 121 (1995)

In the Matter of the Compensation of
KELLY J. TRUSSELL, Claimant
WCB Case No. 94-02447
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Neal's order that affirmed an Order on Reconsideration finding that claimant's aggravation claim for a low back condition was not prematurely closed. On review, the issue is premature closure.

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

On October 21, 1993, Dr. Steinhauer, claimant's then-treating physician, declared claimant medically stationary. (Ex. 11). A November 1, 1993 Notice of Closure Order closed the claim with an award of temporary disability benefits. (Ex. 12).

On April 14, 1994, Dr. Slack examined claimant and concluded that he was not medically stationary and that his "capacity is readily expandable with the appropriate course of functional restorative therapy." (Ex. 26-2). Slack recommended a trial of diagnostic/therapeutic nerve blocks and functional restorative therapy. (Id).

Claimant relies on Dr. Slack's report as proof that his aggravation claim was prematurely closed. That argument fails, because Dr. Slack did not address claimant's medically stationary status as of November 1, 1993, the date of claim closure. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985) (a claimant's medically stationary status is to be evaluated as of the date of claim closure, without consideration of subsequent changes in his or her condition).

The SAIF Corporation argues that, because Dr. Slack's prescription was designed solely to improve claimant's functional abilities, and not to improve claimant's low back condition, Slack's report is not pertinent to the determination of the claimant's medically stationary date under ORS 656.005(17). SAIF's argument is based on Clarke v. SAIF, 120 Or App 11, 13-14 (1993).

In Clarke, the claimant's treating physician found that, on June 16, 1989, the claimant had reached a plateau in recovering from a back condition and had permanent right leg weakness. The physician prescribed a leg brace to support the claimant's weak leg and ankle. On March 27, 1990, the physician approved the final fit of the leg brace and released the claimant from further treatment. The Board found that the claimant was medically stationary on June 16. The claimant appealed, arguing that ORS 656.005(17), which defines "medically stationary," encompasses treatment solely for the improvement of the functional abilities given a particular condition. Id. at 13. The court disagreed, saying:

> "The purpose for determining when a claimant is medically stationary is to establish the point at which a disabling condition can be rated for permanent disability. Ratings for permanent disability are on the basis of the physical condition of the claimant. ORS 656.214. Consequently, medical treatment prescribed solely to improve a claimant's functional abilities is not pertinent to the determination of a claimant's medically stationary date under ORS 656.005(17)." Id. at 13-14.

Because there was no evidence that the claimant's brace had been prescribed to improve his physical condition, the court concluded that claimant had failed to establish that he was not medically stationary. Id. at 14.

In Frank M. Douglas, 46 Van Natta 1445 (1994), we were faced with a similar situation. There, on January 19, 1994, the claimant's treating physician concluded that the claimant was medically stationary, but would need, as necessary, a prosthetic fitting for his above-knee amputation. The physician subsequently reiterated that the claimant would need ongoing prosthetic care, but did not need ongoing orthopedic treatment. The claimant contested the ensuing claim closure, arguing that, because his functional abilities would improve with a better prosthesis, he was not medically stationary. We rejected the claimant's argument, relying on Clarke v. SAIF, supra. We concluded that, because there was no evidence that a new prosthesis had been prescribed to improve the condition of claimant's amputation stump, claimant was medically stationary on January 19. Id. at 1446.

Clarke and Douglas concerned claimants who, notwithstanding their need for prosthetic services, were medically stationary. In both cases, the claimants continued to need treatment akin to palliative care, in that the treatment would not effect an improvement in their underlying conditions, but would merely increase their ability to function within the limitations of those conditions. Both of these cases must be distinguished from those in which a physician prescribes treatment that, although nominally to improve a claimant's "functional abilities", is actually designed to improve the claimant's underlying condition.

Here, Dr. Slack concluded that claimant was not medically stationary and that he would benefit from a course of diagnostic/therapeutic nerve blocks and "functional restorative therapy." Although Slack did not specifically state the goals the therapy was designed to achieve, it appears that he may have been seeking to effect an improvement in claimant's low back condition. If that were the case, neither Clarke nor Douglas would apply. We need not resolve this issue, however, because we have concluded that Dr. Slack's report is insufficient for the reason stated earlier.

For these reasons, we affirm the Referee's decision upholding the Order on Reconsideration.

ORDER

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

In the Matter of the Compensation of
ADAM H. BERKEY, Claimant
WCB Case No. 90-19924
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney
D. Kevin Carlson, Assistant Attorney General

This matter is before the Board on remand from the Court of Appeals. Berkey v. Department of Insurance and Finance, 129 Or App 494 (1994). The court has affirmed those portions of our prior order, Adam H. Berkey, 45 Van Natta 237 (1993), which found that claimant was an Oregon subject worker temporarily working out-of-state for Noah Berkey when he suffered a compensable injury. However, the court has reversed that portion of our previous order which declined to find that Noah Berkey was a noncomplying employer. Reasoning that we are authorized to determine the noncompliance issue, the court has remanded for reconsideration.

In light of our prior finding that claimant was a subject worker for Noah Berkey and in the absence of a contention that Noah Berkey was covered by workers' compensation coverage at the time of claimant's compensable injury, we conclude that Noah Berkey was a noncomplying employer. Since the SAIF Corporation had previously denied claimant's injury claim pursuant to its statutory claim processing obligations under ORS 656.054, we set aside its denial and remand the claim to SAIF for further processing in accordance with law.

IT IS SO ORDERED.

In the Matter of the Compensation of
KELLY A. CLINE, Claimant
WCB Case No. 93-03705
ORDER ON REVIEW
Kelley & Kelley, Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

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

Claimant requests review of Referee Holtan's order that: (1) upheld the self-insured employer's denial of claimant's claim for a cyst condition in his left thigh; and (2) declined to award penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Beginning in 1989, claimant drove a refrigerated tractor-trailer for the employer, a supermarket chain, along the I-5 corridor between Medford, Portland and Seattle. He unloaded the truck at each destination. The cargo was on pallets weighing from 400 to 4,000 pounds that were stacked on manual pallet jacks. Unloading entailed jacking up the pallets with a hydraulic jack and physically pulling them off the trailer to storage areas within the stores. Oftentimes the pallets would be frozen to the floor or there would be ice on the floor. Claimant would put his foot against the wall to break a frozen pallet loose, and would slip, fall or bump his legs as a part of a normal day at work moving pallets.

On August 14, 1990, claimant sought treatment for swelling in the anterior superior medial of his left knee. He was diagnosed with acute bursitis and fluid was withdrawn from the knee. (Ex. 4).

In 1992, claimant developed a hernia from pulling the pallets. The hernia was surgically repaired. After the hernia, claimant relied more on his legs than his upper body to move the pallets. His legs became stronger and more muscular with this use.

On February 6, 1993, claimant unloaded his truck in Seattle before driving back to Portland. After unloading the pallets and getting back in his truck, claimant noticed pain and a golf ball sized knot on the inner part of his left knee. Claimant drove to Portland, reported the problem to the employer, and filed a workers' compensation claim. (Ex. 8).

Claimant went to a hospital emergency room, where he reported progressive left knee pain and swelling for about two weeks that had worsened on February 6, 1993. His pain increased with pushing movements. Dr. Lindberg diagnosed a swelling in the vastus medialis muscle of the left thigh and referred claimant to a specialist. (Exs. 5 and 6).

On February 9, 1993, claimant sought treatment from Dr. McWeeney, orthopedist. Claimant reported increased swelling and pain along the inside of his knee, which had become more acute over the past several days, and which had worsened with doing the quadriceps work necessary to push and pull the pallets. Dr. McWeeney eliminated various knee problems and diagnosed a cyst, probably secondary to inflammation of the quadriceps. McWeeney was reluctant to aspirate the cyst because of the possibility that it might be malignant. (Ex. 9).

The employer denied claimant's claim on February 11, 1993 on the basis that it had insufficient objective medical evidence of an injury and that work at the employer was not the major contributing cause of claimant's condition or a worsening of his condition. (Ex. 10).

On February 18, 1993, Dr. Larson performed a biopsy, which failed to produce diagnostic tissue. (Ex. 15). Dr. McWeeney referred claimant to Dr. Bos, orthopedic oncologist, who excised the cyst from the left distal medial vastus medialis obliquus muscle in the thigh. (Ex. 17). The pathologist reported that the mass was benign, consistent with fibrosis and cystic/mucoid degeneration after a remote traumatic muscle injury. (Ex. 18).

On March 23, 1993, Dr. Bald performed a chart review for the employer and on July 27, 1993, he reviewed Dr. Bos' deposition. (Exs. 34 and 39).

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant failed to prove the compensability of his claim because he failed to mention his 1990 left knee bursitis to any physician and he failed to give consistent histories to his treating doctors. Because we do not find claimant's shortcomings as a medical historian to be fatal to his claim, we disagree.

The threshhold question is whether claimant can establish a compensable claim on either an injury theory or an occupational disease theory. The test for distinguishing between an industrial injury and an occupational disease requires a determination of whether the claimed medical condition was unexpected or expected, and whether the onset was sudden or gradual. James v. SAIF, 290 Or 343, 348 (1981); LP Company v. Disdero Structural, 118 Or App 36 (1993); Valtinson v. SAIF, 56 Or App 184, 187 (1982); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975).

Here, claimant's work was very physical, especially in using his thigh muscles and legs in pulling pallets, using leverage against a wall to break frozen pallets loose, and slipping, falling or bumping his legs in his daily work moving pallets. The medical evidence indicates that claimant damaged his left thigh muscle at some time prior to the onset of the acute pain and swelling on February 6, 1993, probably from multiple bumping injuries, and which formed deep scar tissue around the degenerating muscle, which became encapsulated. Consequently, although the onset of pain, swelling and inflammation was sudden, the development of the cyst prior to the acute stage was gradual and was not an unexpected result of the multiple bumping incidents that claimant endured in his work unloading pallets. Based on the record as a whole, we conclude that claimant's condition should be analyzed as an occupational disease rather than an injury.

To establish the compensability of an occupational disease, claimant must prove that employment conditions were the major contributing cause of the disease or its worsening, which must be established by medical evidence supported by objective findings. ORS 656.802(2).

Two doctors provided opinions as to the cause of claimant's cyst condition, Dr. Bos and Dr. Bald. For a number of reasons, we conclude that Dr. Bos' opinion is more persuasive.[1] Uris v. Compensation Department, 247 Or 420, 424 (1967) (Where causation is a complex medical question, resolution of the issue requires expert medical evidence); Weiland v. SAIF, 64 Or App 810, 814 (1983) (Great weight is given to the opinion of the treating physician, absent persuasive reasons to do otherwise). Moreover, unlike Dr. Bald, Dr. Bos had an opportunity to examine and observe claimant.

Dr. Bald opined that claimant's condition was not related to work because claimant reported no specific work injury or single traumatic event and because of the discrepancies in his histories of the onset of the condition prior to the acute onset on February 6, 1993. (Exs. 34 and 39). We have disposed of these matters above and in Footnote 1.

In contrast, Dr. Bos, who is an orthopedic oncologist specializing in evaluation and treatment of tumors and who was claimant's treating surgeon, opined that claimant probably sustained muscle damage from a remote traumatic injury or multiple small injuries, which comports with the kind of ongoing bumping, falling and slipping claimant experienced in his work. He also opined that the acute pain claimant experienced on February 6, 1993 resulted either from rupture of the cyst or muscle tissue pulling away from the cyst. Dr. Bos explained that the time frame of the onset of pain is different from that of an acute injury, such as pulling a ligament, in that claimant could have had partial pulls of muscle for several weeks, which may have been due to pushing pallets. Dr. Bos opined that claimant's work activities, including those work activities associated with the acute condition that arose on February 6, 1993, were the major contributing cause of claimant's condition and need for surgery. Consequently, we conclude that claimant has proved a compensable occupational disease.

Penalties and Attorney Fees

In determining whether a denial is unreasonable, the question is whether the employer had a legitimate doubt as to its liability at the time of its denial. If the employer based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988).

Here, at the time of its denial, the employer had received claimant's 801 claim form and a 827 form report from Dr. McSweeney. (Exhibits 7 & 8). The latter report attributed claimant's complaints to pulling pallets out of his employer's truck. The 801 claim provided a similar history, but the employer had marked the "unknown" box in indicating whether the injury was work-related. Finally, the employer had also received an emergency room report and the hospital's "comprehensive occupational medicine program" form. (Exhibits 5 & 6). Neither document related claimant's condition to work nor off-work activities. Moreover, the emergency room report noted progressive pain / swelling for the past two weeks, with the pain increasing during pushing movements.

The aforementioned reports establish that, at the time of the employer's denial, claimant was experiencing pain and swelling. Although some of the reports suggest a work relationship for those complaints, other reports leave that question unanswered. In light of such circumstances, we conclude that the employer had a legitimate doubt regarding its liability for the claim.[2] Consequently, we do not consider the employer's denial to have been unreasonable. Accordingly, we decline to award a penalty under ORS 656.262(10).

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[1] We do not find claimant's failure to mention the 1990 bursitis in his knee relevant here. There is nothing to suggest that a relatively minor trauma to the bony part of claimant's knee, resulting in an inflammation of the bursa, caused a condition arising within the musculature of his thigh two and a half years later. Furthermore, Dr. McWeeney, who expected to find osteochondroma and bursitis in the knee, evaluated and tested the knee and eliminated a knee condition as the cause of claimant's symptoms. See Ex. 9.

Moreover, claimant's report of the onset of his acute symptoms to his doctors is consistent. Claimant bumped his legs and used his thigh muscles regularly in his work. He had been pulling pallets in Seattle and noticed pain and swelling that became more acute as he drove back to Portland. Claimant did not claim a specific injury to his thigh. Therefore, analysis of the development of an intramuscular cyst and its cause is more appropriately within the province of expert medical opinion. Finally, a faulty medical history is not necessarily fatal to Dr. Bos' opinion, where, as here, the omitted facts regarding claimant's bursitis do not have bearing on the relevant issue of the cause of claimant's cyst within the musculature of his thigh. See Palmer v. SAIF 78 Or App 151 (1986); Maria Gonzales 46 Van Natta 466 (1994).

[2] This doubt was subsequently fortified by Dr. McWeeney's later chart note, which raised the possibility (eventually proved unfounded) of a malignancy. (Exhibit 9).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,250, 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 appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated December 29, 1993 is reversed in part and affirmed in part. The self-insured employer's denial is set aside and the claim is remanded to the self-insured employer for processing according to law. Claimant's attorney is awarded $3,250 for services at hearing and on Board review, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed.

Board Member Gunn dissenting in part.

I concur with that portion of the majority's decision which finds claimant's cyst condition compensable. However, I disagree with the majority's conclusion that the self-insured employer's denial was not unreasonable.

When the employer issued its denial, it had received claimant's claim form and medical reports which supported a conclusion that his complaints arose while pulling pallets from his truck at work. Without taking claimant's statement, scheduling a medical examination, or requesting further information from his attending physician, the employer issued its denial of the claim. The denial, which was mailed 5 days after claimant filed his claim, was based on a lack of objective findings and a contention that claimant's work activities were not the major contributing cause of his condition.

The medical reports are replete with objective findings supporting claimant's complaints. Moreover, these reports, as well as claimant's claim, make no reference to an off-the-job cause for his need for medical treatment. Finally, I am particularly distressed by the employer's decision to deny the claim within 5 days of its filing without conducting an independent investigation. See Patrick J. Casey, 45 Van Natta 1536 (1993); Philip A. Parker, 45 Van Natta 728 (1993); Kenneth A. Foster, 44 Van Natta 148 (1992), aff'd mem SAIF v. Foster, 117 Or App 543 (1992).

In light of such circumstances, I cannot share my colleague's conclusion that the employer's denial was based on a legitimate doubt regarding its responsibility for the claim. Consequently, I would award a penalty for an unreasonable denial.

In the Matter of the Compensation of
SHELLY K. FUNKHOUSER, Claimant
WCB Case Nos. 94-01028 & 94-01027
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
David O. Horne, Defense Attorney
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests, and Wausau Insurance cross-requests, review of those portions of Referee Hoguet's order that: (1) set aside Wausau's denial of claimant's claim for a bilateral hand, wrist and arm condition; and (2) upheld Georgia Pacific Corporation's denial of claimant's occupational disease claim for the same condition. Wausau also cross-requests review of that portion of the Referee's order that assessed a penalty for an allegedly unreasonable denial of compensability. On review, the issues are responsibility and penalties.

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

After our review of the record, we agree with the Referee's conclusion that claimant's current bilateral hand, wrist and arm condition is the same condition accepted by Wausau in 1985. Thus, in order for responsibility to shift to Georgia Pacific, it must be established that claimant suffered a new occupational disease while Georgia Pacific was on the risk. Because claimant's condition is preexisting, a pathological worsening of the condition must be shown in order for a new occupational disease to be established.

On review, claimant asserts that physical findings such as increased pain, dropping of objects and positive Tinel's signs establish that her condition has pathologically worsened. However, whether or not such physical findings represent a pathological worsening of claimant's condition is a medical, rather than a legal question. Thus, expert medical evidence is necessary to establish that the physical findings represent a pathological worsening of the condition. In the absence of such medical evidence, we are unable to conclude that a pathological worsening has occurred. Thus, we agree with the Referee that a new occupational disease claim has not been established. Consequently, Wausau remains responsible for claimant's condition.

Claimant also argues that, since her condition in 1985 was accepted as nondisabling and her current condition is disabling, a worsening has been established as a matter of law. We agree that the reclassification of claimant's claim is evidence of a "worsening." However, claimant's argument begs the question. The question is whether a "pathological" worsening has been established. A worsening may arguably be symptomatic as opposed to "pathological" and may nonetheless be disabling. In order to make the determination that claimant's worsening is pathological as opposed to symptomatic, expert medical evidence is necessary. This record contains no such expert evidence on the question of a pathological worsening. Accordingly, in the absence of such evidence, we conclude that a new occupational disease has not been established and that responsibility remains with Wausau.

ORDER

The Referee's order dated May 17, 1994 is affirmed.

January 27, 1995 Cite as 47 Van Natta 127 (1995)

In the Matter of the Compensation of
DORIS I. GILLETTE, Claimant
WCB Case No. 93-08320
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Crumme's order which upheld the insurer's denial of claimant's pulmonary edema. On review, the issue is compensability.

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

Claimant contends that because her pulmonary edema developed over a short, discrete period of time following the physical and emotional stress of breaking up two altercations at work, her claim should be analyzed as an injury claim. The record shows, however, that claimant has preexisting hypertensive heart disease, hypertension, and chronic pulmonary disease and that such conditions combined with the work events to cause the pulmonary edema. When a work-related incident combines with a preexisting condition to cause disability or the need for treatment, the resultant condition is compensable only if the compensable injury is the major contributing cause of the disability or need for treatment. ORS 656.005(7)(a)(B); see Tektronix, Inc. v. Nazari, 177 Or App 409 (1992). Therefore, in order to prevail, claimant must prove that her work-related incident was the major contributing cause of the disability or need for treatment. Id.

Considering claimant's preexisting conditions, the resolution of the causation issue is a complex medical question requiring competent expert opinion. Kassahn v. Publishers Paper Company, 76 Or App 105 (1985).

Claimant asserts that the incidents at work, rather than her preexisting conditions, were the major contributing cause of her pulmonary edema and respiratory failure. Relying on Dr. Weaver's testimony, claimant contends that but for her exposure to the altercations at work, it is unlikely that she would have gone into pulmonary edema. However, medical opinion based on a temporal relationship is insufficient to carry claimant's burden of proof, particularly in light of the contrary medical evidence that claimant's work activities alone would not have caused the pulmonary edema in the absence of her preexisting conditions. See Ruben G. Rothe, 45 Van Natta 369 (1993); see also ORS 656.266.

Rather, we rely on the opinions of Drs. Toren and DeMots. Dr. Toren, cardiologist, opined that claimant's work activities played a significant role, but that her preexisting hypertensive heart disease was the major contributing cause of her pulmonary edema and respiratory failure. He explained that without this preexisting condition, it was extremely unlikely that the stressful work activities would have led to the pulmonary edema and respiratory failure.

Dr. DeMots, head of the cardiology division at OHSU, concurred with Dr. Torens. Dr. DeMots explained that a normal heart would not go into pulmonary edema simply on the basis of physical effort. He noted that hypertension and its consequences are the leading cause of pulmonary edema. He further explained that chronic obstructive pulmonary disease does not lead to pulmonary edema, although it can contribute to its development when there is co-existing heart disease. Dr. DeMots opined that claimant's chronic obstructive lung disease and the rebreathing may have been aggravating factors, but the major contributing factors were her hypertension and hypertensive heart disease. Drs. Toren and DeMots also opined that the work activities did not worsen claimant's underlying conditions.

Based on the opinions of Drs. Toren and DeMots, we find that claimant has failed to prove that the incidents at work were the major contributing cause of the pulmonary edema and respiratory failure.[1] Accordingly, the insurer's denial is upheld.

ORDER

The Referee's order dated May 2, 1994 is affirmed.

[1] Board Member Gunn has previously dissented, contending that a heart attack, like a pulmonary edema, represents a pathological worsening of the disease under Mathel v. Josephine County, 319 Or 235 (1994), and its progeny. Member Gunn would find that claimant's disease constitutes an injurious event and the claim compensable. However, no court has yet agreed with this reasoning. Member Gunn is, therefore, compelled to follow the current state of the law.

In the Matter of the Compensation of
EVERARDO LIZARRAGA, Claimant
WCB Case No. 93-12271
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Garaventa's order which assessed a $1,200 attorney fee for overturning a "de facto" denial of claimant's cervical spine injury claim. The insurer cross-requests review of that portion of the order which set aside its "de facto" denial. On review, the issues are compensability and attorney fees.

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

COMPENSABILITY

The Referee concluded that there was no direct report addressing causation of claimant's cervical condition from Dr. Zapf, claimant's initial treating physician. Nevertheless, the Referee relied on the record analysis of Dr. Lee, claimant's treating physician, to conclude that Dr. Zapf's first medical report constituted evidence that claimant's June 16, 1993 work injury was a material contributing cause of his cervical condition. We agree.

Claimant's history to Dr. Zapf was that 80 pallets of strawberries fell off a truck, onto his left side. (Ex. 1A). Dr. Zapf noted decreased range of motion in the cervical and lumbar spine. Zapf diagnosed cervical and lumbosacral spine sprain/strain. The doctor authorized time loss for approximately 5 days, and provided treated for claimant. Other than the first medical report from Dr. Zapf, the record contains no further opinion from him.

On August 25, 1993, claimant was examined by physicians from the Western Medical Consultants. The physicians examined claimant's lumbar and cervical spine. (Ex. 2-2). Claimant exhibited decreased range of motion in the cervical area. (Ex. 2-2; see Ex. 21-26).

On September 30, 1993, claimant changed treating physicians to Dr. Lee. At that time, claimant reported only low back and left leg pain. On April 26, 1994, the parties deposed Dr. Lee. Dr. Lee stated that, in terms of the original injury, the opinion of the first doctor "should be highly evaluated." (Ex. 21-15). Dr. Lee further stated that, by looking at Dr. Zapf's first medical report, there is no doubt that claimant suffered from a problem in the cervical area. (Ex. 21-24). Dr. Lee concluded that claimant's June 1993 injury was the major contributing cause of his cervical spine strain/sprain and need for medical treatment. (Ex. 21-27, 28). Based on Dr. Lee's analysis of the medical record, we agree with the Referee that claimant's June 1993 injury was a material cause of his cervical condition following the injury. Accordingly, we affirm that portion of the Referee's order that set aside the insurer's "de facto" denial.

ATTORNEY FEE

Claimant contends that the Referee erred in awarding a $1,200 attorney fee for his counsel's services at hearing in setting aside the "de facto" denial of a cervical condition. Specifically, claimant argues that the Referee "minimalized" the benefit conferred. We disagree.

Here, the Referee considered all of the factors in OAR 438-15-010(4) in making her award. After our de novo review of the record, we conclude that the Referee's award was reasonable.

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

ORDER

The Referee's order dated June 20, 1994 is affirmed. For services on Board review, claimant is awarded an assessed attorney fee of $800, payable by the insurer.

January 27, 1995 Cite as 47 Van Natta 129 (1995)

In the Matter of the Compensation of
GARY A. LOVELL, Claimant
WCB Case No. 93-11178
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Myzak's order that set aside the insurer's denials of claimant's occupational disease claim for bilateral hand and bilateral elbow conditions. On review, the issue is compensability.

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

The insurer contends that the Referee erred by finding that claimant was a credible witness. 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). The Referee found that claimant testified in a credible, albeit nervous, manner. 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).

The Referee also found that any substantive inconsistencies in claimant's testimony could be attributed to nervous misunderstanding and defensiveness. 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).

The insurer argues that claimant provided an inaccurate history of the onset of his symptoms to Drs. Phipps, Long and Nathan. Dr. Phipps, a neurologist, reported on May 25, 1993 that claimant had been experiencing symptoms for the "last 6 months or so," (Ex. 3), which would place the onset of claimant's symptoms in late November 1992. Dr. Long, a psychiatrist, reported that claimant's symptoms began in "late 1992." (Ex. 9). Finally, Dr. Nathan, an orthopedic surgeon, reported on August 3, 1993 that claimant's symptoms began "about six or seven months ago." (Ex. 6). According to Dr. Nathan's report, claimant's symptoms began in early January 1993 or February `1993.

Occupational diseases are distinguished from accidental injuries on the basis that they are gradual, rather than sudden in onset. See Mathel v. Josephine County, 319 Or 235, 240 (1994). Neither party disputes that claimant's condition should be analyzed as an occupational disease. In light of the fact that claimant's condition was gradual in onset, we find no material inconsistencies between claimant's reported dates of onset ranging from late November 1992 to early 1993.

The insurer contends that claimant provided an inaccurate history of his work hours to Dr. Long, who reported that claimant typically worked 10 hour days, 5 days a week , but sometimes worked up to 70 or 80 hours per week. (Ex. 9). At hearing, claimant testified that he works about 48 hours per week on the average. We find no material difference between the 50 hour work week as understood by Dr. Long and the average 48 hour work week as reported by claimant. Although claimant admitted on cross-examination that he had not worked 70 to 80 hours per week in the past two years, he also testified that he had worked 62 hours the previous week. We do not find that to be a significant inconsistency.

The insurer also contends that claimant's failure to inform his doctors about prior hand, arm and wrist problems demonstrates that he is not a credible witness. We disagree. When asked about claimant's prior problems at deposition, Dr. Long replied that he did not think it was a major issue. (Ex. 18-10). The record establishes that Dr. Long was aware of claimant's previous problems and had reviewed his prior medical records. (Ex. 18). Inconsistent statements related to such collateral matters are not sufficient to defeat claimant's claim where, as here, the record as a whole supports his testimony. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

Finally, the insurer asserts that the Referee erred by giving greater weight to the opinion of Dr. Long rather than Dr. Nathan. Both physicians agree that claimant has entrapment neuropathies of both median and both ulnar nerves, although they disagree about causation.

When the medical opinion is divided, we rely on those opinions that are well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). After reviewing the record, we agree with the Referee's reasoning that Dr. Long's opinion is more persuasive.

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 issue, and the value of the interest involved.

ORDER

The Referee's order dated July 19, 1994 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
THOMAS A. WEAVER, Claimant
WCB Case No. 93-05854
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of that portion of Referee Davis' order which set side its partial denial of claimant's current right knee condition. On review, the issue is compensability. We modify.

We adopt the Referee's findings and conclusions, with the following supplementation and modification.

First, we briefly summarize the pertinent facts. Claimant sustained a compensable injury when he fell at work in April 1992. That claim was accepted for a medial collateral ligament (MCL) strain of the right knee. (Exs. 16, 25).

On March 19, 1993, the insurer issued a partial denial of claimant's current bilateral knee conditions, specifically identified as "severe valgus instability of the right knee, lateral subluxation of the right patella with moderate degenerative changes of the patella femoral joint of the right knee, moderate degenerative arthritis of the medial and lateral compartments of the right knee." (Ex. 51-1).

The Referee's order identified the issue for resolution as "the [March 19, 1993] current condition denial as to the right knee." (Opinion and Order at 1). On review, neither party argued that the left knee condition is compensable. Thus, we conclude that litigation in this case was confined to the right knee condition.

The Referee concluded that claimant's current condition is MCL laxity, which he found to be compensable. On the basis of these findings, the Referee ordered:

> "The insurer's March 19, 1993 denial letter is set aside to the extent that it denies claimant's current disability and need for medical services are compensable. It is further set aside to the extent it denies the compensability of the current condition of claimant's medial collateral ligament and the resulting symptoms and conditions." (Opinion and Order at 5-6).

On review, the insurer contends that the Referee's order implies that the insurer is liable for all the conditions specifically identified in its denial letter. We disagree with the insurer's characterization of the Referee's order.

After our review of the record, we agree with the Referee's determination that claimant's current condition that requires treatment is right knee instability due to MCL problems. Accordingly, we find that the Referee properly set aside the insurer's denial to the extent it denies claimant's current condition, disability and need for treatment related to problems with the right MCL. Specifically, we set aside that portion of the partial denial which denies claimant's "severe valgus instability of the right knee."

The insurer also denied right knee conditions described as lateral subluxation of the right patella and degenerative changes in the right patella femoral joint, as well as degenerative arthritis of the medial and lateral compartments of the right knee. We uphold the denial with respect to these conditions, based on the following reasoning.

A carrier 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 diagnoses identified in the insurer's denial were made by an examining physician, Dr. Farris, who recommended treatment (knee brace) only for the valgus condition. (Ex. 50-6 to -7). Dr. Farris' report alone would not put the insurer on notice of potential claims. However, we find that the record as a whole serves to notify the insurer of potential claims for the conditions identified in the denial.

Consulting orthopedist Dr. Rubinstein identified claimant's condition as MCL disruption, as well as disruption of the medial retinaculum causing lateral subluxation of the patella. (Exs. 45, 47). Dr. Rubinstein described claimant's knee problems as complex, interrelated and difficult to treat. He recommended full reconstruction of the right knee. (Exs. 42-A, 47).

Dr. Neitling provided a second opinion on referral from Dr. Rubinstein. (Ex. 51A). He diagnosed claimant's condition as "[c]omplete medial collateral ligament disruption, right knee, with severe instability." He concurred with Dr. Rubinstein and recommended surgical reconstruction of the right knee. Specifically, Dr. Neitling opined that the "entire posteromedial corner and medial side will require reconstruction." (Ex. 51A-2).

Based on the reports and treatment recommendations made by consulting physicians Drs. Rubinstein and Neitling, we find that the insurer had notice of potential claims for patella problems and degenerative changes, in addition to MCL problems. We find that both doctors recommended comprehensive treatment for claimant's right knee problems. Accordingly, we conclude that the insurer's "precautionary" partial denial of patellar and degenerative problems in the right knee was proper. (See Ex. 51).

We modify the Referee's order by upholding those portions of the March 19, 1993 partial denial which denied right knee patellar and degenerative conditions. In so doing, we are merely clarifying the Referee's order, rather than substantively reducing claimant's award of compensation. Because claimant succeeded in having a portion of the insurer's partial denial set aside at hearing, which we did not reduce or disallow on review, we find that the attorney fee awarded by the Referee for claimant's counsel's services at hearing is reasonable.

Because the insurer requested review of the Referee's order and because we did not disallow or reduce the compensation awarded, claimant is also entitled to an assessed attorney fee under ORS 656.382(2) for services on board review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability of claimant's right knee valgus condition is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 26, 1994 is modified in part and affirmed in part. To the extent that the insurer's March 19, 1993 partial denial denies patellar and degenerative right knee conditions, the partial denial is upheld. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
SCOTT C. CLARK, Claimant
WCB Case No. 94-04162
ORDER OF DISMISSAL
Pozzi, Wilson et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The insurer requested review of Referee Mills' order that set aside its denial of claimant's right knee injury claim. Claimant moves to dismiss the insurer's request for review on the ground that, after it filed the request for review, the insurer formally accepted his claim. We grant the motion.

FINDINGS OF FACT

On September 2, 1994, the Referee issued an Opinion and Order setting aside the insurer's denial of claimant's right knee injury claim. On September 30, 1994, the insurer requested Board review of that order.

On October 5, 1994, the insurer sent claimant a letter stating that it had accepted his claim. The next day, the insurer sent claimant another letter explaining its contract with a managed care organization. The letter stated, "You have an accepted Workers' Compensation claim with [the insurer] due to the above referenced injury." The letter referred to claimant's right knee injury claim.

Claimant has moved to dismiss the request for review.

CONCLUSIONS OF LAW AND OPINION

Subsequent to the Referee's order, the Court of Appeals issued its decision in SAIF v. Mize, 129 Or App 636 (1994). There, pursuant to a Board order, a carrier accepted the claimant's claim by a Notice of Acceptance; the notice did not specify that the acceptance was contingent on the carrier's right to appeal. Two weeks later, the carrier petitioned for judicial review of the Board's order. The same day, the carrier sent the claimant a letter stating that its earlier Notice of Acceptance "'was made contingent upon [its] right to appeal this case.'" 129 Or App at 638.

The claimant asserted that, in view of the carrier's acceptance, the petition for review should be dismissed. The carrier argued that it issued the acceptance notice so that the claim could be processed and that it had not intended the acceptance to terminate its appellate rights. The carrier did not argue that the Notice of Acceptance was not an acceptance or that it had been issued by mistake.

The Mize court characterized the issue as concerning the legal effect of the carrier's acceptance with regard to its right to contest the compensability of the claim. The court first concluded that a carrier is not required to accept a claim during the processing of the claim while the compensability issue is being litigated. Id. at 639.

Next, the court determined that the carrier's acceptance was clear and unqualified. Therefore, the court concluded, because the carrier had officially notified the claimant of the acceptance, it could not subsequently deny compensability without complying with ORS 656.262(6).

Finally, the court concluded that, once the carrier had accepted the claimant's claim, the parties were no longer adverse to each other; that is, the controversy over compensability had become moot. Because addressing the merits of the carrier's petition under those circumstances would be to issue an advisory opinion, the court dismissed the petition for review. Id. at 640.

In Timothy L. Williams, 46 Van Natta 2274 (1994), we addressed a similar issue. There, the employer accepted the claimant's claim by a Notice of Acceptance that did not, in any way, specify that it was contingent on the employer's right to appeal. Then, several days later, the employer purported to correct or modify the acceptance by issuing a letter explaining that the Notice of Acceptance had been issued in error and that the claim had been appealed by means of the employer's motion for reconsideration of a referee's order.

Analyzing the case under Mize, we concluded that, in light of the employer's initial clear and unqualified acceptance, it could not subsequently deny compensability without complying with ORS 656.262(6). Id. at 2275. Because the employer's "correction" letter did not comply with that provision, we concluded that, once the employer accepted claimant's claim, the parties were no longer adverse to each other, and the controversy over compensability had been rendered moot. Id. Because an opinion issued under those circumstances would have been purely advisory, we dismissed the employer's request for review. Id.

This case is markedly similar to Mize and Williams. Here, as in those cases, the insurer's October 5 acceptance letter did not, in any way, specify that its acceptance was contingent on its right to appeal. Additionally, the insurer's October 6 letter clearly and unqualifiedly indicated that it had accepted claimant's right knee injury claim. Accordingly, in view of Mize and Williams, we conclude that, once the insurer accepted claimant's claim, the parties were no longer adverse to each other, and the controversy over compensability (initially raised by the insurer's September 30 request for Board review) was subsequently rendered moot. Because an opinion issued under those circumstances would be purely advisory, we dismiss the insurer's request for review.

Our decision in Janice M. Hunt, 46 Van Natta 1145 (1994) is distinguishable from the case at bar. In Hunt, while a referee's order was on review, the insurer issued a "Notice of Acceptance", accepting the claimant's claim as disabling. Simultaneously, the insurer notified the claimant of its intent to continue to challenge the referee's classification determination. In view of those facts, we concluded that the insurer's Notice of Acceptance was not inconsistent with its assertions on appeal that the claimant's condition was not disabling. Accordingly, we denied the claimant's motion to dismiss the request for review.

Here, unlike Hunt, the insurer's acceptance was not qualified by any statement that it was pursuing an appeal of the Referee's order. On that ground, we find Hunt distinguishable.

To recapitulate, we conclude that, because the insurer's "post-Referee order/request for Board review" acceptance of claimant's claim was clear and unqualified, the controversy between the parties regarding the compensability of the claim has been rendered moot. Accordingly, we dismiss the insurer's request for Board review.

Finally, claimant is not entitled to an assessed attorney fee under ORS 656.382(2) for services on Board review. Timothy L. Williams, supra, 46 Van Natta at 2276 (citing Terlouw v. Jesuit Seminary, 101 Or App 493 (1990) and Agripac Inc. v. Kitchel, 73 Or App 132 (1985)).

IT IS SO ORDERED.

In the Matter of the Compensation of
DARLENE L. BARTZ, Claimant
WCB Case No. 94-01905
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Nichols' order that decreased 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.

Claimant argues that, because the self-insured employer did not appeal the Order on Reconsideration's medically stationary date of May 12, 1993, the Referee erred in declining to award temporary disability benefits through that date. We disagree.

Claimant's substantive entitlement to temporary disability accrues on claim closure and is based on proof of disability due to the compensable claim while the claim was open. See SAIF v. Taylor, 126 Or App 658 (1994). Claimant is not substantively entitled to temporary disability benefits through her medically stationary date in the absence of proof that she was disabled due to her compensable carpal tunnel conditions through that date. See id.

We agree with the Referee that the evidence establishes that claimant was disabled due to her compensable bilateral carpal tunnel conditions for a period of eight weeks following each of the two surgeries she underwent for those conditions. (See Ex. 6). Any additional disability claimant experienced was related to her noncompensable thumb conditions and is not a basis for a temporary disability award. (See Exs. 2A, 2B-2, 3-5, 4, 5-1, 9-3). Although claimant was declared "medically stationary" more than 8 weeks after either of the two surgeries,[1] in the absence of proof that she was disabled due to her compensable carpal tunnel conditions beyond the 8-week periods following the two surgeries, we conclude that claimant's substantive entitlement to temporary disability benefits is limited to those two periods. See SAIF v. Taylor, supra. The Referee did not err in so concluding.

ORDER

The Referee's order dated June 8, 1994 is affirmed.

[1] It appears that claimant's May 12, 1993 medically stationary date concerned both her compensable and noncompensable conditions. (See Ex. 2B-2). Therefore, that date does little to assist claimant's argument that she is entitled to temporary disability benefits through May 12, 1993.

In the Matter of the Compensation of
PHILLIP L. BEABER, Claimant
WCB Case No. 93-01770
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Niedig and Hall.

Claimant requests review of Referee Baker's order that affirmed that portion of an Order on Reconsideration that awarded no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability.

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

On review, claimant contends that he is entitled to impairment values for loss of strength in his right leg and a chronic condition that limits the use of his right leg. We agree with the Referee that claimant has not met his burden of proving the claimed impairment is due to the compensable injury. ORS 656.266.

The record establishes that claimant sustained a compensable low back injury that resulted in a herniated L5-S1 disc, which required a right hemilaminectomy and excision of the herniated L5-S1 disc. (Ex. B). Dr. Corson, claimant's attending physician, performed the surgery. In his closing examination, Dr. Corson misidentified the surgical level as being at L4-5. (Ex. 21A-1). After examining claimant, Dr. Corson stated that claimant "has minimal residuals of the right L4-5 disc rupture which produces right L5 radiculopathy." (Ex. 21A-2). In addition, Dr. Corson concurred with a physical capacities evaluation (PCE) that found some L4-5 symptoms. (Exs. 22, 23).

Claimant argues that Dr. Corson simply repeated his misidentification of the level of surgery in concluding that the L4-5 disc rupture produced L5 radiculopathy. Claimant further argues that we should interpret Dr. Corson's closing report and his concurrence with the PCE as establishing that any right leg impairment is due to the compensable injury that resulted in surgery to the S1 nerve. In effect, claimant is arguing that Dr. Corson's reference to the L4-5 level and the L5 radiculopathy is merely a scrivener's error.

While we agree that Dr. Corson misidentified the level of surgery, the medical record does not support a finding that the compensable injury that resulted in surgery to the S1 nerve caused any right leg impairment. After examination, both Dr. Corson and the PCE specifically identified L4-5 symptoms. There is no evidence that Dr. Corson's scrivener's error extended beyond the misidentification of the surgical level. More importantly, neither Dr. Corson's report, nor any other medical report, relates the L4-5 symptoms to the compensable injury.

ORDER

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

January 30, 1995 Cite as 47 Van Natta 136 (1995)

In the Matter of the Compensation of
HARVEY CLARK, Claimant
WCB Case No. 93-11592
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Neidig and Turner-Christian.

The self-insured employer requests review of that portion of Referee Mongrain's order that increased claimant's unscheduled permanent disability for a back and shoulder injury from zero, as awarded by an Order on Reconsideration, to 17 percent (54.4 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

On April 6, 1993, claimant's attending physician, Dr. Black, indicated agreement with the report of Dr. Brooks and Coletti, a panel that examined claimant on behalf of the employer. (Ex. 67). This agreement was made with the notation: "Except, he, also, has pain in the upper lumbar musculature on the left." (Id.)

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted lumbar and thoracic strain claim with the employer. A Notice of Closure awarded temporary disability but no permanent disability. An Order on Reconsideration increased claimant's temporary disability, but also awarded no permanent disability. The Referee modified the Order on Reconsideration, finding that claimant proved entitlement to 17 percent unscheduled permanent disability.

The employer challenges this conclusion, asserting that the medical evidence fails to establish any valid findings of impairment and, therefore, claimant is not entitled to permanent disability. We agree.

With the exception of the medical arbiter, only the attending physician at the time of claim closure can make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. See OAR 436-35-007(8); Roseburg Forest Products v. Owen, 127 Or App 442 (1994).

With regard to claimant's impairment, the record includes a report from Dr. Brooks, neurologist, and Dr. Coletti, orthopedist. The attending physician, Dr. Black, agreed with the report, additionally noting that claimant had pain in his upper lumbar spine. However, because his notation did not contradict his previous agreement with any portion of the report concerning impairment, we find that Dr. Black ratified such findings. Therefore, we consider the panel's impairment findings.

The panel diagnosed a thoracic strain, based on claimant's history, that was not substantiated by objective findings. The panel also found functional overlay and noted that the "evaluation today cannot be used to determine any permanent impairment." (Ex. 64-4).

Remaining evidence regarding impairment is from Dr. Donahoo, the medical arbiter. Dr. Donahoo found that claimant's history of unrelenting symptoms was not typical of a strain or degenerative spine and that claimant exhibited exaggerated pain behavior. According to Dr. Donahoo, such factors suggested that the "functional component is the overriding element at this time." (Ex 71-6). Dr. Donahoo also reported that the recorded ranges of motion "are not felt to be valid." (Id. at 7).

Claimant bases entitlement to permanent disability on the range of motion findings by Dr. Donahoo. The Referee, although acknowledging Dr. Donahoo's observation that claimant's range of motion findings were not valid, found that, because his measurements satisfied criteria set forth in Bulletin No. 242, such findings proved impairment.

Bulletin No. 242 describes methods for measuring the thoracic and lumbar spine for purposes of determining permanent impairment. The Bulletin also provides "validity criterion" for each measurement. We have previously held that the determination concerning the validity of testing as prescribed by Bulletin No. 242 must be made by the medical examiner performing the range of motion tests. Michael D. Walker, 46 Van Natta 1914 (1994); Benjamin G. Santos, 46 Van Natta 1912 (1994).

Here, Dr. Donahoo expressly indicated that claimant's range of motion findings were not valid. This is consistent with the panel's findings of functional overlay and its report that, despite having measured claimant's range of motion, its examination could not be used to determine impairment. Based on these findings and opinions, we conclude that claimant failed to prove impairment and, consequently, is not entitled to unscheduled permanent disability. See Beverly L. Cardin, 46 Van Natta 770 (1994) (medical arbiter's report finding that range of motion findings were unreliable provided no evidence of impairment).

ORDER

The Referee's order dated April 8, 1994 is reversed. The August 11, 1993 Order on Reconsideration awarding no unscheduled permanent disability is affirmed. The Referee's attorney fee award based on his increased award of permanent disability is reversed.

January 30, 1995 Cite as 47 Van Natta 137 (1995)

In the Matter of the Compensation of
PHILIP ENGEN, Claimant
WCB Case No. 94-01638
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Moscato, Byerly, et al., Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

The self-insured employer requests review of that portion of Referee Hazelett's order that set aside its denial of claimant's L4-5 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but not the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant's compensable back strain injury claim was closed more than five years ago, he only had jurisdiction to determine whether claimant was entitled to additional medical services for his current L4-5 disc herniation. Then, analyzing this case under ORS 656.273(1), the Referee concluded that, because claimant had established that his 1988 compensable back strain was at least a material contributing cause of his current L4-5 disc herniation, and because the employer had not proven that an off-work accident was the major contributing cause of the current condition, claimant had established his entitlement to additional medical services.

The employer argues that this case should be analyzed as a consequential condition case. Accordingly, the employer argues, under ORS 656.005(7)(a)(A), to prevail, claimant must establish that his compensable back strain was the major contributing cause of his current L4-5 disk herniation. Claimant's theory is unclear. He asserts that this "is a claim for a progression of the L4-5 disc pathology that started with [his] compensable injury in May, 1988." (Claimant's Respondent's Brief at 4). Therefore, claimant maintains, the Referee correctly analyzed the case under the material contributing cause standard. (See id. at 3).[1] We need not resolve this dispute because we conclude that, under either the major or material contributing cause standard, claimant's claim fails.

Before we analyze the evidence, we note that, at hearing, the parties agreed that the issues were compensability, aggravation, penalties and attorney fees. (Tr. 2). Because claimant's 1988 low back claim was closed more than five years before the alleged worsening (i.e., the onset of his current condition), the Referee was without jurisdiction to address the aggravation issue. ORS 656.278. Accordingly, only the compensability of claimant's current condition was properly at issue. For the following reasons, we conclude that claimant has failed to establish the compensability of that condition.

On May 10, 1988, claimant sustained a compensable lumbar strain. (Exs. 1, 2-2). By May 19, 1988, according to Dr. Wilson, claimant's then-treating physician, claimant had "nearly made a full recovery." (Ex. 6-1). The claim was closed by Notice of Closure on July 19, 1988 without a permanent disability award. (Ex. 12). In early August 1988, claimant experienced an exacerbation of back pain, as well as leg pain, that was "totally different" than the pain he had experienced in May 1988. (Ex. 6-1). An August 19, 1988 MRI revealed central disk bulging at L4-5 and L5-S1. (Ex. 5).

Claimant sought no further medical treatment for his back condition until August 1993, when claimant saw Dr. Mason, neurosurgeon, for severe low back pain. (Ex. 14-1). The back pain had begun six weeks earlier, but became particularly acute while claimant was at home on vacation and after he had been plumbing a well at home. (Exs. 14-1, 16A). Claimant did not tell Dr. Mason about the home plumbing work. (See Ex. 14). An MRI revealed a large left L4-5 disc herniation. (Exs. 14-2, 15). Dr. Mason recommended surgery. (See Ex. 14-2).

Thereafter, claimant consulted Dr. Wilson for a second opinion. Dr. Wilson concluded that, based on claimant's report that his back symptoms never went away following the 1988 back strain, "it is medically probable that his current disc herniation is in fact related to the old injury from 1988." (Ex. 16-2).

The employer subsequently apprised Dr. Mason of claimant's plumbing activities. (Ex. 16A). Dr. Mason concluded that claimant's current back pain was more clearly related to his work, rather than his plumbing activities. (Ex. 17). Thereafter, Dr. Wilson was apprised of claimant's plumbing activities. (Ex. 20). He adhered to his opinion that claimant's current back condition was due the 1988 work injury. (Ex. 20-2).

Finally, in response to a letter from the employer's counsel, Dr. Wilson concluded that claimant's 1988 work injury probably was not the cause of his current complaints. (Ex. 22-1). That conclusion was based on the assumption that claimant had engaged in significant work at home; that he had displayed no signs of pain at work 60 days prior to his current incapacitation; that he had not complained of pain to his supervisor, who carefully observed employees for physical problems; that the supervisor first learned of claimant's current back problem after claimant had been on vacation; that claimant had reported that he had hurt his back at home; and that the claimant's work medical record revealed no documented low back or leg pain complaints for five years prior to his current incapacitation. (Ex. 22). Dr. Mason concurred with Dr. Wilson's opinion. (Ex. 24).

On this record, we conclude that claimant has failed to establish the compensability of his L4-5 disc herniation. Both Dr. Wilson and Dr. Mason ultimately determined that, based on a factual scenario that was borne out at hearing, that condition was not work-related.

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[1] Claimant also appears to assert that this is a medical services claim. (Claimant's Respondent's Brief at 1). That assertion is belied by his request for hearing, which asserts that he sustained a work-related accidental injury or occupational disease; it does not assert that claimant is only entitled to additional medical care and treatment.

The record establishes that, when his current back condition became acute in August 1993, claimant had been at home on vacation, engaged in plumbing a well. (E.g., Tr. 67-71). Mr. Derryberry, claimant's supervisor, testified that, prior to August 1993, claimant had not acted as if he was in pain and that claimant had not complained of pain to him. (Tr. 112, 114, 119, 121; see Tr. 129). Derryberry also testified that he observes employees for physical impairments as they begin work. (Tr. 109-110; 112). Finally, Derryberry testified that he first learned of claimant's current back problem while claimant was on vacation, and that claimant told him that he had hurt his back at home. (Tr. 112, 120; see Tr. 98, 127). Ms. Rasmussen, one of the employer's nurses, testified that there was no record of any back complaints from claimant between 1988 and 1993. (Tr. 131).

This evidence substantiates the history on which Drs. Mason and Wilson relied in issuing their final opinions that claimant's 1988 lumbar strain probably was not the cause of his 1993 back condition. Because those opinions are based on complete and accurate information, see Somers v. SAIF, 77 Or App 259, 263 (1986), and because there is no persuasive evidence to the contrary, we rely on them in concluding that claimant has failed to establish the compensability of his L4-5 disc herniation, under either a major or material contributing cause standard. Accordingly, we reverse the Referee's decision setting aside the employer's denial of that condition.

ORDER

The Referee's order dated June 6, 1994 is reversed. The self-insured employer's denial of claimant's current L4-5 disc herniation is reinstated and upheld in its entirety. The Referee's attorney fee award of $1,600 is reversed. The remainder of the Referee's order is affirmed.

January 30, 1995 Cite as 47 Van Natta 139 (1995)

In the Matter of the Compensation of
ROBERT L. FAWCETT, Claimant
WCB Case No. 93-01016
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Referee Crumme's order that: (1) set aside its partial denial of claimant's injury claim for a herniated L5-S1 disc condition; and (2) awarded a $5,000 attorney fee under ORS 656.386(1) for overturning that denial. In his respondent's brief, claimant seeks additional temporary disability and an increased attorney fee award. On review, the issues are compensability, temporary disability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability of herniated L5-S1 disc

We adopt the Referee's reasoning and conclusion on this issue, which is contained in the sections entitled "Discussion of Findings" and "I. Compensability of Herniated Disc," on pages four through 7 of the Opinion and Order.

Temporary Disability

The Referee found that SAIF paid temporary disability compensation (TD) for the period from June 11, 1993 until August 14, 1993 and some, but not all, TD for the period from May 29, 1992 through July 1, 1992. Reasoning that claimant was procedurally entitled to TD, the Referee directed SAIF to pay any unpaid temporary partial disability (TPD) for the period from December 19, 1991 through February 6, 1992 and any unpaid temporary total disability (TTD) for the period from May 29, 1992 through May 3, 1993.

SAIF has not contested that portion of the Referee's order. In his respondent's brief, claimant argues entitlement to TD for the entire period from December 19, 1991 (when he was first disabled due

to his December 17, 1991 injury) until May 3, 1993 (when he concedes that he was medically stationary). Considering the time periods for which claimant's TD is not disputed by SAIF, the only TD at issue is for the period from February 7, 1992 through May 28, 1992.

We note at the outset that Dr. Freeman, claimant's then-current attending physician, authorized claimant's return to regular work as of February 7, 1992. (Exs. 9-6, 14). Claimant worked, following his release, until he was fired for reasons unrelated to his injury on March 16, 1992. (See Ex. 14A). Under these circumstances, ORS 656.268(3)(b) authorized SAIF to terminate TD as of February 7, 1992, when claimant returned to his regular work.

A worker whose temporary disability has been properly terminated becomes procedurally entitled to resumption of temporary total disability payments if, prior to claim closure, the attending physician again authorizes time loss. See former OAR 436-60-030(4)(a)&(6)(a). See also Rodgers v. Weyerhaeuser Company, 88 Or App 458, 460 (1987); Robert D. Gudge, 42 Van Natta 812 (1990).

Relying on the opinions of Drs. Aversano, osteopath, and Harris, chiropractor, claimant contends that he has been disabled ever since his December 1991 work injury. (See Exs. 22, 25). Arguably, this evidence is relevant to claimant's substantive entitlement to TD; that issue, however, is not before us because the claim was open at the time of hearing. Given the facts of this case, our inquiry is limited to whether SAIF's procedural duty to reinstate TD after claimant was fired on March 16, 1992 was triggered by notice from the attending physician of claimant's injury-related inability to work. See former OAR 436-60-030(4)(a)&(6)(a); Robert D. Gudge, supra. Furthermore, we find insufficient evidence that SAIF was procedurally required to pay TD for the period between March 16, 1992 (the effective date for claimant's job termination) through May 28, 1992.

In this regard, we note that SAIF states (in its Reply Brief) that it "apparently" received notice of claimant's inability to work on May 29, 1992, because it resumed paying TD as of that date. Thus, SAIF appears to concede that it did receive notice sufficient to require resumption of TD benefits when it began paying them again. Claimant offers no evidence that SAIF had earlier notice of authorized time loss after his March 16, 1992 job termination. Under these circumstances, we conclude that claimant has not established entitlement to TD benefits in addition to those awarded by the Referee.

Attorney fees

SAIF objects to the Referee's $5,000 attorney fee award for claimant's counsel's services in connection with overturning its partial denial of claimant's L5-S1 disc condition. On review, claimant submits his counsel's statement of services requesting a $7,600 fee for services at the hearing level and a $2,600 fee for services on review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the compensability issue is $5,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented the hearing record, counsel's statement of services and SAIF's objections to the Referee's attorney fee award), the complexity of the issue, the value to claimant of the interest involved, and the risk that claimant's counsel might go uncompensated.

In addition, claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value to claimant of the interest involved. We further note that claimant is not entitled to an attorney fee for his counsel's unsuccessful services regarding the temporary disability issue. In addition, claimant is not entitled to an attorney fee for his counsel's efforts regarding the Referee's attorney fee award. See Dotson v. Bohemia, Inc., 80 or App 233 (1986).

ORDER

The Referee's order dated May 19, 1994 is affirmed. For services on review, claimant's counsel is awarded a $1,500 attorney fee, payable by SAIF.

In the Matter of the Compensation of
LEONARDO FERRANTE, Claimant
WCB Case No. 93-12812
ORDER ON REVIEW (REMANDING)
Reeves, Kahn, & Eder, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Podnar's order that: (1) found that the SAIF Corporation had correctly calculated claimant's rate of temporary disability benefits; and (2) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties and attorney fees. We remand.

FINDINGS OF FACT

On July 1, 1992, claimant, a toolmaker, filed an occupational disease claim for chronic rotator cuff tendonitis, right shoulder. Claimant was laid off in September 1992 and, as of the hearing date, had not worked as a toolmaker since that time. Claimant has been receiving unemployment benefits since he was laid off.

In January 1993, claimant opened a coffee shop and deli. For purposes of claimant's unemployment compensation, he agreed to claim 10 to 20 hours at minimum wage in order to avoid the paperwork of asserting how much he should be claiming from his business. (Tr. 18-19). The weekly earnings he claimed ranged up to $95 per week. (Ex. 20-5). Claimant received unemployment benefits ranging from $266 to $271 per week. (Id).

In February 1993, claimant's treating physician requested authorization for shoulder surgery. (Ex. 11A). SAIF accepted claimant's shoulder claim on May 25, 1993. (Ex. 14). On September 28, 1993, Dr. Brenneke performed surgery on claimant's shoulder. Claimant sought temporary disability benefits for four weeks. Claimant did not receive any unemployment compensation during this four-week temporary disability period. (Ex. 20-5). His business closed two weeks after his surgery and he later sold the business. (Tr. 38).

SAIF calculated claimant's temporary disability using the highest rate of earnings claimant had reported to the unemployment office, which was $95 per week. (Tr. 58). Claimant requested a hearing, challenging the temporary disability rate and requesting penalties and attorney fees for unreasonable claim processing.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had reported wages of approximately $95 per week to the Employment Division and SAIF had used that data to determine claimant's wages at the time of surgery. The Referee concluded that SAIF had properly calculated claimant's wage rate and denied penalties and attorney fees.

The calculation of temporary total disability (TTD) 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). ORS 656.210(2)(b)(B) provides:

> "The benefits of a worker who incurs an occupational disease shall be based on the wage of the worker at the time there is medical verification that the worker is unavailable to work because of the disability caused by the occupational disease. If the worker is not working at the time that there is medical verification that the worker is unable to work because of the disability caused by the occupational disease, the benefits shall be based on the wage of the worker at the worker's last regular employment."

Here, the first "medical verification" of claimant's inability to work occurred on September 28, 1993, the date of his shoulder surgery. Under ORS 656.210(2)(b)(B), we must determine whether claimant was a "worker" and working at that time and, if so, the amount of his wages.

Claimant asserts that he was not "working" at the coffee shop at the time of his medically verifiable disability as that term is used in ORS 656.210(2)(b)(B). He contends that he is entitled to a TTD rate of $16 per hour based on his last regular employment as a toolmaker. On the other hand, SAIF argues that claimant's benefits should be based upon the wage he was earning at the time of his surgery, i.e., his earnings from the coffee shop.

Claimant opened the coffee shop in January 1993 and eventually employed four people. For purposes of unemployment compensation, he claimed minimum wage earnings, in varying amounts, up to $95 per week, from his coffee shop. However, claimant testified that he lost money in the business and never took any funds from the business. He explained that he had agreed to claim 10 to 20 hours at minimum wage in order to avoid the paperwork of asserting how much he should be claiming from his business. Claimant testified that his actual hours varied and sometimes he would stay all day.

At hearing, SAIF called claimant's sister as a witness to establish that claimant was working and earning wages in his coffee shop. The Referee disallowed the witness's testimony as irrelevant. In addition, no financial records were admitted, despite SAIF's "pre-hearing" request for such. (Tr. 35-37).

Based on this record, we cannot determine whether claimant was a "worker" and received "wages" at the time of his medically verified disability. ORS 656.005(28) defines a "worker" as "any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *." ORS 656.005(27) defines "wages" as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident."

We may remand a case to the Referee for further evidence taking if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, there is a compelling reason to remand. To begin, this is our first opportunity to apply ORS 656.210(2)(b)(B) to a situation in which a claimant has opened a business. Moreover, the evidence at hearing was insufficiently developed primarily because the Referee ruled that evidence related to claimant's business was irrelevant. The lack of such excluded evidence prevents us from determining whether claimant was a "worker" and earning "wages" at the time of his medically verified disability as required by ORS 656.210(2)(b)(B).

Such additional evidence is vitally important to resolution of this issue for the following reasons. If claimant was actually a "worker" earning "wages" at the relevant time, the second portion of ORS 656.210(2)(b)(B), which provides that the benefits shall be based on the wage of the worker at the worker's last regular employment, does not apply. If claimant had no "remuneration", ORS 656.210(2)(c) provides that the director, by rule, may prescribe methods for establishing the worker's weekly wage. See OAR 436-60-025(5). If that situation applies, the parties should also be prepared to address, on remand, which subsection of OAR 436-60-025(5) applies, and if no subsection of the rule applies, whether the Director should adopt a new rule or whether the Referee should proceed to determine a weekly wage. See Nathaniel P. Baker, 46 Van Natta 233 (1994) (Director does not have exclusive, original jurisdiction over "reasonable wage" disputes).

Accordingly, we remand this matter to Referee Podnar for further proceedings consistent with this order. These proceedings may be conducted in any manner that the Referee determines achieves substantial justice. At the further proceedings, the parties may present documentary and testimonial evidence as to whether claimant was a "worker" and received "wages" at the time of his medically verified disability. See ORS 656.005(28) and ORS 656.005(27). The parties may also present documentary and testimonial evidence of the amount of claimant's "wages" at that time, if any. Finally, the parties are also entitled to present documentary and testimonial evidence regarding the applicability of the Director's weekly wage calculation methods (OAR 436-60-025(5)), as well as any other standard for determining a weekly wage which they consider appropriate.

ORDER

The Referee's order dated February 2, 1994 is vacated. The matter is remanded to Referee Podnar for further action consistent with this order. The Referee may conduct these further proceedings in whatever manner the Referee determines achieves substantial justice. Thereafter, the Referee shall issue a final, appealable order.

January 30, 1995 Cite as 47 Van Natta 143 (1995)

In the Matter of the Compensation of
GARY W. HELZER, Claimant
WCB Case No. 93-11957
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Moscato, Byerly, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Holtan's order that upheld the self-insured employer's denial of claimant's claim for mental stress and stress-related gastrointestinal conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Mental Stress Claim

We adopt and affirm the Referee's analysis regarding this issue, with the following supplementation.

Claimant, a truck driver, began working for the employer in June 1992. The employer hired a new trucking division general manager in November 1992. In early 1993, the new manager began subcontracting some of the employer's trucking work to outside truckers, which led several employees, including claimant, to file grievances pursuant to a union contract. The employer and the union have submitted the subcontracting dispute to an arbitrator.

Claimant argues that, following his filing of several grievances, the employer engaged in a course of harassment that caused his mental stress and gastrointestinal conditions. We agree with the Referee that no such "harassment" occurred.

Claimant argues that, following his filing of the grievances, he was "wrongly accused" of knocking over a steel post in the employer's truck yard, performing sloppy work for a bakery, and delivering products late. On this record, we conclude that there is insufficient evidence of any "wrongful accusations," much less that those "accusations" were designed to harass claimant. See Tammy G. Dodson, 46 Van Natta 1895 (1994) (the claimant's stress claim failed, in part, for lack of evidence of false charges of the claimant's poor performance).

Claimant also argues that he was harassed by the employer's disciplining him for falsifying his trucking logs and for an incident of alleged sexual harassment of another employee. We agree with the Referee that the employer's disciplinary actions were reasonable. See ORS 656.802(3)(b). Furthermore, after reviewing the evidence, we conclude that the employer's disciplinary actions were not a part of a pattern of post-grievance harassment.

Finally, claimant argues that the employer's "shorting" him on several paychecks and calling him into work and then telling him that no work was available was part of the employer's harassment of him. The record reveals that the "short" paychecks were due to problems in the employer's

bookkeeping system, and that claimant being called into work when none was available was, at most, a mistake on the employer's part.[1] There is no evidence that the employer "shorted" claimant's paychecks or changed claimant's work assignments in retaliation for his filing the grievances. Accordingly, we conclude that neither the "short" paychecks nor the mistaken calls into work constituted harassment of claimant.

For these reasons, we find no pattern of harassment following claimant's filing of grievances with the employer.

Claimant next argues that the new manager's "stricter" management style is a cognizable basis for a compensable stress claim. We disagree. New management and administrative procedures are generally inherent in every working situation. Karen M. Colerick, 46 Van Natta 930 (1994). Therefore, we conclude that, although the new manager's actions may have contributed to claimant's stress, we may not consider those actions in evaluating the compensability of that claimant's psychological condition. See ORS 656.802(3)(b).

Claimant argues that the Referee erred in concluding that union-management disagreements are generally inherent in every working situation. Particularly, claimant argues that, because the phrase "generally inherent in every working situation" is directed to conditions presumed to be present in all jobs, see Housing Authority of Portland v. Zimmerly, 108 Or App 596 (1991), and because not all jobs involve union employees, the Referee's conclusion is erroneous. We need not address that argument. Even if the union-management conflict in this case is of the type that is not generally inherent in every working situation, the medical evidence fails to meet claimant's burden, because it does not exclude from consideration the noncognizable elements set forth in ORS 656.802(3)(b), some of which we discussed above. Mary A. Murphy, 45 Van Natta 2238 (1993) (medical experts' reliance on a condition generally inherent in every working situation basis for upholding carrier's denial of the claimant's mental condition).

In sum, for the reasons set forth in the Referee's order, as supplemented herein, we conclude that claimant has failed to establish the compensability of his mental condition.[2]

Gastrointestinal Conditions

Relying on ORS 656.802(3)(c), the Referee concluded that "the preponderance of the medical evidence does not support a finding that claimant's [gastrointestinal] problems were related in major part to his psychological condition." (Opinion and Order at 6). Therefore, the Referee concluded that claimant had failed to establish the compensability of his gastrointestinal conditions. We agree with and adopt the Referee's conclusion that claimant's gastrointestinal conditions are not compensable, but offer the following reasoning.

Subsequent to the Referee's order, the Supreme Court rejected the view that all claims based on stress must be analyzed as occupational disease claims. Mathel v. Josephine County, 319 Or 235 (1994). In Mathel, the claimant suffered a heart attack due to high stress levels at work. The Court concluded that the cause of a condition does not determine whether a claim is for an injury or a disease. Rather, interpreting ORS 656.005(7)(a) and 656.802, the Court concluded that the proper inquiry is whether the condition is an event or an ongoing condition or state of the body or mind. Id. at 240. The Court then held that a heart attack, even one precipitated by job stress, is an injury within the meaning of ORS 656.005(7), and is compensable if it meets the statutory requirements for accidental injuries. Id. at 242-43.

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[1] Evidently, claimant's "short" checks were corrected; he does not assert that the employer failed to pay him at all.

[2] The employer argues that claimant has failed to establish an emotional disorder that is generally recognized in the medical or psychological community. In view of our conclusion that claimant's mental condition is, for other reasons, not compensable, we need not address that argument.

In Dibrito v. SAIF, 319 Or 244 (1994), the Court expanded its holding in Mathel. There, the claimant sought compensation for an episode of colitis and a personality disorder. The Court agreed with the Board's application of ORS 656.802 to the personality disorder claim. Id. at 249. However, citing Mathel, the Court held that the Board had erred in not analyzing separately the claim for colitis under ORS 656.005(7). The Court explained that, whether caused by physical factors, job stress, or both, the episode of colitis was an "event" constituting an accidental injury. Id. at 248-49.

Applying this reasoning, we find that claimant's gastrointestinal conditions are an ongoing condition or state of the body. The record does not refer to an isolated "event" marking the onset of claimant's gastrointestinal conditions; rather, the medical evidence suggests a gradual onset of symptoms that eventually developed into the conditions for which claimant currently seeks compensation. (E.g., Exs. 5, 23, 24). Therefore, we analyze claimant's gastrointestinal conditions claim as an occupational disease claim under ORS 656.802(1) and (2). See Laurie L. McKinley, 46 Van Natta 2329 (1994) (Board analyzed the claimant's fibromyalgia symptoms, which were gradual in onset, as an occupational disease). Accordingly, claimant has the burden of establishing that his work exposure was the major contributing cause of his gastrointestinal conditions or their worsening. ORS 656.802(2). For the reasons stated in the Referee's order, we conclude that claimant has failed to meet that burden. Accordingly, we affirm the Referee's decision upholding the employer's denial of claimant's gastrointestinal conditions.

ORDER

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

Board member Gunn specially concurring.

I write separately to address a concern I have regarding claimant's argument that union-management conflicts are not generally inherent in every working situation.

As a former union representative, I am aware of the stress inherent in the grievance process. Although management may acknowledge the process's legality, and even support it as part of the labor contract, I have yet to find anyone who liked the process.

It has also been my experience that management routinely makes known its displeasure with grievances, in ways both overt and subtle. By its very nature, the act of filing a grievance exposes a worker to management scrutiny. This increased scrutiny often leads to disputes over matters that might have gone unnoticed but for the grievance activity. Therefore, workers who pursue grievances do so at the risk of increased, and perhaps, unfair, management scrutiny. It goes without saying that taking such a risk is stressful.

I believe that it remains an open question whether stress occasioned by the grievance process is generally inherent in every working situation. Given my union and non-union work experience, my inclination would be to answer the question, "no."

This case does not, however, afford us the opportunity to address that issue. Most of the medical evidence supports the conclusion that the major contributing cause of claimant's stress was reasonable disciplinary action. Therefore, under the current law, claimant's mental stress claim is not compensable. See ORS 656.802(3)(b). For this reason, I reluctantly agree that, notwithstanding the concerns I have regarding claimant's union-management argument, the Referee's decision must be affirmed.

In the Matter of the Compensation of
WANDA KELLEY, Claimant
WCB Case No. 94-03215
ORDER ON REVIEW (REMANDING)
Roberts, et al., Defense Attorneys

Claimant, pro se, requests review of Referee Brown's order that upheld the insurer's denial of claimant's left knee injury claim. Submitting some "post hearing" reports and statements, claimant contends that her claim is compensable. We remand.

The Referee upheld the insurer's denial of claimant's left knee condition. On review, claimant has submitted evidence that was not presented at hearing. We treat submission of this additional evidence as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1995). We grant the motion.

We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly incompletely or otherwise insufficiently developed. ORS 656.295(5). 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).

Among the evidence claimant seeks to have admitted, is evidence that Dr. Webb performed surgery on claimant's left knee on July 12, 1994, more than a month after the May 31, 1994 hearing.

Claimant was seen for the first time by Dr. Webb on May 18, 1994. Dr. Webb diagnosed intrapatellar tendinitis of the left knee and probable intra-articular pathology consisting of meniscal tearing. (Ex. 12). Before seeing Dr. Webb, only claimant's tendinitis condition had been diagnosed. The question presented by this case is whether claimant's left knee condition is compensable. In order to make that determination, it is necessary to have evidence concerning the nature and cause of the left knee condition. Thus, evidence stemming from the surgery is relevant to the question of compensability. Given the facts of the present case, we find a compelling reason to remand. See Parmer v. Plaid Pantry #54, 76 Or App 405 (1985) (Evidence arising from post-hearing surgery can constitute grounds for remand).

Without the surgical report and evidence derived from the surgery, we find the record incompletely developed. The surgical report and evidence derived therefrom concern disability and are reasonably likely to affect the outcome of the case. Moreover, the surgical report was not obtainable with due diligence at the time of hearing since the surgery did not take place until after the hearing. See Wonder Windom-Hall, 46 Van Natta 1619, 1620 (1994) (Evidence derived from "post-hearing" surgery not obtainable with due diligence).

Under such circumstances, we conclude that the case should be remanded to Referee Brown for further development. Accordingly, the Referee's order is vacated and this matter is remanded to the Referee to reopen the record for additional evidence from the parties regarding claimant's surgery and the resulting findings regarding the cause(s) of claimant's left knee condition. The Referee may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The Referee shall then issue a final appealable order reconsidering those issues raised at hearing.

ORDER

The Referee's order dated June 10, 1994 is vacated. This matter is remanded to Referee Brown for further proceedings consistent with this order.

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[1] Claimant also seeks admission of a statement from a co-worker, a physical therapy progress report and some prescriptions from Dr. Peterson for physical therapy. In light of our decision to remand for additional evidence regarding claimant's "post-hearing" left knee surgery, we find it unnecessary to address admissibility of the the co-worker's statment, the physical therapy report or Dr. Peterson's prescriptions. If claimant wishes to present such evidence at hearing, it will be up to the Referee to determine, within his discretion, whether such evidence should be admitted.

In the Matter of the Compensation of
MERRY J. MORGANS, Claimant
WCB Case No. 92-07022
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

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

Claimant requests review of that portion of Referee Crumme's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a psychological condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, but not his Ultimate Findings of fact, with the following supplementation.

In June, 1989, the Governor appointed Glenn Ford (Ford) as director of SAIF's insured, the International Trade Division of the Economic Development Department of the State of Oregon (the employer). Ford immediately embarked upon a major redirection of the employer's operations that stressed private sector experience and markedly different job functions. Ford sought to hire only young, energetic persons with private sector experience to fill professional staff vacancies. He told at least one employee that he wished to hire only young men. Most newly hired professional staff were young men with private sector backgrounds.

After Ford's appointment, there developed a common practice engaged in by newer employees, including Ford and claimant's supervisor, Roger Weyel (Weyel), of disparagingly referring to any long-term state employee as a "lifer." Claimant and others heard the term "lifer" used often at work in reference to career public employees.

As time went on, the atmosphere at the employer deteriorated to the point where employees, including Ford, recognized a distinction between "A team" and "B team" employees, the former consisting of mostly newer employees, and the latter consisting of several long-term state employees, including claimant.

In the meantime, Weyel had told other employees of his plans to terminate long-term public employees and of his belief that persons who were civil servants for more than two years lacked any ambition. According to one of claimant's co-workers, Ford agreed that employees who have more than two years of tenure with the state lacked ambition.

Claimant was a long-term employee of the employer. Most recently, she had served as a trade specialist and trade development officer. Through early 1989, she had earned at least satisfactory, and often outstanding, performance ratings. In July 1990, however, claimant received an unfavorable performance review from Ford, based on her inability to conform to management's expectations. (Ex. C-1). In the review, Ford stated that part of claimant's "problem" was her inability to produce marketing plans in a timely manner, although he stated, in claimant's defense, that she was not familiar with developing marketing plans. (Id. at 2). The review stated that disciplinary action would be taken, unless there was significant improvement in six months time. However, no follow up performance review was performed, nor was any formal disciplinary action taken.

Claimant's relationship with Weyel (and with Ford, to a lesser extent) was strained. Many employees heard Weyel raise his voice at claimant (actually scream or yell) on several occasions. After claimant complained about this treatment, Ford took over claimant's supervision.

Claimant's condition began to deteriorate in the fall of 1991. In September 1991, she began to experience abdominal pain; thereafter, she developed high blood pressure, shortness of breath and emotional problems. She treated with Dr. Hartnett.

Before 1989, trade development officers, including claimant, had served in industry-specific capacities. After Ford was appointed, the trade development officer position became country-specific. Furthermore, to be hired as a new trade development officer, one would need job qualifications that claimant did not have, i.e., private sector experience, a history of foreign country residency and fluency

in a foreign language. These new job qualifications were not applied to existing trade development officers, such as claimant.

In late 1991 and early 1992, claimant had serious difficulties in performing her work in a manner satisfactory to management. Ford instituted a program that moved the employer away from trade shows and trade missions (with which claimant had been recognized in the industry for her proficiency), and toward providing more technical marketing analysis and assistance to individual companies. Although Ford knew that claimant was not skilled at the latter analysis, he nevertheless expected claimant to provide services in accord with the new program.

On December 10, 1991, Ford advised claimant that he wanted her to complete feasibility reports for four companies within the next two months. (Ex. G). He gave claimant a copy of a sample report from two other employees. Ford rejected claimant's first draft for one of the reports for failure to follow the approved format and lack of certain relevant information. (Ex. H).

Ford found claimant's second draft inadequate. He stated that "the major problem is that the report lacks clarity and does not provide [the company] with the information they need." (Id). Ford advised claimant to perform company-specific research. (Id).

In a note dated December 20, 1991, Ford noted that claimant's third draft was an improvement, but needed additional information regarding goals, the company's obligations, feasibility, product history and product features and specifications. (Ex. I-1). Ford also noted that the report's organization was improved, but that claimant still had "a lot more research to do." (Id. at 2).

On January 7, 1992, Ford noted that claimant had yet to complete the report. (Ex. J). He also noted the claimant had been ill on the previous Thursday, after "ma[king] a very public display of her condition by lying down in the break room," and that claimant had gone home early on Friday. (Id). The same day (January 7), claimant informed Ford that she had been talking to contacts regarding the report on which they had been working. (Ex. K).

The next day, Ford noted that claimant had "submitted a slightly better version, but we are a long way off." (Ex. L). He also noted that he had obtained more information with a couple of telephone calls than claimant had obtained in the past several months. (Id). Ford asked another employee to help claimant with the report. (Id). Ford also noted that:

> "[d]uring our discussion today regarding my frustration over the lack of progress being made on the contracts, [claimant] made a point of making me aware of her ulcer problems. She went home early as a result. Every time I increase the pressure, [claimant] is attacked by some ailment." (Id).

Claimant called in sick on January 9, 1992. (Ex. M). On January 14, 1992, claimant again sought treatment from Dr. Hartnett, who authorized a leave from work. Claimant had high blood pressure, an irregular heartbeat, and complained of having recurrent abdominal pain, difficulty sleeping and of a great deal of stress at work. Dr. Hartnett diagnosed anxiety and depressive state, hypertension and a probable old myocardial infarction based on an electrocardiogram and claimant's history of an episode of chest pain and fainting in November 1991.

In January 1992, claimant began seeing a counselor. In March 1992, Dr. Hartnett referred claimant to Dr. Paltrow, psychiatrist, who diagnosed major depression, single episode. (Ex. 14-1). Paltrow opined that, "on the basis of reasonable probability, [claimant's] working environment was the major contributing cause in causing both [claimant's] current disability and need for treatment." (Id). Claimant continued to see both the counselor and Dr. Paltrow.

Claimant was examined on SAIF's behalf by Dr. Glass, psychiatrist, and by Dr. Turco, psychiatrist. Both psychiatrists diagnosed adjustment disorder with mixed emotional features and some physical symptoms. Dr. Glass concluded that claimant's psychological condition was work-related and that there were no off-work stressors. (See Ex. 7-9).[1] Dr. Turco concluded that claimant's employment activities were the direct cause of her emotional difficulties and that nonwork factors did not contribute to her need for psychological treatment. (Ex. 16-9).

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[1] Dr. Glass noted that claimant had attributed her psychological condition to her employment conditions and that there were no off-work stressors. (Ex. 7-9). We read Dr. Glass' opinion as concluding that claimant's psychological condition was work related.

CONCLUSIONS OF LAW AND OPINION

To establish the compensability of a stress-related mental condition, a claimant must prove that the employment conditions are the major contributing cause of her 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 medical 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. The parties' dispute centers around three issues: (a) whether claimant's condition was caused by conditions other than those generally inherent in every working situation; (b) whether claimant's condition was the result of reasonable disciplinary, corrective or performance evaluation actions; and (c) whether the physicians who treated and examined claimant properly excluded from their consideration those aspects of claimant's work and off-work activities that are not cognizable under ORS 656.802(3)(b) in determining the cause of claimant's psychological condition. We begin with the first issue.

The phrase "generally inherent in every working situation" means those conditions that are usually present in all jobs and not merely in the specific occupation involved. See Kathleen M. Payne, 42 Van Natta 1990, 1906 on recon 42 Van Natta 2059 (1990), rev on other grounds City of Portland v. Payne, 108 Or App 771 (1991). The Board determines which conditions are generally inherent in every working situation on a case-by-case basis. See SAIF v. Campbell, 113 Or App 93 (1992).

We find that the employment conditions that contributed to claimant's psychological condition were: (1) major and fundamental changes in the direction of the agency, including changes in its primary methods of doing the work to accomplish the agency's mission; (2) the existence of an atmosphere which belittled the value and worth of career public employees to such a point that managers and employees felt no hesitation to openly refer to career civil servants in disparaging terms; and (3) claimant's inability to complete reports that she had never done before, within designated time frames and to the satisfaction of management, and management's displeasure with her inability to do so.

In identifying these conditions as the cause of claimant's psychological disorder, we disagree with SAIF's contention that a working environment hostile to career public employees did not exist, but instead was imagined by claimant. We find that the evidence preponderates greatly to the contrary.

Following Ford's appointment, the employer declared that the agency's mission could be better accomplished if professional employees were recruited exclusively from the private sector, characterizing such persons as more capable, desirable and valuable to the agency than career civil servants. Eventually, an atmosphere developed at the workplace in which employees and managers felt free to openly refer to career public employees in disparaging terms (i.e., "lifers"). One of the most vociferous critics of career public employees was the assistant director, Weyel, whose active participation lent official approval to the view that career public employees were inferior. Ultimately, the office became divided into two groups: the "A team" and the "B team." Whereas the "A team" employees understandably took no personal offense when the career public employees were described with disdain, claimant and the other career public employees were offended or hurt. For the latter group, a hostile work environment existed in a real and objective sense.

As previously discussed, the Board determines which conditions are generally inherent in every working situation on a case-by-case basis. Here, we have no difficulty concluding that the hostile work environment in which claimant performed her duties is not a condition generally inherent in every working situation. The program changes claimant had to deal with presented a more complex question.

Undoubtedly, all employees, whether in the private or public sector, must accept, as a normal condition of employment, some measure of change in the operations and direction of the employer, including changes in the work done by the employee. SAIF would go further, however. SAIF argues that the Board should regard even drastic reorganizations and reassignments, including employee demotions, as conditions generally inherent in every working situation, provided there is a reasonable basis for the decision.

We conclude that SAIF's argument misses the point of claimant's case. Claimant contends, and we agree, that she was expected to adapt to major and fundamental changes in the agency's operations and methods, in an environment where employees and managers openly expressed disdain for career public employees, including claimant. We conclude such circumstances are not generally inherent in every working situation.

We turn to the corrective action issue. SAIF argues that Ford's actions in December 1991 and January 1992 with respect to the feasibility report were reasonable, and hence, could not be considered in determining the cause of claimant's psychological condition. See ORS 656.802(3)(b). We disagree.

The record reveals that claimant was skilled at trade shows and trade missions; Ford knew she was not skilled at providing technical marketing analysis and assistance to individual companies. (See Ex. C-2). Yet, with only a sample report and minimal instructions as a guide, Ford expected claimant to provide those services immediately and without any modicum of training. When claimant failed to produce satisfactory draft reports, Ford told her that her reports lacked clarity and that she needed to perform more research. His feedback was sketchy, at best. The end result was that, after several failed attempts, both claimant and Ford became frustrated by claimant's inability to produce a satisfactory report. Finally, Ford assigned another employee to assist claimant with the report. Claimant became disabled before the report was completed.

We conclude that, when taking into consideration the hostile work environment together with Ford's corrective action, the combined impact was unreasonable. First, he expected claimant to produce a technical report for which he knew she had virtually no training. Second, and most important, we conclude that, in light of the increasingly hostile work environment that claimant was faced with, the feedback that she received from Ford during December 1991 and January 1992 was simply too little and too late to be of any real assistance to her. Under the circumstances, we conclude that Ford's corrective action was not reasonable.

SAIF argues that we should not consider Ford's corrective action in determining the cause of claimant's psychological condition because claimant did not apprise any physician of that action. We disagree. First, Dr. Paltrow's report is too conclusory to enable us to conduct a meaningful review. See Kelso v. City of Salem, 87 Or App 630 (1987); Moe v. Ceiling Systems, 44 Or App 429 (1980). Because Drs. Glass and Turco refer, albeit obliquely, to Ford's corrective actions, we reject SAIF's argument with respect to their reports. (See Exs. 7-3, -4; 16-4). Moreover, we conclude that claimant likely failed to discuss the events that transpired in December 1991 and January 1992 in great detail because she reasonably perceived them to be merely a part of the generally antagonistic atmosphere (about which she did report) that had existed at the employer ever since Ford had assumed the directorship.

SAIF also argues that claimant has failed to meet her burden of proof because she failed to apprise the psychiatrists of her adverse July 1990 performance appraisal. We disagree. Claimant's current psychological condition became disabling over 18 months after the July 1990 appraisal. Furthermore, no follow up appraisal was performed, nor any disciplinary action taken. We conclude that claimant's July 1990 performance appraisal had no bearing on her current psychological condition. Accordingly, claimant's failure to apprise the psychiatrists of the appraisal was harmless.

Next, claimant argues that the Referee erroneously discounted the medical evidence on the ground that it was not based solely on work factors cognizable under ORS 656.802(3)(b). We agree. Dr. Glass expressly addressed the factors to be excluded from consideration under ORS 656.802(3)(b), concluding that there were a number of inherent pressures in claimant's job. (Ex. 7-9, -10). However, there is no evidence that Glass relied on those pressures in determining that claimant's psychological condition was work-related. Furthermore, both Drs. Glass and Turco obtained histories from claimant that focused on the work conditions that we have earlier concluded are not generally inherent in every working situation or that constituted what we have determined to be unreasonable corrective action. Under the circumstances, we conclude that both Dr. Glass and Dr. Turco's opinions were based only on factors cognizable under ORS 656.802(3)(b).

Finally, claimant argues that the Referee erroneously concluded that several off-work factors contributed to claimant's psychological condition. We agree. There is no medical evidence that claimant's off-work situation had any bearing on her psychological condition. Both Drs. Glass and Turco discussed claimant's 1991 heart problems, but declined to give that factor any weight in their final conclusions regarding the cause of claimant's psychological condition. Furthermore, claimant was not apprised of her heart problem by her physicians until after she became disabled. Therefore, we conclude that that condition played no role in her psychological condition before she left work. Lastly, we conclude that the fact that neither Dr. Glass nor Dr. Turco discussed claimant's concerns regarding her own or her family's health was of no import, inasmuch as there is no evidence that those concerns caused claimant's psychological condition.

In sum, we conclude that, on this record, claimant has met her burden of establishing the compensability of her psychological condition. We note that neither Dr. Glass nor Dr. Turco used the precise words "major contributing cause" in rendering their opinions. However, reading each of their reports as a whole, we conclude that both reports establish that the major contributing cause of claimant's psychological condition was her cognizable work conditions. See ORS 656.802(3)(b); see also Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992). ("magic word" not required). Accordingly, we reverse the Referee's order upholding SAIF's denial of that condition.

Claimant is entitled to an assessed attorney fee for prevailing on the claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $8, 250, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's and reply briefs, counsel's statement of services, and the hearing record), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated May 24, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for further processing according to law. For services at hearing and on review, claimant's counsel is awarded a $8,250 attorney fee to be paid by SAIF.

Board Chair Neidig dissenting.

The majority has concluded that claimant has established that the major contributing cause of her psychological condition was her work conditions at the employer. Because I agree with the Referee that the medical evidence is simply too flawed to pass muster under ORS 656.802(3)(b), I dissent.

The Referee found that no physician had rendered an opinion that excluded from consideration those work stressors that are generally inherent in every working situation. On that basis, among others, the Referee concluded that claimant had failed to establish the compensability of her mental disorder. I agree.

To establish the compensability of a stress-related mental condition, claimant must prove that the employment conditions are the major contributing cause of the disease and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder 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. Based on my review of the record, I would conclude that claimant has failed to meet her burden.

Dr. Glass, psychiatrist, examined claimant on SAIF's behalf. He diagnosed adjustment disorder with mixed emotional features and physical symptoms. (Ex. 7-8). He noted that claimant attributed her psychological problems to her work; he did not, however, render an opinion regarding causation. (See id. at 9).[1]

In response to an inquiry regarding whether claimant's work stressors were inherent in every working condition, Glass opined:

> "[Claimant] notes that her job is political. There are a number of inherent stressors. There are new administrative changes and priorities. From what she tells me, she has been able to survive throughout the various changes, administrations and political situations." (Id. at 10).

Dr. Paltrow, claimant's treating psychiatrist, diagnosed major depression, single episode. (Ex. 14-1). In a perfunctory letter opinion, he concluded that, "on the basis of reasonable probability, [claimant's] working environment was the major contributing factor in causing both [claimant's] current disability and need for treatment." (Id).

Dr. Turco, psychiatrist, examined claimant at SAIF's request. He diagnosed adjustment disorder with mixed emotional features and some physical symptoms. (Ex. 16-8). He opined that claimant's psychological condition was directly caused by her work activities and that non-work factors did not contribute to her need for psychological treatment. (Id. at 9).

I would conclude that none of these opinions is sufficient to meet claimant's burden of proof. Dr. Paltrow's opinion is so conclusory as to render adequate review impossible. See Kelso v. City of Salem, 87 Or App 630 (1987); Moe v. Ceiling Systems, 44 Or App 429 (1980). Furthermore, although Dr. Paltrow addressed the appropriate legal standard -- whether claimant's employment was the major contributing cause of her mental disorder -- and Dr. Turco acknowledged that claimant's work involved a number of inherent stressors, neither they nor Dr. Glass factored out those conditions generally inherent in every working situation in addressing the cause of claimant's mental disorder. See ORS 656.802(3)(b); Mary A. Murphy, 45 Van Natta 2238 (1993) (medical experts' reliance on a condition generally inherent in every working situation basis for upholding carrier's denial of claimant's mental disorder). On these grounds alone, I would accord little weight to their opinions.

I also disagree with the majority that claimant's failure to apprise the psychiatrists of her adverse performance review in July 1990 was harmless. ORS 656.802(3)(b) expressly provides that compensability of a mental disorder may not be predicated on reasonable disciplinary, corrective or job performance evaluation actions by the employer. Claimant does not argue that her July 1990 performance evaluation was unreasonable.[2] I disagree with the majority's conclusion that, because claimant did not become disabled for more than a year after the 1990 evaluation, the evaluation had no bearing on this case. Because I believe that this is a question for the medical experts, I would hold that the psychiatrists in this case should have been given the opportunity to consider the impact, if any, of the July 1990 performance appraisal on claimant's psychological condition.

Next, I strongly disagree with the majority's conclusion that Glenn Ford's (Ford's) corrective action in December 1991 and January 1992 with respect to claimant's marketing reports was unreasonable. To determine whether corrective action is reasonable, we inquire whether an employer's concerns were legitimate and whether its responses were not excessive. See Mary A. Murphy, supra, 45 Van Natta at 2239.

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[1] The majority interprets Dr. Glass' opinion as concluding that claimant's psychological condition was work-related. The majority is wrong. The most Dr. Glass does is report that claimant attributed her condition to her work. (See Ex. 7-9). In fact, Dr. Glass stated that a review of claimant's personnel records and investigative reports would be indicated to assess claimant's perceptions. (Id. at 10). In view of that evidence, I strongly disagree with the majority's conclusion that Glass himself reached an opinion regarding the cause of claimant's psychological condition.

[2] Claimant argues that her psychological condition was the cause, not the result, of her negative performance appraisal. Because the medical evidence establishes that claimant's psychological condition did not manifest itself until 1991, I find that argument unpersuasive.

The evidence in this case reveals that Ford's actions were legitimate. After he became the employer's director, Ford instituted a new policy to require more detailed, analytic marketing reports for foreign companies, instead of trade shows claimant was used to doing. Ford had every right to institute this new policy and to expect claimant to produce these reports. On this record, I would conclude that the concerns underlying Ford's corrective action were wholly legitimate.

Likewise, I would conclude that Ford's method of seeking to correct claimant's behavior was not excessive. Ford attempted, on several occasions, to give claimant relatively detailed instructions regarding how to produce a satisfactory report. Nothing in the record suggests that Ford displayed any rancor towards claimant during this process. Given that Ford's corrective actions were both legitimate and not excessive, I would find that those actions were reasonable and, therefore, not cognizable under ORS 656.802(3)(b).

Lastly, I have found no persuasive evidence that Drs. Glass and Turco (or Dr. Paltrow, for that matter) was aware of several other potential off-work stressors that may have affected claimant's psychological condition, including claimant's concerns regarding her own medical problems (other than her heart condition) and the health of her children and mother. I would discount Drs. Glass' and Turco's opinions accordingly. See Somers v. SAIF, supra; Alexander Dombrowski, supra.

For the foregoing reasons, then, I would affirm the Referee's conclusion that claimant has failed to meet her burden of establishing the compensability of her psychological condition. Because I believe that the medical evidence is insufficient to meet claimant's burden of proof, I would not address the "lifer" issue. However, since the majority has addressed that issue at length, I write only to express my view that the majority has mischaracterized what actually happened in this case. I agree that the term "lifer" was used at claimant's workplace; however, I am not convinced that it was used with such frequency and animus as to have created the hostile and disparaging environment that the majority envisions. Therefore, were I to fully address the "lifer" issue, based on my review of the record, I would likely conclude that what transpired was, although perhaps unkind and in poor taste, among those conditions generally inherent in every working situation.

For these reasons, then, I respectfully dissent.

January 30, 1995 Cite as 47 Van Natta 153 (1995)

In the Matter of the Compensation of
BUCK E. SIMS, Claimant
WCB Nos. 93-13293 & 93-13292
ORDER ON REVIEW
Coons, Cole, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney
Janelle Irving (Saif), Defense Attorney

Claimant requests review of that portion of Referee Brazeau's order that upheld the SAIF Corporation's and Liberty Northwest Insurance Corporation's denials of claimant's dyshidrotic eczema. Liberty cross-requests review of that portion of the Referee's order that set aside its denial of claimant's current bilateral hand allergic contact dermatitis. On review, the issues are compensability and responsibility.

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

SAIF asserts that, because Liberty failed to timely comply with the notice requirements of ORS 656.308(2), and because claimant did not raise the responsibility issue on review, Liberty is precluded from contesting the Referee's responsibility decision on review. We need not address that issue. Even if Liberty could contest the Referee's decision, we find that the evidence supports the Referee's responsibility decision.

We agree with the Referee's analysis, with the following supplementation.

Dr. Maliner, dermatologist, examined claimant on Liberty's behalf, concluding that claimant's employment for Liberty's insured was not the major contributing cause of his current need for treatment for his bilateral hand contact dermatitis. (Ex. 31-5). In a subsequent concurrence letter from Liberty's counsel, Maliner agreed that the major contributing cause of claimant's contact dermatitis was claimant's earlier employment with SAIF's insured. (Ex. 33-1). Because Maliner's concurring opinion lacks any meaningful explanation, we decline to give it any probative weight. See Marta I. Gomez, 46 Van Natta 1654 (1994). Rather, as did the Referee, we rely on the reports of Drs. Storrs and Bell, dermatologists, which support the conclusion that the major contributing cause of claimant's current contact dermatitis was his employment with Liberty's insured. Accordingly, we affirm the Referee's decision settomg aside Liberty's denial of claimant's bilateral hand contact dermatitis.

Claimant argues that the Referee erred in failing to order one of the carriers to accept a "fragile skin condition." That condition was allegedly brought about by claimant's use of corticosteroids to treat his contact dermatitis. SAIF asserts that no error was committed, because claimant never made a claim for that condition. We agree.

With one exception, the medical reports in this record only refer to two conditions: contact dermatitis and dyshidrotic eczema (or atopic dermatitis). Dr. Maliner, examining physician, referred to a third problem, viz., the fragile skin condition. (Ex. 31-4).

Although a physician's report requesting medical treatment for a specific condition may constitute a claim, ORS 656.005(6), 656.005(8), Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992), an observation in an examining physician's report does not constitute a claim. Shannon M. Evans, 42 Van Natta 227, 228 (1990). Because the only evidence in the record regarding a "fragile skin condition" consists of an examining physician's observation, we conclude that claimant never made a claim for that condition. Consequently, we conclude that the Referee did not err in failing to order the acceptance of the "fragile skin condition."

ORDER

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

In the Matter of the Compensation of
JOHN A. THOMPSON, Claimant
WCB Case No. 93-12075
ORDER ON REVIEW
Foss, Whitty, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Emerson's order that: (1) set aside its denial of claimant's left leg and hip injury claim; and (2) awarded claimant a $4,000 assessed attorney fee. SAIF also asks that claimant's request for assessed attorney fees on Board review be denied as untimely. On review, the issues are whether claimant's injury arose out of and occurred in the course of his employment, and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of facts.

CONCLUSIONS OF LAW AND OPINION

Claimant is employed as a long haul truck driver by SAIF's insured. In early 1991, unknown to the employer, and in violation of a published company policy, claimant began carrying a cut-down rifle for protection at work. On September 22, 1993, after completing a road trip, claimant returned to the employer's terminal. While claimant was removing his personal belongings from the sleeper cab of the truck, his rifle fell from his bedroll, struck the pavement, and discharged, shooting claimant in the left leg and hip.

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). That a worker is injured on the employer's premises during working hours does not of itself establish a compensable injury. Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983). Harms resulting from risks that are distinctly associated with the employment are universally compensable; harms resulting from risks personal to the claimant are universally noncompensable. Henderson, supra, 127 Or App at 338 (quoting 1 Larson, Workmen's Compensation Law 3-12, § 7 (1990)). Thus, the inquiry is whether being shot by a firearm carried in violation of the employer's "no weapon" policy was a risk connected to claimant's employment as a truck driver. We conclude that it was not.

We find no evidence of any condition associated with truck driving that brought about claimant's injury. Claimant's injury was caused by the rifle bullet, not by unloading the truck. The mere unloading of his personal belongings from the truck (which activity was, at least implicitly, contemplated by the employer and claimant) did not expose claimant to the risk of being shot. Rather, the risk of being shot was the direct result of claimant bringing on the employer's premises a firearm in violation of the employer's "no weapon" policy.

There is no evidence that carrying a rifle was an ordinary risk of claimant's employment as a truck driver. Other than the fact that claimant's injury occurred in the employer's terminal, we find no other connection between claimant's injury and his employment. Accordingly, we conclude that claimant's injury did not result from an act that was an ordinary risk of, or incidental to, his employment and thus, did not "arise out of" his employment. Consequently, we conclude that claimant has failed to establish compensability of his left leg and hip injury.

This conclusion is bolstered by the unreasonableness of claimant's actions. This case involves an "imported danger", that is, a firearm that claimant brought to work. See 1 Larson, supra, at 3-348.75, § 12.31 (1985). Professor Larson states that, "if the carrying of a weapon is not unreasonable, in view of the nature of the employment, as in the case of a claimant who made night deliveries and some collections, injury from accidental discharge of the weapon may be held compensable." Id. at 3-348.76-77, § 12.31 (emphasis added).

The record reveals that claimant's possession of the "sawed-off" rifle was illegal. (See Tr. 57; Ex. 12A-4, -6). See ORS 166.272 (prohibiting possession of certain short-barrelled firearms). We conclude that, as a matter of law, carrying an illegal firearm is unreasonable. Therefore, claimant's possession of the illegal rifle was unreasonable. That conclusion is further support for the noncompensability of claimant's hip and leg injuries. See 1 Larson, supra, at 3-348.76-77, § 12.31.

SAIF also argues that claimant overstepped the boundaries defining his ultimate work by carrying a firearm and, thus, that the prohibited act and resulting gunshot injury are outside the course of his employment. See Davis v. R & R Truck Brokers, 112 Or App 485 (1992). In light of our conclusion that claimant's injury did not arise out of his employment, we need not address that argument.

Attorney Fees

On review, SAIF argues both that the assessed attorney fee awarded by the Referee was excessive, and that claimant's untimely request for an assessed attorney fee on Board review should be denied. In light of our conclusion that claimant's gunshot injury is not compensable, the attorney fee issue is rendered moot.

ORDER

The Referee's order dated May 3, 1994 is reversed. The SAIF Corporation's denial is reinstated and upheld in its entirety. The Referee's assessed attorney fee award is also reversed.

In the Matter of the Compensation of
CHRISTOPHER A. WEBB, Claimant
WCB Case No. 94-00366
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Referee Brazeau's order which assessed a penalty pursuant to ORS 656.262(10) for SAIF's allegedly unreasonable discovery violation. On review, SAIF contends that it properly withheld the disputed evidence for impeachment purposes.

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

On November 24, 1993, claimant sustained an injury to his upper back and neck. George Snelling, who owns a business next to claimant's employer, saw claimant between the hours of 11 a.m. and noon on the day of injury. Claimant indicated that he had just injured his back at work. Mr. Snelling attempted to "pop" claimant's back.

During its investigation, SAIF's investigator interviewed Mr. Snelling. A report which contained a summary of Mr. Snelling's statement was not disclosed to claimant's attorney before the hearing. At hearing, when claimant's attorney learned of the report, he raised the issues of penalties and attorney fees for failure to timely disclose the report. SAIF responded that, pursuant to OAR 438-07-017, it had properly withheld the statement to use for impeachment of what it believed would be a key witness for claimant. Other than its counsel's representations, SAIF did not offer evidence in support of its position.

The Referee concluded that SAIF had not shown that it withheld the investigative report only for impeachment purposes. The Referee also assessed a penalty under ORS 656.262(10) after finding that SAIF's conduct was unreasonable. See SAIF v. Cruz, 120 Or App 65 (1993). We agree with the Referee's conclusion.

In Cruz, the court concluded that the Board had incorrectly relied on a carrier's counsel's unsworn representation that the only purpose of the claimant's written statement was for its use as impeachment evidence. The court reasoned that it is the Board's responsibility to determine, after evaluating the record and the withheld evidence, whether the party withholding evidence could reasonably have believed that the evidence was relevant only for purposes of impeachment. SAIF v. Cruz, supra, 120 Or App at 69; see OAR 438-07-017. If the Board determines that the party violated the rule, the court instructed that the Board should further consider whether the party acted unreasonably so as to justify a penalty or related attorney fee under ORS 656.262(10).

Here, the evidence in question is Mr. Snelling's statement to SAIF's investigator that: (1) he had heard claimant reporting the injury to the employer immediately after it happened; (2) he had attempted to help claimant by "popping" his back; and (3) he was concerned about the employer's employees because he felt the shop was unsafe. (Tr. 107-108).

At hearing, during cross-examination of SAIF's investigator, claimant's attorney learned that more than one investigative report had been prepared, and that one had not been disclosed to claimant. (Tr. 98). SAIF objected to claimant's request to see the investigative report, stating that it believed that the report was privileged attorney work-product. After SAIF's counsel consulted with the claims adjuster and determined that the report was not work-product, SAIF's counsel then stated he thought the reason it was kept was for impeachment of Mr. Snelling. (Tr. 99). SAIF's counsel stated that:

> "[Claimant's attorney] has been up front with this since the get-go in this case, since I first got the case, saying that he had this witness who was going to contradict everything we present in terms of the credibility issue. That's why I was so interested to see what Mr. Snelling said, because we took the position that that simply wasn't the case." (Tr. 100).

We first find that SAIF could not have reasonably believed that Mr. Snelling's statement that claimant informed him of his injury could be used for impeachment purposes because such evidence supported claimant's case. We find some support of a reasonable belief that Mr. Snelling's "popping" of claimant's back could "impeach" evidence regarding causation. However, because such evidence would also be relevant to the issue of causation, it cannot reasonably be said that the statement was intended only for impeachment purposes. In light of our evaluation of the record and the withheld statement, we conclude that SAIF has violated OAR 438-07-017 because it did not show that it had a reasonable belief that Mr. Snelling's statement was relevant only for purposes of impeachment. See SAIF v. Cruz, supra.

We now consider whether claimant proved that SAIF acted unreasonably "under all the circumstances" so as to be entitled to a penalty under ORS 656.262(10). Id at 68-69. After our evaluation of the record and the withheld evidence, and after considering SAIF's explanation for withholding the evidence, we conclude that SAIF did act unreasonably so as to justify a penalty under ORS 656.262(10).

Finally, SAIF contends that a penalty is not justified because there were no amounts due arising from the discovery violation. We disagree.

In Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), the court reiterated the Supreme Court's holding in Morgan v. Stimson Lumber Company, 288 Or 595 (1980), that failure to provide discovery can interfere with the payment of compensation. 108 Or App at 257. However, in Jackson, the court found that an attorney fee award was improper because the employer had paid the entire award of compensation prior to the discovery violation and thus, there was no unreasonable resistance to the payment of compensation. Id.

Here, compensability of claimant's injury claim was directly at issue during the hearing, and there is no evidence that any compensation had been paid up to the time that the Referee set aside SAIF's denial and remanded the claim to SAIF for acceptance. Under such circumstances, we conclude that there are amounts then due on which to base a penalty. See Leona M. Brooks, on recon, 46 Van Natta 1925 (1994). Accordingly, we conclude that SAIF's discovery violation manifested an unreasonable delay in the payment of compensation justifying the assessment of a penalty under ORS 656.262(10). See OAR 438-07-015(5).

SAIF also contends that OAR 438-07-015(5) is inconsistent with ORS 656.262(10) because the statute expressly requires unreasonable delay or refusal to pay compensation, whereas the rule provides that an unreasonable discovery violation shall be considered delay or refusal under ORS 656.262(10). In Morgan v. Stimson Lumber Company, supra, the Supreme Court considered whether the rule that failure to comply with discovery requirements could be considered an unreasonable delay or refusal to pay compensation is within the Board's authority. The Court held that it is, stating that the Board is entitled to require:

> "within its responsibility for and experience with administering hearings, that a practice of prompt disclosure of all relevant information to the claimant will generally expedite the disposition of a claim and the eventual payment, and that failure or delay in such disclosure will tend to obstruct or delay a proper disposition and payment of a claim." 288 Or at 604.

Accordingly, the Referee properly assessed a penalty pursuant to ORS 656.262(10) for SAIF's unreasonable failure to timely disclose its investigative report.

Claimant is not entitled to an attorney fee for defending against the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated May 17, 1994, as reconsidered June 2, 1994, is affirmed.

In the Matter of the Compensation of
ROSEMARY A. WEISENBACH, Claimant
WCB Case No. 93-08606
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of Referee Crumme's order that affirmed a Director's order under ORS 656.327(2) finding that claimant's lumbar surgery at L3-4 and L4-5 was not appropriate. On review, claimant contends that: (1) the Referee erred in finding that the Director's order was supported by substantial evidence; (2) the Referee erred in excluding evidence submitted by claimant at hearing, which consisted of testimony from claimant's treating neurosurgeon; and (3) the Director's order is legally defective because the insurer allegedly did not comply with the rules for processing requests for approval of proposed elective surgery. On review, the issues are evidence and review of a Director's order in a medical treatment dispute. We affirm.

FINDINGS OF FACT

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

Dr. Nash is claimant's treating neurosurgeon and performed the lumbar surgery on February 22, 1993. He testified at the October 21, 1993 hearing.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

Although allowing Dr. Nash to testify, the Referee confined his review to the record developed before the Director. The Referee took this action in reliance on the Board's decision in Iola W. Payne-Carr, 45 Van Natta 335 (1993), aff'd mem Payne-Carr v. Oregon Portland Cement Company, 126 Or App 314 (1994).

Subsequent to the Referee's order, we issued our decision in Julie Sturtevant, 45 Van Natta 2344 (1993), in which we disavowed our holding in Payne-Carr and concluded that, on the basis of the text and context of ORS 656.327(2), the legislature intended referees to find facts independently based on an evidentiary record developed at hearing. Sturtevant, supra at 2347. The insurer acknowledges our holding in Sturtevant; however, it requests that we reconsider and disavow that holding.

We adhered to our rationale in Sturtevant in our recent decision in Ruby L. Goodman, 46 Van Natta 810, n.3 (1994). In Goodman, we acknowledged that the Court of Appeals affirmed Payne-Carr without opinion. Payne-Carr v. Oregon Portland Cement Company, supra. Nevertheless, we noted that the Board alternatively found in Payne-Carr that the result would have been the same if the Board considered the additional evidence offered by the claimant. 45 Van Natta at 337. We reasoned that the court's affirmance could have been based on either this alternative finding, or the Board's conclusion that a referee review of a Director's order under ORS 656.327(2) is limited to the record developed before the Director.

Accordingly, because we do not interpret the court's affirmance of Payne-Carr as necessarily inconsistent with Sturtevant, we continue to follow Sturtevant. Willie A. Sowers, 46 Van Natta 1054 (1994). Accordingly, we deny the insurer's request to revisit our decision in Sturtevant and disavow our holding in that case. Therefore, in determining whether substantial evidence supports the Director's order, we review the record developed by the Referee, including Dr. Nash's testimony. Accordingly, we proceed with our review.

Substantial Evidence Review

Pursuant to ORS 656.327(2), the Director's order may be modified only if the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding when the record, reviewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990). We apply those principles to the present case.

On February 22, 1993, Dr. Nash performed two surgical procedures on claimant: (1) decompressive laminectomy (lumbar canal decompression at L3-4 and lateral recess and foraminal decompression with neurolysis at L4-5 left); and (2) transverse process fusion at L4-5.

Dr. DeMent, M.D., performed a record review for the Director. (Ex. 315). This record review included Dr. Nash's operative and post-operative reports. Dr. DeMent opined that the decompressive laminectomy procedure was not appropriate treatment for claimant's current condition, explaining that "a decompressive laminectomy is appropriate when imaging studies showing neurological structures being compressed correlate with physical findings on examination." (Ex. 315-8). He found neither of these conditions present in claimant's case. He agreed with Dr. Rosenbaum, examining neurosurgeon, who opined that the L3-4 findings did not appear to represent a surgical lesion, and that, without a diagnostic myelogram, it could not be inferred from the existing studies that surgery would likely be beneficial. (Exs. 286-6, 315-8).

Dr. Nash testified that the surgery revealed pathologic changes at L3-4 which justified surgery. (Tr. 30, 31, 34). Regarding Drs. DeMent's and Rosenbaum's recommendations of a diagnostic myelogram, Dr. Nash testified that, even if he had been aware of such a recommendation before surgery, he would not have performed another myelogram on claimant because of the increased likelihood of the development of arachnoiditis that such a test presented to claimant. (Tr. 35-36).

Dr. DeMent also opined that the transverse process fusion at L4-5 was not appropriate. He noted that, although tests performed in 1985 showed that claimant's L4-5 fusion was incomplete, tests performed on December 20, 1991, and February 11, 1993, showed no evidence of motion at L4-5. (Ex. 315-7). Furthermore, Dr. DeMent opined that the January 6, 1993 CT scan showed an intact L4-5 fusion mass on the right, although the record did not support an intact fusion mass on the left. He noted that there was "absolutely no motion on the plain films at L4-5 regardless of the status of the left-sided fusion mass." (Ex. 315-8). He explained that the lack of an intact fusion mass on the left was not clinically significant because it is generally accepted by spinal surgeons that a fusion that is intact on one side provides sufficient spinal stability. (Ex. 315-7). Dr. Rosenbaum also opined that the L4-5 fusion was solid and that there was no rationale to repeat the fusion procedure, despite the fact that the fusion existed primarily on the right. (Ex. 286-6).

At hearing, Dr. Nash disputed Dr. DeMent's statement that "[i]t is difficult to explain the lack of motion on repeated x-rays with Dr. Nash's notation in the operating room of 'hypermobility at L4-5.'" (Tr. 39, Ex. 315-8). Dr. Nash stated that he "saw [mobility] on the plain films before, and this was documented by operative findings." (Tr. 39). Dr. Nash does not explain which previous plain films showed mobility. Both Drs. DeMent and Rosenbaum state that the current films show no mobility.

Dr. Nash testified that a one-sided fusion was insufficient and that stability of vertebral segments require two of the three segments to be intact. (Tr. 29). He discussed a recent study regarding the Steffe plate method of fusion in which Dr. Steffe stated that one cannot stabilize the spine with a unilateral fusion, although Dr. Nash agreed that there is controversy regarding Steffe plating. (Tr. 44-46).

Dr. Nash testified that he performed the lumbar surgery based on claimant's worsening, as documented by his January 8, 1993 letter and the atrophy of claimant's left calf, although he would have performed the surgery in the absence of any atrophy. (Tr. 27, 55, Ex. 276). However, as the Director noted, neither Dr. Rosenbaum nor Dr. Noyes, consulting physician, noted any atrophy of claimant's left calf. (Exs. 286-5, 293-2). Furthermore, although Dr. Nash noted progression of motor loss in the lower extremities, Dr. Rosenbaum noted that motor strength testing in the lower extremities was normal in all muscle groups. (Exs. 276, 286-5).

Dr. Nash testified that his surgical findings were corroborated by claimant's diagnostic imaging. (Tr. 31-32). However, both Drs. DeMent and Rosenbaum opined that the diagnostic imaging did not demonstrate the need for surgery. (Exs. 286, 315). In addition, Dr. DeMent stated that, given the results of the diagnostic testing, there was no well-established diagnosis before the surgery. (Ex. 315-8). Dr. Nash disagreed with this statement and testified that he listed the pre-operative diagnoses without equivocation. (Tr. 39).

In a June 9, 1993 letter, Dr. Nash stated that after the surgery claimant improved subjectively and objectively, with significant objective improvement in her neurologic findings. (Ex. 317-1). Prior to hearing, Dr. Nash's only specific finding of objective neurologic improvement following the surgery was that claimant's sensation in her left calf and foot had returned. However, neither Drs. Rosenbaum nor Noyes had reported any left lower extremity sensation loss in their examinations. Therefore, it is not clear that the surgery caused the return of sensation in claimant's left leg.

At hearing, Dr. Nash again mentioned the improvement in claimant's left calf sensation and added that claimant "still has some compromise of reflex activity, but all the reflexes are elicitable." (Tr. 44). However, prior to surgery, the record regarding reflex activity is equivocal, with Dr. Rosenbaum noting knee reflexes equal and Achilles reflexes absent bilaterally and Dr. Noyes noting reflexes "normal at the knees and just minimal at the Achilles bilateral." (Exs. 286-5, 293-2). Given these equivocal pre-surgical findings, it is not clear that the surgery caused any improvement in claimant's reflexes.

After our review of the record, including the evidence developed at hearing, we agree that the Director's order is supported by substantial evidence in the record. In this regard, we note that it is not unreasonable for the Director to rely on Dr. DeMent's and Dr. Rosenbaum's opinions that a unilateral fusion provides sufficient stability, even though Dr. Nash's opinion supported another theory. Considering both supporting and countervailing evidence, we conclude that the record as a whole would permit a reasonable person to make a finding that lumbar surgery was not appropriate in this case. Thus, although there is medical evidence supporting the reasonableness of Dr. Nash's decision to perform the lumbar surgery, there is also medical evidence from Drs. DeMent and Rosenbaum supporting the Director's conclusion that lumbar surgery was not appropriate in this case. Accordingly, we affirm the Director's June 14, 1993 order.[1]

Validity of the Director's Order

At hearing and on review, claimant argued that the Director's order is legally defective because the insurer allegedly did not comply with the rules for processing requests for approval of proposed elective surgery. We adopt the Referee's reasoning and conclusions regarding this issue.

ORDER

The Referee's order dated November 22, 1993 is affirmed.

[1] We note that ORS 656.327(2) provides that when the Director finds medical treatment is not compensable, the worker is not obligated to pay for such treatment.

In the Matter of the Compensation of
GENE T. BURR, Claimant
WCB Case No. 93-00776
ORDER ON RECONSIDERATION
Emmons, Kropp, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

On November 21, 1994, we issued an Order on Review that affirmed a Referee's order that upheld the self-insured employer's denial of claimant's occupational disease claim for left ear hearing loss. Asserting that our decision contains factual errors, claimant seeks reconsideration.

On December 21, 1994, we abated our November 21, 1994 Order on Review to further consider claimant's motion for reconsideration and granted the employer an opportunity to respond to claimant's motion. Having received the employer's response, we proceed with our reconsideration.

Claimant contends that we relied on an incorrect work history. Our order adopted the Referee's findings of fact. Having adopted those findings, we necessarily also adopted her finding that:

"Claimant started working for this employer in their paper production plant in 1962. Prior to that date he had worked for this same employer in the sawmill division on the trimmer saw." By adopting that finding of fact, we considered the correct work history urged by claimant. Under the circumstances, we do not agree that our prior decision contains factual errors.

More importantly, claimant does not explain how his work for the employer from 1959 to 1962 could remedy the fact that treating physician Stevens' opinion was not persuasive because he did not know critical information about claimant's work exposure. As we noted, Dr. Stevens: (1) could not recall at what decibel level hearing damage occurs; (2) failed to ask claimant about the sound control booths, or the percentage of time he worked inside the control booths, or the percentage of time spent in certain areas of the plant, or other specific work exposures; and (3) failed to inquire what type of hearing protection claimant used or whether claimant wore hearing protection when he was out of the control booth.

Therefore, upon further consideration, we continue to find that claimant has failed to establish that his left ear hearing loss or its worsening is compensable under ORS 656.802(1)(c). Accordingly, on reconsideration, as supplemented herein, we adhere to our November 21, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DARLENE M. CORONADO, Claimant
WCB Case Nos. 93-05908, 93-04916, 93-05907 & 93-02611
ORDER ON REVIEW (REMANDING)
Jon C. Correll, Claimant Attorney
Williams, Zografos, et al., Defense Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (Liberty) requests review of Arbitrator McWilliams' order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for a bilateral wrist condition; and (2) upheld Safeco Insurance Company's (Safeco) denial of responsibility for the same condition. On review, the issue is responsibility. We remand.

Claimant has neither requested nor cross-requested review of the Arbitrator's responsibility determination and, in fact, seeks its affirmance. Because claimant challenges no aspect of the Arbitrator's decision affecting claimant's right to receive compensation or the amount thereof, no matter concerning a claim is directly in issue before us. Therefore, we review the Arbitrator's responsibility determination for questions of law only. ORS 656.307(2); see Jack W. Sanford, 45 Van Natta 52 (1993).

To begin, we note Liberty's contention that "the last injurious exposure rule" does not apply because actual causation is proven with respect to claimant's employment with Safeco's insured. We disagree.

We have stated that 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. Maria Gonzales, 46 Van Natta 466, 467 (1994). Here, the Arbitrator (acting as finder of fact) concluded that actual causation is not established on this record. Given our role, we do not review and thus do not disturb that factual determination. Based on the Arbitrator's factual findings, we agree that the last injurious exposure rule is applicable. See Gloria C. Garcia, 45 Van Natta 1702, 1703 n.1 (1993) (citing Fred A. Nutter, 44 Van Natta 854 (1992) (Where the condition has previously not been accepted or otherwise determined to be compensable, responsibility is determined pursuant to the last injurious exposure rule). Accordingly, we proceed to evaluate whether the Arbitrator properly applied the last injurious exposure rule in this case.

The Arbitrator concluded that the standard to be applied in this responsibility case is that pronounced in Bracke v. Baza'r, 293 Or 239 (1982); Progress Quarries v. Vaandering, 80 Or 160 (1986); and SAIF v. Cary, 63 Or App 68 (1983). We agree that the principles set out in these cases are applicable. However, the Court of Appeals has further refined the last injurious exposure rule in Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994) and SAIF v. Kelly, 130 Or App 185 (1994).

Under the rule, the "onset of disability" is the triggering date for initial assignment of responsibility. See Bracke v. Baza'r, supra. If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, supra. In addition, the Kelly court held that the dispositive date is the date claimant first sought treatment for symptoms (even if the condition was not correctly diagnosed until later). SAIF v. Kelly, supra at 188.

Here, in evaluating responsibility for claimant's occupational disease claim, the Arbitrator concluded that if a claimant was not disabled, the onset of disability was determined by the date that medical treatment was first sought for the compensable condition. As discussed above, for purposes of assigning presumptive responsibility under the last injurious exposure rule, the onset of disability is the date that claimant first receives treatment for symptoms of a compensable condition even if claimant does not experience time loss until sometime thereafter.

Under such circumstances, we conclude that the Arbitrator's application of the last injurious exposure rule is inconsistent with Timm and Kelly. Id. Accordingly, we vacate the Arbitrator's order and remand to Arbitrator McWilliams for reconsideration. See ORS 656.307(2).

ORDER

The Arbitrator's order dated June 22, 1994 is vacated. This matter is remanded to Arbitrator McWilliams for reconsideration in accordance with this order.

January 31, 1995 Cite as 47 Van Natta 162 (1995)

In the Matter of the Compensation of
SUSAN A. MICHL, Claimant
WCB Case No. 93-04959
ORDER ON RECONSIDERATION
David C. Force, Claimant Attorney
Roberts, et al., Defense Attorneys

The self-insured employer requests reconsideration and abatement of our January 11, 1995 Order on Review, which set aside its denial of claimant's left knee injury claim. The employer contends that we erred in not finding the major contributing cause standard of ORS 656.005(7)(a)(B) applicable . It invites us to provide guidance regarding the meaning of a "combined" condition. Having received and considered claimant's response, we proceed with our reconsideration.

To begin, our task is to review the record and apply the relevant statutory provisions. The application of one of those provisions is contingent on the presence of a compensable injury which "combined" with a preexisting condition to form a resultant disability or need for medical treatment. See ORS 656.005(7)(a)(B). In conducting this evaluation, we consider all potential contributors to claimant's current condition, not just the precipitating cause. See Dietz v. Ramuda, 130 Or App 397 (1994).

Here, contending that "it seems obvious claimant's work incident combined with the compromised, easily dislocated knee to produce the current diagnosis of a recurrent subluxation," the employer challenges our prior conclusion that there was no "combination." Although referring to medical evidence it asserts is suggestive of the required "combination," the employer is unable to cite us to any specific opinion that expressly supports such a conclusion. To the contrary, as discussed in our prior opinion, Dr. Nagel expressly determined that the prior dislocated patella was "entirely stabilized and the current injury is the sole result of the March 8, 1993 accident."

Therefore, upon further review of the medical record, we continue to adhere to our conclusion that the medical evidence is insufficient to establish that claimant's preexisting left knee condition and March 8, 1993 injury "combined" to cause disability or a need for medical treatment. While the use of "magic words" is not required, we find the medical record does not support the inference that the employer wishes us to draw. Thus, ORS 656.005(7)(a)(B) is not applicable.

Claimant's counsel is entitled to an additional assessed attorney fee for time spent responding to the employer's reconsideration request and finally prevailing over the employer's denial. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4), and applying them to this claim, we find that an additional reasonable fee for claimant's counsel's services regarding the employer's request for reconsideration is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the claimant's response to the reconsideration request), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our January 11, 1994 order. On reconsideration, as supplemented and modified herein, we continue to adhere to the reasoning and conclusions reached in our original order. Consequently, we republish our January 11, 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
JAY A. NERO, Claimant
WCB Case No. 92-04986
THIRD ORDER ON REMAND
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Claimant requests reconsideration of our October 26, 1994 Second Order on Remand which held that claimant is not entitled to an attorney fee under either ORS 656.382(1) or ORS 656.388(1) for his counsel's efforts in obtaining a penalty under ORS 656.268(4)(g). Specifically, claimant's counsel requests an out-of-compensation attorney fee under ORS 656.386(2).

On November 25, 1994, we abated our October 26, 1994 order for reconsideration. After considering the parties' motion and responses, as well as the record and pertinent legal authority, we decline to award claimant's counsel an out-of-compensation attorney fee.

In our Second Order on Remand, we held that claimant was not entitled to an attorney feel under either ORS 656.382(1) or ORS 656.388(1). We found that the insurer's conduct in issuing a Notice of Closure awarding no permanent disability had not been unreasonable. Therefore, claimant was not entitled to an assessed attorney fee under ORS 656.382(1). We also held that claimant was not entitled to an assessed attorney fee under ORS 656.388(1) because claimant prevailed after remand solely on a penalty issue, and because penalties do not constitute "compensation." We adhere to our reasoning regarding the availability of attorney fees under these two statutes.

Claimant now contends that his counsel is entitled to an out-of-compensation attorney fee under ORS 656.386(2). That statute provides: "In all other cases attorney fees shall continue to be paid from the claimant's award of compensation except as otherwise provided in ORS 656.382."

Here, we find no "award of compensation" from which the attorney fee could be paid. Claimant obtained a penalty under ORS 656.268(4)(g), not an "award of compensation." It is well-established that a "penalty" does not constitute "compensation" within the meaning of the Workers' Compensation Law. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

The term "compensation" is defined in ORS 656.005(8) as "all benefits, including medical services, provided for a compensable injury to a subject worker . . . by an insurer or self-insured employer pursuant to this chapter." Claimant argues that the term "benefits," which is not specifically defined in the workers' compensation statutes, should be interpreted to encompass the penalty paid to claimant under ORS 656.268(4)(g).

Although the term "benefits" is not defined in the statutes, the court has previously interpreted the term. In Dotson v. Bohemia, Inc., supra, 80 Or App at 236, the court held that "benefits . . . provided for a compensable injury" refers to the benefits identified in former ORS 656.202 to ORS 656.258, including payments for a worker's death, disability, medical services and vocational assistance. In Dotson, the court concluded that attorney fees are not included in "compensation".

In Saxton v. SAIF, supra, the court applied its reasoning in Dotson to penalties, holding that penalties are excluded from the the term "compensation." Authoritative court interpretations of a statute become a part of that statute as if written into it at the time of enactment. SAIF v. Allen, 320 Or 192 (1994). We have long accepted the court's authoritative interpretation of the terms of "compensation" and "benefits" as set forth in Saxton and Dotson, supra. We find no reason not to continue to do so here. Accordingly, we reject claimant's argument that the term "benefits" should include the penalty payable to claimant under ORS 656.268(4)(g).

Attorney fees may be awarded only as specifically authorized by statute. SAIF v. Allen, supra, 320 Or at 299; Forney v. Western States Plywood, 297 Or 628, 632 (1984). ORS 656.268(4)(g) authorizes the payment of a penalty directly to the worker, under the specified circumstances. The statute does not authorize the payment of a portion of the penalty to the attorney as an attorney fee. When the legislature intended a penalty to include an attorney fee, it said so explicitly. Compare ORS 656.262(10). The legislature did not authorize an attorney fee to be paid out of the penalty assessed under ORS 656.268(4)(g). We are not at liberty to add to the statute provisions which the legislature has excluded. Accordingly, we find no authority for awarding an attorney fee under ORS 656.386(2) in the circumstances of this case.

Claimant also contends that he is entitled to an attorney fee under ORS 656.386(1) or 656.382(2). We disagree.

ORS 656.386(1) authorizes an attorney fee only when a claimant finally prevails "from an order or decision denying the claim for compensation."[1] Here, claimant finally prevailed on a penalty issue regarding the extent of his permanent disability. See Jay A. Nero, 46 Van Natta 2155 (1994). No denial of a "claim for compensation" was involved in this case. Therefore, no attorney fee is available under ORS 656.386(1). Short v. SAIF, 305 Or 541, 545 (1988); see also SAIF v. Allen, supra.

Likewise, no attorney fee is available under ORS 656.382(2).[2] That statute authorizes an attorney fee when a claimant prevails over a carrier's request for review. Here, claimant initiated review from the Referee's order, as well as from the Board's order. Under such circumstances, no attorney fee is available under ORS 656.382(2).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 26, 1994 order. The parties's rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] ORS 656.386(1) provides, in pertinent part:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney." (Emphasis supplied.)

[2] ORS 656.382(2) provides:

"If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal." (Emphasis supplied.)

In the Matter of the Compensation of
JOHN C. BEAVER, Claimant
WCB Case No. 93-15251
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Referee Peterson's order which: (1) upheld the self-insured employer's denial of claimant's current low back condition; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the employer's denial of claimant's current low back condition under ORS 656.005(7)(a)(B), reasoning that claimant had failed to sustain his burden of proving that his accepted low back injury of February 3, 1993 is the major contributing cause of his current low back condition and need for surgery. The Referee also determined that the employer's denial was not unreasonable. Thus, the Referee concluded that no penalty was warranted.

On review, claimant contends that the employer's denial is procedurally and substantively invalid for several reasons. We agree with claimant that the employer's denial is procedurally invalid, but for a different reason.

Claimant sustained a compensable low back injury on February 3, 1993. The claim was eventually accepted as a nondisabling acute low back strain on April 26, 1993. (Ex. 47). The claim was later reclassified to disabling on July 20, 1993. (Ex. 51). On December 15, 1993, the employer denied claimant's current low back condition on the grounds that it was due to a "preexisting condition" unrelated to claimant's accepted condition or work activities, and that claimant's employment activities did not worsen or contribute to claimant's current back condition. (Ex. 56-1). There is no indication in the record that the compensable February 3, 1993 claim has ever been closed.

Claimant's primary contention is that the employer's December 15, 1993 denial is procedurally impermissible because claimant's "preexisting condition" was accepted by a negotiated settlement of October 28, 1988 executed in connection with claimant's compensable April 25, 1988 low back injury. Thus, claimant asserts that the employer cannot now deny the compensability of claimant's current low back condition on the grounds that it is the result of preexisting degenerative disc disease when it had previously accepted the degenerative condition. We need not address the issue of whether the employer accepted claimant's degenerative condition by reason of the 1988 settlement, for we find that the employer is barred by claim preclusion from denying that it is part of the compensable 1993 claim. Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994).

In Messmer, the claimant injured his neck and right shoulder at work. The claim was subsequently closed by a Determination Order which awarded permanent disability based in part on the effects of surgery that treated claimant's degenerative disc disease. The employer did not appeal the Determination Order. The claimant later filed an aggravation claim for a worsening of his degenerative condition, which the employer denied. The claimant argued that the employer was barred from denying the compensability of his degenerative condition because the employer had failed to appeal the Determination Order's award of permanent disability for his degenerative condition.

We concluded that the carrier was not precluded from denying the compensability of claimant's aggravation claim, on the ground that neither the carrier's approval of surgery nor its failure to challenge the Determination Order constituted an acceptance of the claimant's degenerative neck

condition. Richard J. Messmer, 45 Van Natta 874 (1993). The court disagreed, reasoning that the scope of the compensable claim was inseparable from the determination of extent of disability. 130 Or App at 258. Inasmuch as the employer did not challenge the permanent disability award in the Determination Order, the court determined that the employer was barred from later arguing that the condition for which the award was made was not part of the compensable claim. The Messmer court emphasized that the result was not that the degenerative condition was accepted, but that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id.

The circumstances of this claim are similar. The employer accepted claimant's April 25, 1988 low back claim in the October 1988 stipulated settlement. The claim was then closed by April 5, 1989 Determination Order, which awarded claimant 7 percent unscheduled permanent disability for reduced range of motion in claimant's low back. (Ex. 36). This award was based on the February 3, 1993 closing examination of claimant's attending physician, Dr. Kendricks, which documented reduced range of motion. (Ex. 34). Dr. Kendrick commented: " Mr.Beaver has chronic disc disease at L5-S1 and has been left with some permanent partial mild disability which physically is as described above."

Like the claimant in Messmer, claimant in this case received an award of permanent disability based on the effects of a preexisting degenerative condition. Since the employer did not challenge the award of permanent disability granted in the April 1989 Determination order, and in fact granted additional permanent disability for "injury to the low back region" in a September 13, 1989 stipulated settlement, the employer is now barred by claim preclusion from denying the compensability of claimant's low back degenerative disc disease. The employer must, therefore, treat claimant's lumbosacral degenerative disc disease as a compensable condition under the 1988 claim. Messmer, supra; see Wayne L. Duval, 46 Van Natta 2423, 2424 (1994); Roger L. Wolff, 46 Van Natta 2302, 2304 (1994). It, therefore, follows that its December 15, 1993 denial based on claimant's degenerative condition is improper.

Moreover, even if the employer's December 15, 1993 denial was not barred by claim preclusion, we would reject the employer's assertion that its denial was substantively and procedurally proper under ORS 656.005(7)(a)(B). The employer issued its alleged "resultant condition" denial prior to closure of the 1993 claim. Inasmuch as the medical evidence does not establish that claimant's "current condition" is separable from the accepted condition, the December 15, 1993 denial is an invalid preclosure partial denial of an accepted condition. See Sheridan v. Johnson Creek Market, 127 Or App 259 (1994); United Airlines v. Brown, 127 Or App 253 (1994).

Claimant also asserts that the employer's denial was unreasonable when issued. We agree.

The employer's December 15, 1993 denial alleged that claimant's "low back strain" of February 3, 1993 had "resolved" and that claimant was currently suffering from a "preexisting condition." However, we have previously determined that the employer was precluded from contesting the compensability of claimant's degenerative disc disease. Moreover, as claimant notes, there was no medical evidence that he was even suffering from a "low back strain" when the employer accepted his claim, and when it issued its December 15, 1993 denial. In addition, there is no medical evidence that claimant's accepted condition had resolved prior to the denial. In light of this, we conclude that the employer did not have a "legitimate doubt" as to its continued liability for claimant's low back condition. See Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). For these reasons, we disagree with the Referee's refusal to assess a penalty for unreasonable claim processing.

Therefore, we assess a 25 percent penalty pursuant to ORS 656.262(10) for the employer's unreasonable denial of his current low back condition, to be shared equally by claimant and his attorney. This penalty shall be based on all amounts due as of the date of the hearing as a result of this order.

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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel may go uncompensated.

ORDER

The Referee's order dated April 8, 1994 is reversed. The December 15, 1993 denial is set aside, and the claim is remanded to the employer for processing in accordance with law. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the employer. Claimant is also awarded a 25 percent penalty pursuant to ORS 656.262(10) based on all amounts due as of the date of the hearing payable as a result of this order, to be shared equally by claimant and his attorney.

February 1, 1995 Cite as 47 Van Natta 167 (1995)

In the Matter of the Compensation of
RITA R. LOVELACE, Claimant
WCB Case Nos. 93-08412 & 93-04822
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Schwabe, et al., Defense Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer, City of Rogue River (hereafter "Rogue River"), requests review of those portions of Referee Lipton's order that: (1) assessed a penalty for an allegedly unreasonable denial; and (2) awarded a $5,000 attorney fee, under ORS 656.386(1), against Rogue River. In claimant's respondent's brief, she requests that the Referee's penalty award be split between Rogue River and Builder's Square. On review, the issues are penalties and attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the additional finding that Builder's Square denied both compensability and responsibility at hearing.
(Tr. at 3).

CONCLUSIONS OF LAW AND OPINION

Penalties

Claimant developed a left foot condition while working for Rogue River, but she did not seek treatment for that condition until she began working for Builder's Square. Claimant subsequently filed an occupational disease claim against both employers. At hearing, both employers denied compensability and responsibility of that left foot condition. Finding that claimant's work activities were the major contributing cause of her left foot condition, the Referee applied the last injurious exposure rule and concluded that Builder's Square was the responsible employer because claimant's work exposure there could have contributed to that condition. See Bennett v. Liberty Northwest Ins. Co., 128 Or App 71 (1994).

We adopt and affirm the Referee's finding that Rogue River unreasonably denied the compensability of claimant's left foot condition. In finding that Rogue River had no legitimate doubt concerning the compensability of that condition, the Referee relied upon the medical opinions of Drs. Kayser, Shoen and Wall that claimant's condition was work-related. Based upon these same opinions, we conclude that Builder's Square's October 6, 1993 denial of compensability was unreasonable as well. See Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988); cf. Hutchison v. Fred Meyer, Inc., 118 Or App 288 (1993).

Inasmuch as both employers unreasonably denied the compensability of claimant's left foot condition, a separate penalty could be assessed against each. SAIF v. Whitney, 130 Or App 429, 432 (1994). However, claimant requests that, since both compensability denials were unreasonable, "[t]he penalty should be split between the two employers." (Claimant's Resp. Br. at 3).

We grant claimant's request and modify the Referee's penalty award to divide equally between the two employers the 25 percent penalty based on the compensation due claimant by Builder's Square up through the date of hearing (as a result of the Referee's order). Specifically, half of the penalty (12.5 percent) is payable by Rogue River and the other half (12.5 percent) is payable by Builder's Square. ORS 656.262(10); see Michael P. Yauger, 45 Van Natta 419 (1993) (Relying on SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983), Board held that where five insurers unreasonably denied compensability, it was within the Referee's discretion to apportion a single penalty equally between all the insurers, regardless of which one was ultimately found responsible).

Attorney Fees

Reasoning that Rogue River's compensability denial placed claimant's entitlement to compensation at risk, the Referee found it responsible for paying the assessed attorney fee award. ORS 656.386(1). Rogue River argues that, inasmuch as Builder's Square also denied compensability of claimant's occupational disease claim for a left foot condition, Builder's Square is solely liable for paying the Referee's assessed attorney fee award. (App. Br. at 8). Thus, Rogue River contends that the $5,000 assessed attorney fee should be paid by the responsible employer, Builder's Square. We agree.

Under ORS 656.386(1), a claimant's attorney is entitled to an assessed attorney fee for successfully setting aside an employer's denial of compensability. In Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993), the court explained that ORS 656.386(1) permits the assessment of an attorney fee award against a nonresponsible insurer, if that insurer denied compensability, thereby preventing issuance of an order designating a paying agent under ORS 656.307. Here, by contrast, both the responsible employer, Builder's Square, and the nonresponsible employer, Rogue River, denied the compensability of claimant's occupational disease claim. Inasmuch as the responsible employer had denied compensability, an order designating a paying agent could not have issued, regardless of whether the nonresponsible employer had denied compensability.

Moreover, the Referee set aside Builder's Square's denials in their entirety, whereas Rogue River's responsibility denials were upheld. Inasmuch as claimant did not establish that Rogue River was responsible for her occupational disease claim, we reinstate and uphold its denials. Therefore, claimant did not "finally prevail" over Rogue River's denial. Since Rogue River's denials were upheld, rather than set aside, no attorney fee award is authorized because claimant failed to prevail over those denials. Consequently, the issue of compensability as to that employer is moot. Accord Safeway Stores, Inc. v. Hayes, supra.

However, claimant did "finally prevail" over Builder's Square's denials in their entirety. Accordingly, we reverse the Referee's attorney fee award and assess it, instead, against Builder's Square. ORS 656.386(1).

Claimant's counsel is not entitled to an attorney fee for defending on the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The Referee's order, dated June 28, 1994, is modified in part and affirmed in part. That portion of the order that assessed a 25 percent penalty against Rogue River is modified to divide the assessment of that penalty equally and separately against both Rogue River and Builder's Square. That portion of the order that assessed a $5,000 attorney fee, payable by the City of Rogue River, is modified to make the $5,000 assessed fee payable solely by Builder's Square. Rogue River's denials are reinstated and upheld in their entirety. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JUDY L. MAGILL, Claimant
WCB Case No. 93-14941
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cowling, Heysell, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Peterson's order that set aside its denial of claimant's aggravation claim for a low back condition. In claimant's respondent's brief, she requests that Exhibits 18 and 19 (a letter from claimant's counsel to Dr. Schwartz[1] and his subsequent reply) be admitted into evidence. On review, the issues are aggravation and evidence.

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

Preliminarily, we address the admissibility of claimant's Exhibit 18 (an April 12, 1994 letter from claimant's counsel to Dr. Schwartz) and Exhibit 19 (Dr. Schwartz' April 18, 1994 reply). The Referee's order indicates only that Exhibits 1 through 17 were received into evidence. In her respondent's brief, claimant contends that, in lieu of Dr. Schwartz' deposition, the parties mutually agreed to admit claimant's Exhibits 18 and 19.

There is no dispute that the Referee left the record open for the deposition of Dr. Schwartz. However, the deposition never transpired and the record was closed on May 24, 1994, with the receipt of the parties' written closing arguments. Claimant submitted Exhibits 18 and 19 with her closing arguments and noted therein that the parties had mutually agreed to submit those documents in substitution for Dr. Schwartz' deposition. The employer did not object to claimant's representation. Moreover, the employer's written closing arguments and appellate briefs refer to those exhibits as well.

Inasmuch as the employer has raised no evidentiary objections, we conclude that the Referee intended to admit, and implicitly did admit, Exhibits 18 and 19. See Nikki Burbach, 46 Van Natta 265, 266 (1994); Aletha R. Samperi, 44 Van Natta 1173, 1174 (1992). Since those exhibits are present in the record, we proceed with our review.

The Referee relied upon the opinion of claimant's treating physician, Dr. Kendrick (neurosurgeon), and found that claimant's current low back condition and bulging disc at L5-S1 were due to her accepted low back strain of January 11, 1993. The employer asserts that claimant's current low back condition should be analyzed as a consequential condition. See ORS 656.005(7)(a)(A). We disagree.

Initially, we note that while Board review was pending, the Court of Appeals issued its holding in Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994). In Jocelyn, the court reasoned that ORS 656.005(7)(a)(B) does not affect the standard of proof for aggravation claims; rather, "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."

The court did not indicate whether its reasoning in Jocelyn controls the standard for an aggravation claim involving a consequential condition under ORS 656.005(7)(a)(A), or whether that reasoning only applies to situations were the aggravation claim involves a preexisting condition as defined in ORS 656.005(7)(a)(B). It is arguable whether Jocelyn applies to all aggravation claims for a worsened compensable condition, so long as that worsening was not caused in major part by an off-the-job injury. Jocelyn v. Wampler Werth Farms, supra; see ORS 656.005(7)(a)(A). If the court's reasoning in Jocelyn is applicable, claimant would need only prove that her January 11, 1993 low back strain was a material, rather than major, contributing cause of her allegedly consequential L5-S1 condition. However, as explained below, we find claimant's condition to be compensable regardless of the applicability of Jocelyn.

---

[1] The record contains medical opinions from Drs. John Schwartz and Bruce Schwartz. However, our discussion of "Dr. Schwartz'" opinion refers only to Dr. John Schwartz.

A preponderance of the evidence indicates that claimant's L5-S1 disc condition arose directly from the January 11, 1993 work incident. Hence we agree with the Referee's application of the material contributing cause standard. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We offer the following discussion by way of clarification.

The issue at hearing was whether claimant's current L5-S1 disc condition was causally connected to her January 11, 1993 low back strain. (Tr. 8). Dr. Kendrick opined that claimant's current low back condition "is certainly consistent with the type of injury the patient claims she had on January 11, 1993." (Ex. 12). The Referee found claimant to be a credible witness. Relying upon the medical opinion of Dr. Kendrick, the Referee concluded that claimant's L5-S1 condition was due to the accepted low back strain of January 1993.

The employer argues that the medical opinion of Dr. Schwartz is more persuasive. However, Dr. Schwartz believes that any opinion regarding a causal connection between claimant's January 1993 low back strain and her current L5-S1 disc condition would be speculation. (Ex. 13A-2). Consequently, his medical opinion is of little probative value regarding the issue of causation.

Instead, we agree with the Referee that Dr. Kendrick's opinion is the most persuasive. See Weiland v. SAIF, 64 Or App 810 (1983). Based on Dr. Kendrick's opinion, we find that claimant's L5-S1 condition arose directly from claimant's January 1993 work incident. This finding is also consistent with a February 24, 1993 chartnote from Dr. Bruce Schwartz indicating that claimant could have injured a disc and may have ongoing or even more severe problems in the future. (Ex. 3). Furthermore, Dr. John Schwartz' November 12, 1993 chartnote stated that claimant's injury likely "predisposed her to further bulging of the disc." (Ex. 6-2).

Considering Dr. Kendrick's persuasive opinion, we find that claimant has met the requisite standard of causation under Albany General Hospital v. Gasperino, supra; and, thus, she has established the compensability of her L5-S1 disc condition (i.e., that the work incident was a material contributing cause of her disability and need for treatment). Accordingly, we agree with the Referee that the employer's denial must be set aside.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 6, 1994 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,400, payable by the self-insured employer.

In the Matter of the Compensation of
MONTE L. NOFFSINGER, Claimant
WCB Case No. 93-09115
ORDER ON REVIEW
Johnson, Cram & Associates, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

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

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's claim for a toxic reaction to solvents. On review, the issue is compensability.

We adopt and affirm the Referee's order.

ORDER

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

Board Member Gunn dissenting.

The majority concludes that claimant failed to prove medical causation, based on a finding that the treating physician's diagnosis is based solely on claimant's recitation of symptoms. This is patently untrue.

Dr. Wiltse (who has been claimant's treating physician since claimant was an infant), examined claimant right after claimant's work exposure to toxic solvents. At that time, Dr. Wiltse observed and recorded "odor of solvent on [claimant's] clothing and breath," as well as claimant's symptoms of sore throat, cough, nausea, and feeling "high." (Ex. 3). Clearly, Dr. Wiltse did more than recite claimant's symptoms and the majority's finding to the contrary is unsupported. Moreover, based on his examination, Dr. Wiltse diagnosed methyl ethyl ketone (MEK) poisoning. The only medical evidence challenging Dr. Wiltse's opinion is provided by physicians who did not see claimant until long after his symptoms had subsided. Under these circumstances, there is simply no good reason to discount the observations and conclusion of claimant's treating physician.

The majority's apparent suspicion that claimant is motivated by secondary gain is similarly unsupported by the record. Only medical services are claimed. It is undisputed that claimant was medically stationary, without impairment, less than two months after his work exposure. Thus, he would take nothing himself if he prevailed. How could he possibly be motivated by secondary gain when there is none to be had?

Because the majority ignores undisputed material facts, I must respectfully dissent. This simple, modest claim is clearly compensable.

In the Matter of the Compensation of
PATSY J. OLSON, Claimant
WCB Case No. 92-15624
ORDER ON REVIEW
Bradley A. Peterson, Claimant Attorney
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial of claimant's left knee posterior cruciate ligament condition; and (2) declined to address the compensability of claimant's current left knee meniscal tears. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant was injured at work on December 16, 1991, not December 17, 1991.

CONCLUSIONS OF LAW AND OPINION

Preliminary Issue

Before we address the compensability issue, we must determine the scope of the matters at issue at hearing. The Referee construed SAIF's denial as a denial of treatment for the posterior cruciate ligament, and not a "current condition" denial related to claimant's left knee. (Opinion and Order at 3). Therefore, the Referee concluded that the compensability of claimant's current left knee problems was not at issue. We disagree.

In 1989, claimant sustained a severe, nonwork-related left knee injury involving her posterior cruciate ligament. Subsequently, in December 1991, she sustained a left knee injury at work. SAIF accepted a left knee contusion. Thereafter, Dr. McCloskey indicated that it would be beneficial to examine claimant under anesthesia to determine whether the posterior cruciate ligament should be augmented. (Ex. 8).

In October 1992, SAIF issued a denial, stating:

> "We have recently received information that you are seeking treatment for posterior cruciate deficient knee problems which you feel is [sic] related to your December 17, 1991 knee injury. After reviewing the information in your file, we are unable to pay for your current treatment because the December 17, 1991 injury is not the major contributing cause of your condition. Therefore, we must issue this partial denial." (Ex. 10).

Subsequently, on January 3, 1994, claimant underwent an arthroscopy in which two large left knee meniscal tears were identified and repaired. (Ex. 19).

Claimant requested a hearing regarding the denial. At hearing, claimant's counsel stated his belief that the issues included a current condition denial; counsel was prepared to litigate the meniscal tear issues. (Tr. 2). SAIF's counsel did not object to this clarification of issues. (See id).

On review, claimant asserts that her current left knee condition falls within the scope of SAIF's written denial. SAIF agrees, in part, with claimant, but argues that the issue on appeal should be limited to claimant's medial meniscus tears and the arthroscopic surgery to repair those tears, and not the compensability of the entire left knee condition. We agree with SAIF.

Although it was not a subject of SAIF's written denial, the parties litigated the compensability of claimant's left knee meniscal tears and ensuing arthroscopy. Parties to a workers' compensation hearing may, by agreement, try an issue that falls outside the express terms of a denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990); Judith M. Morley, 46 Van Natta 882, on recon 46 Van Natta 983 (1994). Because the parties tried the compensability of claimant's left knee meniscal tears and subsequent arthroscopy by implicit agreement (that is, without objection), we conclude that the issue was properly before the Referee. We turn to the merits of the case.

Compensability

The Referee did not address the compensability of claimant's meniscal tears and latest arthroscopy. Claimant seeks either remand to the Referee for consideration of that issue, or a decision by this Board regarding the compensability issue. Because we do not find the record improperly, incompletely or otherwise insufficiently developed, ORS 656.295(5), we decline to remand this matter to the Referee; rather, we will address the compensability issue ourselves.

Because claimant has a preexisting left knee condition arising from her 1989 non-work accident, she must establish that the December 1991 work injury is and remains the major contributing cause of her meniscal tears and need for arthroscopy. ORS 656.005(7)(a)(B). For the following reasons, we conclude that claimant has failed to meet that burden.

The only evidence that addresses the compensability of claimant's meniscal tears and resultant arthroscopy is a January 12, 1994 concurrence letter signed by Dr. McCloskey, claimant's treating physician. In the letter, McCloskey agreed that it was his opinion that

> "the incident of December 17 [sic], 1991, 'loosened' the structure of the knee. This objective loosening or instability of the knee made it more difficult and painful for [claimant] to function. The need for surgery arose from the increased difficulty [claimant] had with the knee after the work-related event. [Claimant's] current need for treatment and surgery is based upon the increased discomfort and changes occurring in the knee after the December 17 [sic], 1991 injury.
>
> "Therefore, it is [my] opinion that the major contributing cause for [claimant's] need for treatment, namely the January 3, 1994 surgery, was the work-related incident of December 17 [sic], 1991." (Ex. 20-1, -2).

In a hand-written addendum, McCloskey stated:

> "Had [claimant] not had the previous injury & subsequent degenerative changes in the knee, it is likely that the [December 16] injury may not have required surgery. However, the knee was weak & injured to the point by the [December 16] injury the recent arthroscopy was required for a torn meniscus & staple removal." (Id. at 2; emphasis in original).

Earlier, Dr. McCloskey had concluded that claimant's December 16 work injury "would have been a minor problem had she not previously had the unstable knee and lack of the functional posterior cruciate [ligament]." (Ex. 8). In a later report dated February 11, 1993, McCloskey again stated that the December 1991 work injury "only slightly aggravated the basic underlying problems in [claimant's] knee." (Ex. 12-2).

We conclude that Dr. McCloskey's reports are insufficient to meet claimant's burden of proof under ORS 656.005(7)(a)(B). First, the January 1994 concurrence letter is equivocal; it states both that claimant's current knee condition was caused, in major part, by the December 1991 work injury, and that, but for the fact of claimant's earlier, non-work knee injury, she would not have required her latest surgery. (Ex. 20). The latter assertion suggests that the earlier, non-work injury was the major cause of claimant's current left knee problems. Because McCloskey's report implies that either the December 1991 work injury or the 1989 non-work injury was the major contributing cause of claimant's current left knee problems, we find it insufficient to establish the compensability of claimant's current meniscal tears and subsequent arthroscopy.

This conclusion finds support in the fact that Dr. McCloskey originally determined that claimant's December 1991 work injury played only a minor role in her left knee problems in 1992 and early 1993. (Exs. 8, 12-2). For this additional reason, we conclude that claimant has failed to establish the compensability of her current left knee meniscal tears and arthroscopy.

ORDER

The Referee's order dated January 20, 1994 is affirmed.

In the Matter of the Compensation of
MICHELE S. THOMAS-FINNEY, Claimant
WCB Case No. 93-13163
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Moscato, Byerly, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Neal's order that: (1) found that claimant was medically stationary on November 5, 1992; (2) increased claimant's scheduled permanent disability for the loss of use or function of the left foot from 30 percent (5.4 degrees) for the great toe, 25 percent (1 degree) for the fourth toe, and 44 percent (1.76 degrees) for the fifth toe, to 13 percent (17.55 degrees) for the left foot; (3) increased claimant's scheduled permanent disability for the loss of use or function of the right foot from 30 percent (5.4 degrees) for the great toe, 25 percent (1 degree) for the fourth toe, and 44 percent (1.76 degrees) for the fifth toe, to 13 percent (17.55 degrees) for the right foot; and (4) allowed the self-insured employer to offset temporary disability benefits it paid for the period from November 6, 1992 through September 3, 1993 against the increased permanent disability. On review, the issues are the propriety of the medical stationary date, offset/temporary disability, and extent of scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

Claimant developed compensable bunions and soft corn formations on both feet. A February 1993 Determination Order found claimant medically stationary on November 5, 1992. In May 1993, an Order on Reconsideration rescinded the Determination Order as prematurely closing the claim. The Order on Reconsideration was not appealed.

In September 1993, another Determination Order issued, again finding claimant medically stationary on November 5, 1992. The order was affirmed by an October 1993 Order on Reconsideration.

The Referee found that the May 1993 Order on Reconsideration "did not involve a litigation to a final judgment" and, therefore, had no preclusive effect by virtue of res judicata on the issue of when claimant was medically stationary. Based on the medical evidence, the Referee also agreed that claimant was medically stationary in November 1992. On review, claimant reiterates her argument that the May 1993 Order on Reconsideration bars any subsequent finding that she was medically stationary on November 5, 1992. Furthermore, claimant asserts that the evidence shows she was not medically stationary until August 19, 1993. We agree with claimant.

Finality attaches to uncontested closure orders for purposes of res judicata. Drews v. EBI Companies, 310 Or 134, 150 n 13 (1990); Hammon Stage Line v. Stinson, 123 Or App 418, 423 (1993). Thus, res judicata applies to the administrative proceeding producing an order closing a claim. Id. Because review by the Department of such an order is the next step in that administrative proceeding, we find that issue and claim preclusion also apply to uncontested Orders on Reconsideration.

The May 1993 Order on Reconsideration, which was not appealed, rescinded the February 1993 Determination Order, expressly finding that claimant was not medically stationary on November 5, 1992 and that claim closure was premature. (Ex. 39). Thus, the issue of whether claimant was medically stationary on November 5, 1992 was actually litigated and determined. Consequently, we conclude that issue preclusion bars another action or proceeding concerning claimant's medically stationary status on November 5, 1992.

Based on this reasoning, we find that the employer was precluded in this proceeding from asserting that claimant was medically stationary on November 5, 1992. However, because there was no actual litigation of, or opportunity to litigate, claimant's medically stationary status following the issuance of the May 1993 Order on Reconsideration, we find no application of res judicata regarding this issue. See Drews v. EBI Companies, supra. Thus, we proceed to address this matter.

On August 19, 1993, Dr. Wisdom, claimant's treating orthopedic surgeon, found claimant medically stationary. (Ex. 43). Based on this evidence, we conclude that claimant was medically stationary on August 19, 1993.[1]

Offset/Temporary Disability

After the September 1993 Determination Order issued again finding claimant medically stationary on November 5, 1992, the employer informed claimant that it considered temporary partial disability benefits paid for the period from November 6, 1992 through September 3, 1993 to be an overpayment and that it would offset such amount against future awards of compensation. (Ex. 44B). After agreeing that claimant was medically stationary on November 5, 1992, the Referee allowed the offset. Claimant contends that, if we find that she was not medically stationary until August 19, 1993, she is entitled to temporary disability through that date.

Inasmuch as the claim has closed, claimant's substantive entitlement to temporary disability is at issue. Therefore, claimant must show that she was at least partially disabled during the pendency of the claim in order to be entitled to temporary disability. See SAIF v. Taylor, 126 Or App 658 (1994). In other words, merely showing that she was medically stationary on August 19, 1993 is not sufficient to establish an entitlement to temporary disability through that date; claimant also must show disability. Id.

On September 14, 1992, Dr. Rothstein found that claimant "would benefit more from a non-weightbearing position" and, when she had convalesced from her surgery, could "tolerate most weightbearing" positions. (Ex. 30-3). As noted above, Dr. Wisdom concurred with the report. (Ex. 31). We find such evidence shows that claimant was partially disabled in that she could not at that time perform weight-bearing activities.

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[1] Alternatively, even if we agreed with the Referee that res judicata did not apply and, therefore, the employer was not precluded from asserting that claimant was medically stationary on November 5, 1992, we would continue to conclude that claimant proved that she was not medically stationary until August 19, 1993.

On September 14, 1992, examining podiatrist Dr. Rothstein found that claimant "shall be considered medically stationary in approximately one month's time, which would be a reasonable time for a postoperative period to exhaust itself." (Ex. 30-3). Dr. Wisdom concurred with the report. (Ex. 31). On November 5, 1992, Dr. Wisdom reiterated in a chartnote that he agreed with Dr. Rothstein's findings, noting "it is always hard to determine when someone is clinically stationary, but probably she is at this point, realizing that there should be slow improvement with diminution of swelling over the ensuing months." (Ex. 29-3).

Finally, on June 24, 2993, Dr. Wisdom again stated that the date of November 5, 1992 "is probably the one that should be picked for when she became medically stationary." (Ex. 40). Dr. Wisdom also noted that he had not examined claimant since November 5, 1992. (Id.) On August 19, 1993, after examining claimant, Dr. Wisdom stated that claimant's condition "now is felt to be medically stationary." (Ex. 43-2).

"Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). We find that the reports before August 19, 1993 merely constituted predictions that claimant would become medically stationary based on the usual period of recuperation for persons undergoing surgery. Furthermore, since the physicians were predicting that claimant would become medically stationary, we find evidence that claimant was not medically stationary at the time of the September 19, 1992 and November 5, 1992 examinations. The only evidence concerning claimant's medically stationary status that was based on claimant's actual condition is Dr. Wisdom's August 19, 1993 report. Consequently, we conclude that the preponderance of evidence shows that claimant was medically stationary on August 19, 1993.

There is no evidence that claimant's disability resolved until Dr. Wisdom's August 19, 1993 report that claimant's "activity only needs to be limited by her discomfort" but that her conditions would not "affect her gainful employment." (Ex. 43-2). Under such circumstances, we agree that claimant showed she was partially disabled between November 6, 1992 and August 19, 1993 and, therefore, entitled to temporary partial disability for this period. Moreover, the employer is not entitled to an offset for any portion of the temporary disability benefits it paid between November 6, 1992 and September 3, 1993.

Extent of Scheduled Permanent Disability

Although the Referee increased the scheduled permanent disability awarded by the Order on Reconsideration, she rejected claimant's contention that she was entitled to an award based on OAR 436-35-200(4), finding that the rule applied to "severe" injuries and that claimant's condition did not qualify as such. Claimant asserts that, because she has undergone seven foot surgeries, OAR 436-35-200(4) is applicable. Furthermore, claimant contends that the Referee in effect found that her impairment was not addressed by the standards and, thus, should have remanded her claim to the Department for adoption of a temporary rule.

Former OAR 436-35-200(4) (WCD Admin. Order 6-1992) provides for an award of 15 percent when a preponderance of evidence "indicates an accepted compensable injury to the foot has resulted in a permanent inability to walk or stand for greater than two hours in an 8-hour period[.]" The rule further states that it is only applicable "in those cases where the objective medical evidence indicates severe injury to the foot has occurred with residual impairment (e.g. severe soft tissue crush injuries, calcaneal fractures, or post-traumatic avascular necrosis)." The rule is equally applicable to occupational diseases. Sandra K. Jones, 46 Van Natta 344 (1994).

At hearing, claimant relied on an October 1993 report from Dr. Wisdom stating that claimant's condition would prevent her from resuming her regular work as an ice skating instructor and she could not tolerate other work "requiring long standing on her feet in dress type heeled shoes." (Ex. 47-2). Although showing that claimant cannot stand for long periods of time while wearing certain shoes, we find no indication from such evidence that claimant is unable to walk or stand for more than two hours in an 8-hour period. Thus, whether or not claimant's condition is sufficiently severe to come under the rule, we conclude that she had not satisfied the requirement of showing that her condition precludes her from walking or standing for more than two hours in an 8-hour period and, therefore, is not entitled to an additional award of 15 percent.

Furthermore, we find no basis for remanding this case to the Director for adoption of a temporary rule. See Gary D. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). Claimant raises this contention for the first time on review and, therefore, failed to preserve it. See, e.g., Robert E. Roy, 46 Van Natta 1909, 1910 (1994).

ORDER

The Referee's order dated June 13, 1994 is reversed in part and affirmed in part. That portion finding claimant medically stationary on November 5, 1992 is reversed. Claimant was medically stationary on August 19, 1993. The October 1993 Order on Reconsideration is modified. Claimant is entitled to temporary partial disability from November 6, 1992 through August 19, 1993. The employer's request for offset is denied. Claimant's attorney is entitled to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
TRACI D. VAIL, Claimant
WCB Case No. 93-09270
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The insurer requests review of that portion of Referee Hoguet's order which: (1) found that claimant's current right wrist condition had been previously accepted; and (2) set aside its denial of claimant's aggravation claim for the right wrist condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In May 1991, claimant saw Dr. Wilson, orthopedist, for numbness, tingling and pain in her right hand. He diagnosed right carpal tunnel syndrome and prescribed a wrist splint and pain medication. (Exs. A-5, 1). Dr. Wilson recommended that claimant report the condition to her employer as he believed it was an overuse problem related to work. Id.

Subsequent chartnotes from Dr. Wilson in May and June 1991 continued to report pain and numbness in the right hand. (Ex. A-6, 7). On May 29, 1991, Dr. Wilson signed a First Medical Report diagnosing claimant's right hand pain and numbness as "right carpal tunnel syndrome." (Ex. 1). An employer-prepared 801 Form dated May 31, 1991 reported increasing pain and numbness in the right hand and listed the nature of claimant's disease as "Carpal Tunnel Syndrome." (Ex. 2). On August 7, 1991, the insurer accepted "Right Wrist Tendonitis." (Ex. 4). At the time of claim acceptance, claimant had not made a claim for tendonitis, and no doctor had diagnosed tendonitis.

Claimant's right wrist claim was closed on March 18, 1992, with no award for permanent disability. (Ex. 14). On June 1, 1993, claimant saw Dr. Puziss, who diagnosed right carpal tunnel syndrome. (Ex. 26). In July 1993, Dr. Puziss requested authorization for a right carpal tunnel release. (Ex. 31-2).

On July 28, 1993, the insurer denied claimant's aggravation claim, contending that claimant's current carpal tunnel condition was not related to her accepted tendonitis condition. (Ex. 29). Claimant contends that her current right wrist condition is the same condition that was originally accepted. The Referee concluded that claimant's current right wrist condition is the same condition the insurer accepted in August 1991.

Scope of Acceptance

The initial dispute in this case concerns the scope of the acceptance. Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). In determining the applicable limits of a "back-up" denial, the Supreme Court has held that acceptance of a claim encompasses only those conditions specifically and officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49, 55-56 (1987). In Johnson, the insurer had accepted in writing fewer than all of the claimant's conditions. The Court concluded that, because the insurer had taken no action regarding one of the claimant's conditions, the insurer had not accepted that condition. Id. at 56.

The present case is distinguishable from Johnson because the insurer's notice of acceptance identified a condition (tendonitis) that was neither diagnosed nor claimed. Unless we treat the insurer's notice of acceptance as a nullity (which we decline to do), we must conclude that the insurer intended to, and did, in fact, accept something. To hold otherwise would leave this claimant, some four years after the original "accepted" injury, with no claim at all. The question is, then, what did the insurer accept?

Because "tendonitis" was neither claimed nor diagnosed at the time of claim acceptance, we are unable to conclude that the insurer accepted a "tendonitis" condition. Instead, consistent with the medical reports which indicate that claimant, indeed, had some wrist condition, albeit undiagnosed, we find that, by its notice, the insurer accepted the condition that caused claimant's symptoms and need for treatment at the time of claim acceptance. See, e.g., Kim D. Wood, 46 Van Natta 1827 (1994). We find that condition was a right wrist condition causing numbness, tingling and pain in the right hand. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988) (Claimant need not establish a specific or certain diagnosis in order to have a compensable claim).

Aggravation

Having ascertained the scope of the insurer's acceptance, we must now address the merits of its aggravation denial. To establish a compensable aggravation, claimant must show a worsened condition resulting from the compensable condition. Perry v. SAIF, 307 Or 654 (1989). An aggravation has two components: causation and worsening. If it is compensable, then we determine whether the compensable condition has worsened. 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).

In its brief, the employer contends that claimant's current right wrist condition should be analyzed as a consequential condition of her accepted right wrist condition and that she must therefore prove that her accepted condition was the major contributing cause of her current condition. See ORS 656.005(7)(a)(A). Subsequent to the Referee's order, however, the Court of Appeals held that 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. Jocelyn v. Wampler Werth Farms, 132 Or App165 (1994). The court interpreted the language in ORS 656.273(1), which provides that a worker is entitled to additional compensation for worsened conditions "resulting from the original injury," as requiring a claimant to prove that the original compensable injury or occupational disease was a material contributing cause of the worsened condition. Id.

In reaching its decision, the Jocelyn court rejected the argument that the "resultant condition" limitation in ORS 656.005(7)(a)(B) applies to aggravation claims. The court did not specifically address the issue of whether the "consequential condition" limitation in ORS 656.005(7)(a)(A) applies to aggravation claims. In any event, we conclude that, under either the material or major contributing cause standard, claimant's aggravation claim is compensable.

Claimant's right hand numbness, tingling and pain persisted throughout 1991 and thereafter. During most of 1992, claimant was pregnant. She occasionally saw Dr. Kemple for conservative treatment of her wrist condition, which became increasingly symptomatic during her pregnancy. (Tr. 27-29). Dr. Kemple told claimant that she would likely continue to struggle with ongoing upper extremity problems reflecting residuals of her on-the-job injury, which he reported as right wrist tendonitis/CTS. (Ex. 19).

On February 12, 1993, Dr. Wilson again saw claimant. (Ex. 20). He noted that pregnancy had worsened her symptoms, and opined that claimant's current wrist condition related to problems that were "initiated at the time of her original claim." Id.

On May 6, 1993, claimant was examined by the Orthopaedic Consultants. (Ex. 23-1). The Consultants noted that claimant had a positive Tinel's over the median nerve at the right wrist, and a positive Phalen's test complaints, involving primarily the long finger. (Ex. 23-4). Notwithstanding the positive test findings, the Consultants stated that "objective findings are nonexistent," and without objective findings, "we cannot causally relate her complaints to her work at [the employer]." (Ex. 23-4, 5). Dr. Wilson checked a box indicating that he concurred with the Consultants. (Ex. 24).

Because we find the report of the Orthopaedic Consultants to be internally inconsistent, we are not persuaded by their opinion. See Somers v. SAIF, 77 Or App 259 (1986). Furthermore, because Dr. Wilson's check-the-box response is unexplained and contrary to his written opinion rendered only three months before, we likewise do not find his opinion concerning causation of claimant's current condition to be persuasive. Somers v. SAIF, supra.

On June 1, 1993, claimant first saw Dr. Puziss, orthopedic surgeon. He obtained a description of claimant's work activities with the employer, and reviewed claimant's medical treatment history. He opined that claimant had not had appropriate medical treatment for her right wrist condition, and that her condition became worse after her claim was closed. (Exs. 26, 28). On August 25, 1993, Dr. Puziss performed a right carpal tunnel release. His preoperative and postoperative diagnoses of right carpal tunnel syndrome were consistent. (Ex. 33).

We are persuaded by the opinions of Drs. Wilson and Kemple, claimant's treating physicians, and Dr. Puziss, treating surgeon, that claimant's right wrist condition has worsened since her last award of compensation. Furthermore, relying on Dr. Wilson's February 12, 1993 opinion, and Dr. Kemple's opinion, we are persuaded that claimant's worsened condition is compensably related to her accepted right wrist condition under either a material or major contributing cause standard. Accordingly, we affirm the Referee's order.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,100, 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 8, 1993 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed attorney fee of $1,100, payable by the insurer.

February 1, 1995 Cite as 47 Van Natta 179 (1995)

In the Matter of the Compensation of
GLENN E. WHITLOCK, Claimant
WCB Case No. 93-13776
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

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

The self-insured employer requests review of Referee Brown's order which set aside its denial of claimant's occupational disease claim for a mental condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, but not the Ultimate Findings of Fact. Additionally, the parties entered into the following stipulations.

"All interaction [by claimant] with the principal, vice-principal, or any other administrator of the school district falls into the category of reasonable disciplinary, corrective, or job-performance activities.

"To the extent that there is information in the 801 or other exhibits that is inconsistent with the above stipulation, the parties agree that those statements are incorrect.

"During the 1992-93 school year, claimant was assigned to [an elementary school], which is 15 miles/20 minutes from home. He was an elementary music specialist. He taught grades K-6; class periods were 30 minutes long. He taught in this position for eleven years.

"During the 1993-94 school year, claimant was assigned to [a school], 35 miles/45 minutes from his home. He was assigned high school social studies, which included 7th grade social studies, 10th grade global history, 12th grade economics, and 12th grade federal government. He had no prior experience teaching those subjects as a regular high school teacher. Class periods were 49 minutes long. He taught six and seven periods in a school day, leaving one preparation period, the same as all high school teachers.

"All grammar music school teachers were laid off. [Claimant] exercised his rights under the Collective Bargaining Agreement to "bump" into a position into the high school. He had an endorsement to teach social studies. A social studies job was offered him under the agreement. He accepted and was "assigned" as above."

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was put in a position for which he had no training and experience because of a collective bargaining agreement, and that a collective bargaining agreement is not generally inherent in every work situation. Thus, claimant had sustained his burden of proving compensability of his mental stress claim. We disagree.

To establish compensability of a stress-related mental disorder, the worker must prove that employment conditions were the major contributing cause of the mental disorder and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). The diagnosed mental disorder must be one that is recognized in the medical or psychological community. ORS 656.802(3)(c).

In addition, the employment conditions producing the mental disorder must exist in a real and objective sense. ORS 656.802(3)(a). They must be conditions other than those generally inherent in every working situation, or reasonable disciplinary, corrective or job performance actions by the employer, or cessation of employment. ORS 656.802(3)(b) (emphasis added). In Housing Authority of Portland v. Zimmerly, 108 Or App 596 (1991), the court concluded that, by adding the emphasized language, the legislature intended to preclude claims for mental disorders that arose from conditions common to all employments. We are authorized to determine what "conditions [are] generally inherent in every working situation" on a case-by-case basis. SAIF v. Campbell, 113 Or App 93, 96 (1992).

Finally, there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(d). If claimant fails to establish any one of these elements, his occupational disease claim for a stress-related mental disorder fails. See Dana Lauzon, 43 Van Natta 841 (1991).

Here, claimant had suspected that music teacher positions may be eliminated due to school funding constraints. Therefore, to avoid being laid off, claimant became certified to teach social studies. Subsequently, when his music teaching position was eliminated, claimant was able to accept a position at a different school, in a different subject area, because of his eleven-year seniority in the district.

The element in contention is whether stressors associated with claimant's social studies teaching job are conditions other than conditions generally inherent in every working situation. ORS 656.802(3)(b). The stressors include no training or experience in a job outside his area of expertise (music), and the number of different classes he had to teach coupled with overwhelming class preparation time, including four to six hours in the evening.

In Barry M. Bronson, 44 Van Natta 1427 (1992), the law had changed to ban the sale of polystyrene products, which adversely affected the claimant's sales position. Therefore, the claimant contended that the ban on polystyrene caused him to develop a mental condition. Relying on Housing Authority of Portland v. Zimmerly, supra, we concluded that operating within everchanging legal parameters is a condition generally inherent in every work place. See also Mary A. Murphy, 45 Van Natta 2238 (1993). Accordingly, we concluded that the claimant's mental condition in Bronson was not compensable.

As with legal parameters, financial constraints (budget cuts) are also everchanging. Employers are constantly required to maintain the operation of their businesses within budgetary paramaters. Therefore, we conclude that operating within financial constraints is a condition generally inherent in every work place.

Due to financial constraints, claimant knew there was the possibility that his music teaching program would be eliminated. Thus, to remain employed as a teacher, claimant became certified to teach social studies, a subject area that was less likely to be eliminated from the curriculum. When the music program was eliminated, claimant chose, rather than being laid off, to accept a position teaching social studies. Claimant subsequently developed a mental condition. Because claimant's change of position was the result of budget cuts, we find that claimant's subsequent mental problems were caused by a condition that is generally inherent in every work place

Claimant contends that he lacked training to teach social studies, and that lack of training is not a condition that is generally inherent in every working situation. Because of claimant's eleven years' experience as a teacher, and his demonstrated proficiency in social studies (sufficient to warrant certification in that subject area), we are not persuaded that, in claimant's case, there was such a lack of training.

Claimant further contends that the lawful requirements for performing work as a licensed professional educator in Oregon public schools, and a collective bargaining agreement, are not generally inherent in every working situation. We disagree with both contentions.

As with financial constraints, operating within legal parameters is a condition generally inherent in every work place. See Barry M. Bronson, supra. Rules and guidelines are conditions that affect all jobs. Furthermore, by becoming certified to teach social studies in Oregon, claimant had, at least, demonstrated proficiency in the subject area. Additionally, although claimant contends, and the Referee found, that the Collective Bargaining Agreement is not generally inherent in every work situation, we conclude that employment contracts, written or otherwise, are certainly inherent in every work situation. Moreover, in this instance, claimant freely chose to exercise his option under the contract, which resulted in "bumping" another teacher because of claimant's seniority in the school district.

Accordingly, we conclude that the stressors that claimant cites are all conditions which are generally inherent in every working situation.

Claimant has therefore failed to prove a compensable psychological claim under ORS 656.802. We therefore reverse the Referee's order.

ORDER

The Referee's order dated March 28, 1994 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award of $2,800 is also reversed.

Board Member Gunn dissenting.

The majority upholds the employer's denial of claimant's mental disorder claim, reasoning that the employment conditions which caused his mental disorder were conditions generally inherent in every working situation. Because I believe that claimant's employment conditions were a unique consequence of public education financing in Oregon, I must respectfully disagree with my colleagues.

Consider the political realities of public education financing in Oregon. By state and federal mandate, we, the citizens, have established minimum requirements for the public education of our children (e.g., Oregon Education Reform Bill). On the other hand, we, the taxpayers, have voted to reduce the taxes necessary to finance this education (e.g., Measure 5). This situation is analogous to imposing production goals at a mill without providing enough funds to purchase the equipment or hire the personnel necessary to meet those goals. Such an employment condition is absurd and cannot reasonably be regarded as generally inherent in every working situation.

It was this political reality which forced claimant to exercise his right under the Collective Bargaining Agreement to "bump" a teacher with less seniority. As a result, claimant, an elementary music teacher for 11 years, was assigned high school social studies. The majority finds that claimant's 11 years of teaching experience and his social studies teaching certificate provided him with adequate training. The majority neglects to mention, however, that claimant obtained his certificate by taking a national exam demonstrating his mastery of the subject matter (high school social studies), but that he had no practical training or experience in teaching social studies to high school students. Lacking such training and experience, claimant was overwhelmed by the work load. He devoted 12 to 14 hours a day to preparation for lessons, only to receive considerable criticism from students and administration regarding his performance.

I would hold that, as a general rule, collective bargaining agreements are not conditions generally inherent in every working situation; after all, less than 14 percent of the work force is organized under unions. The collective bargaining agreement in this case is particularly unique; it

permitted claimant to take a job for which he was not adequately trained. That is clearly not a condition generally inherent in every working situation. Moreover, contrary to the majority's assertion, it is immaterial that claimant voluntarily exercised his "bumping" right under the agreement. The Workers' Compensation Law is still a no-fault system. The focus of our inquiry is on the employment conditions which caused claimant's mental disorder, not on whether those conditions were voluntary or mandated by the employer. The bottom line is that claimant was employed at a teaching position for which he was inadequately trained. Because that employment condition is not generally inherent in every working situation, I would weigh that condition under the "major contributing cause" standard and, based on the undisputed fact that claimant's work-related stress caused his mental disorder, I would find that claimant has established a compensable mental disorder claim under ORS 656.802(1)(b).

I have my own personal example of the difficult and unique employment conditions which teachers endure in the current political climate. My wife is an experienced and qualified teacher who knows her subject matter, yet she spends an average of 12 hours a day in the classroom, grading homework and exams, class preparation, etc. Because her classroom was too small for her students, she obtained a bigger classroom by volunteering to manage the school yearbook. Though she was qualified and experienced in managing a school yearbook, she was not prepared for the scope and magnitude of her new responsibilities. She must now either give up the yearbook management (and lose her larger classroom) or be forced out of teaching.

Teachers devote tremendous time and energy to their students under very difficult circumstances. Many are forced (by practical or economic necessity) to accept responsibilities for which they are unprepared. I believe that is what claimant did in this case. He did so under conditions unique to his employment in public education, not under conditions generally inherent in every working situation. For these reasons, I dissent.

In the Matter of the Compensation of
RONNY L. BRESHEARS, Claimant
WCB Case Nos. 93-12437, 93-09000, 93-09590 & 93-09591
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Bottini, et al., Defense Attorneys
Bostwick, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Hartford Insurance Company (Hartford) requests review of Referee Podnar's order that: (1) set aside its denial of claimant's injury claim for his current right knee condition; and (2) upheld Unigard/GAB's (Unigard's) and Home Insurance Company's (Home's) denials of claimant's injury and/or occupational disease claims for the same condition. On review, Hartford argues that the Referee erred in admitting certain medical reports into the record and that claimant failed to timely file a right knee claim against it. On review, the issues are the timeliness of the claim, evidence, compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the finding that Dr. Martens concurred with Dr. Baldwin's report, and with the following modification and supplementation.

Claimant was not seen by Dr. Stanford; rather, Stanford conducted a records review for Home.

We make the following additional findings:

The hearing in this matter originally convened on November 1, 1993. At hearing, Hartford's counsel requested leave to take post-hearing depositions of Drs. Brown, Baldwin and Stanford and to obtain a medical report from Dr. Martens. (See Tr. Day I, at 1). The Referee granted counsel's request and continued the hearing. (Id. at 6).

The hearing reconvened on January 25, 1994. The Referee admitted Dr. Brown's deposition. Hartford's counsel requested that the record be left open so that he could depose Drs. Baldwin, Stanford and Higgins. (Tr. Day II, at 13). Claimant objected to the request, arguing that the parties had already had adequate time to complete the depositions. (Id. at 14). The Referee agreed, and denied Hartford's request. (Id. at 18).

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claimant's Right Knee Claim Against Hartford

Hartford asserts that claimant failed to timely notify it of his right knee claim. Therefore, Hartford asserts that the Referee erred in setting aside its denial of claimant's right knee condition. We disagree.

The gist of Hartford's argument is that claimant failed to timely notify it of his right knee claim in 1990.[1] We need not address that argument. Even if claimant's notice in 1990 was untimely, we conclude that Hartford has failed to establish actual prejudice as a result of the untimeliness. See ORS 656.265(4)(a); Argonaut Ins. Co. v. Mock, 95 Or App 1, 4, 6, rev den 308 Or 79 (1989). Hartford asserts that Dr. Brown's inability to recall any particulars regarding claimant's 1990 injury and the employer could not now perform a meaningful investigation on a stale claim is clear evidence of prejudice. Those arguments assume that claimant did not make a right knee injury claim in 1990. That assumption is not supported by the record. We conclude that, by virtue of Dr. Brown's November 19, 1990 report to Hartford, claimant made a claim for bilateral knee pain at that time. Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992); see ORS 656.005(6), (8). In view of this conclusion, we reject Hartford's prejudice arguments.

Evidence

Hartford argues that the Referee erred in admitting into evidence the reports of Drs. Baldwin, Stanford and Higgins, because those physicians were not deposed before the record was closed. We disagree.

OAR 436-06-091(2) authorizes a referee to continue a hearing on a showing of due diligence if a party seeks further opportunity to cross-examine on documentary medical evidence. Because the language of OAR 436-06-091 is permissive, the authority to continue a hearing rests in the referee's discretion. Donna J. Ball-Gates, 46 Van Natta 1080 (1994).

Here, Hartford did not present any circumstances that might justify continuing the hearing a second time. At most, the evidence reveals that the Referee granted one continuance for the purpose of conducting several depositions, but that the parties failed to coordinate their efforts to complete the depositions before the hearing was reconvened. That evidence is not sufficient to meet OAR 438-06-091(2)'s "due diligence" standard. See Clifford L. Conradi, 46 Van Natta 854, 857 (1994) (referee did not abuse discretion in refusing to admit the claimant's rebuttal evidence when the claimant failed to meet deadline for submission of evidence).

Furthermore, we note that Hartford sought a second continuance to obtain the depositions of Drs. Baldwin, Stanford and Higgins, when the first continuance had been granted for the limited purpose of obtaining the depositions of Drs. Baldwin, Stanford and Brown and obtaining a medical report from Dr. Martens. In doing so, Hartford sought to extend the purpose for which the Referee had originally continued the hearing. For this additional reason, we conclude that the Referee did not abuse his discretion in refusing to continue the hearing for additional depositions. Compare Darrel L. Hunt, 44 Van Natta 2582 (1992) (where referee leaves record open for a limited purpose, it is within the referee's discretion to exclude evidence that does not comport with that purpose).

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[1] Alternatively, Hartford could be arguing that claimant's 1993 notice of his right knee condition was untimely. If so, we disagree. The record establishes that, although claimant had some right knee symptoms following his October 1990 work accident, his right knee medial meniscal tear did not require treatment until March 1993. On April 12, 1993, less than 30 days later, Dr. Baldwin informed Hartford by letter of claimant's meniscal tear and need for surgery. The letter constitutes a timely notice of claimant's current right knee condition. ORS 656.265(1); Safeway Stores, Inc. v. Smith, supra. Accordingly, we conclude that claimant's 1993 right knee claim is not time barred.

Compensability

The Referee concluded that the parties did not dispute whether claimant's current right knee condition was work-related. Although neither Home nor Unigard denied compensability, Hartford did. Hartford continues to contest compensability on review. Therefore, we first address whether claimant has established the compensability of his right knee condition. We conclude that he has.

Claimant sought treatment for bilateral knee complaints in 1989 while working as a mechanic for his former employer; Unigard was then on the risk. On October 1, 1990, claimant sustained a knee injury while working for the same employer and while Hartford was on the risk. Hartford accepted a left knee strain.

In March 1993, while working as a mechanic for Home's insured, claimant consulted Dr. Baldwin, knee specialist, with complaints of intermittent right knee pain. Baldwin diagnosed a medial meniscal tear related to the October 1990 injury, which he surgically repaired on August 6, 1993.[2]

Claimant asserts that his October 1990 accident/injury caused his right knee problems. Claimant's theory of compensability is not clear. If it is a direct causation theory, the material contributing cause standard applies. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). If it is a consequential or resultant condition theory, the major contributing cause standard applies. ORS 656.005(7)(a)(A), (B); see Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 27 (1993); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We need not resolve that dilemma, because we conclude that, even under the higher standard, claimant prevails.

Several physicians rendered opinions regarding the cause of claimant's right knee condition. Dr. Baldwin initially concluded that claimant's meniscal tear was directly related to his October 1990 injury. (See Ex. 4A; see also Exs. 4B, 4C, 4E). Dr. Martens, orthopedist, examined claimant on Hartford's behalf, concluding that the major contributing cause of claimant's right knee condition was the frequent kneeling, squatting and twisting required in his work as a mechanic. (Ex. 5-3).

Thereafter, Dr. Stanford, orthopedic surgeon, performed a records review on Home's behalf. Stanford concluded that the major contributing cause of claimant's right knee meniscal tear was not his work conditions for Home's insured. (Ex. 6C-2, -3). Rather, Stanford believed that claimant had, at some point, sustained a traumatic tear that had worsened over the years. (Id. at 3). Dr. Brown, who had treated claimant in 1989, concurred with Stanford's report. (Ex. 6F). Stanford thereafter signed a concurrence report, agreeing that some trauma in the late 1980's or the October 1990 incident resulted in the original tear. (Ex. 12-2). Stanford further agreed that the major contributing cause of the tear and resulting disability and treatment was the original traumatic incident sometime before 1991. (Id).

In the meantime, after performing claimant's right knee surgery, Dr. Baldwin reported that claimant had no known prior injury and no prior difficulty with his right knee. (Exs. 6H-1, 9).[3] Baldwin opined that claimant had a degenerative medial meniscus that had been present for some time and that was extended by the October 1990 injury and, thereby, became symptomatic. (Ex. 6H-2). Baldwin subsequently clarified his opinion, to state his belief that claimant's need for surgery arose from the October 1990 incident, that any preexisting problem had little effect on the injury and that any subsequent injury probably did not further affect the condition. (Ex. 9).

Finally, Dr. Higgins, who treated claimant briefly in 1989, concluded that, based on claimant's "benign" examination in 1989, claimant's current symptoms were probably related to post-1989 injuries. (Ex. 13). Higgins thereafter signed a concurrence letter, agreeing that, in 1989, claimant had presented with bilateral patellofemoral crepitation, more symptomatic on the left. (Ex. 14-1). Higgins also agreed that, had claimant had a meniscal tear in 1989, he would have presented with different symptoms. (Id).

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[2] In July 1993, claimant filed a claim with Home's insured for bilateral knee conditions. (Ex. 6A). At hearing, the parties stipulated that only claimant's right knee condition was at issue.

[3] The record contains two references to a March 26, 1993 injury date. (See Exs. 6H, 6H-1.) There is no evidence that claimant sustained an injury on that day. (See Tr. Day II, at 24).

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). Here, we find no persuasive reason not to give dispositive weight to the reports of Dr. Baldwin, claimant's treating surgeon.

Hartford urges us to discount Dr. Baldwin's reports on the ground that he was not aware of claimant's pre-1990 history of bilateral knee pain. In view of the fact that Dr. Higgins found claimant to have a "benign" examination in 1989, we conclude that Baldwin's lack of awareness of claimant's pre-1990 knee problems does not undercut the probative value of his reports. Rather, because Dr. Baldwin performed claimant's right knee surgery in 1993, we conclude that he was in the best position to render an opinion regarding the cause of claimant's right knee condition. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). Thus, we are persuaded by his opinions that claimant's right knee meniscal tear was related, in major part, to his October 1990 work injury, which occurred while Hartford was on the risk.[4]

This conclusion is supported by most of the remaining medical evidence. Drs. Stanford and Brown believed that claimant's meniscal tear was traumatic. (Exs. 6C-3, 6F). In his final report, Dr. Stanford agreed that the October 1990 injury could have resulted in claimant's initial medial meniscal tear. (Ex. 12-2). Furthermore, Dr. Higgins' 1989 findings were substantially different than those claimant experienced in 1993, suggesting some intervening event (such as the October 1990 work accident). (See Ex. 13). Those reports bolster (or at least, are in concert with) Dr. Baldwin's analysis and conclusions.

The only contrary report is that of Dr. Martens, who concludes that claimant's work activities were the major contributing cause of his right knee condition. We find no persuasive reason to discount Dr. Baldwin's theory that claimant's knee condition was the result of acute trauma and degeneration, as compared to Martens' apparent occupational disease theory. For these reasons, we conclude that claimant has established the compensability of his current right knee condition as an injury claim.

Responsibility

Hartford asserts that the Referee erred in assigning it responsibility for claimant's right knee condition. We disagree.

Here, there is no prior accepted claim for a right knee condition and a determination must be made regarding the assignment of initial responsibility for that condition. Therefore, ORS 656.308(1) is not applicable. SAIF v. Yokum, 132 Or App 18 (1994) (ORS 656.308(1) does not apply to initial claim determinations); Eva R. Billings, 45 Van Natta 2142 (1993). Instead, we resort to the judicially created rules governing the initial assignment of responsibility in successive employment cases, e.g., the last injury rule (for injury claims) and the last injurious exposure rule (for occupational disease claims). See John J. Saint, 46 Van Natta 2224 (1994); Eva R. Billings, supra. Where, however, actual causation is proved with respect to a specific employer, we need not resort to those rules. See Eva R. Billings, supra; see also Runft v. SAIF, 303 Or 493, 502 (1987). Rather, we will assign responsibility to the carrier with respect to whom actual causation has been established. Eva R. Billings, supra.

As we discussed earlier, the preponderance of the medical evidence establishes that claimant's torn right meniscus resulted, in major part, from his October 1990 injury with Hartford's insured. The only truly contradictory evidence is that submitted by Dr. Martens. He suggests that claimant's right knee condition is the result of his ongoing work activities (which would include those activities with Home's insured). That theory is in conflict with Dr. Baldwin's theory, viz., that claimant's right knee condition was the result of degeneration and specific work-related trauma in October 1990, and not the result of any post-1990 injuries. In light of Baldwin's status as the treating surgeon, we reject Martens' analysis and conclude that actual causation has been established with respect to Hartford. See Weiland v. SAIF, supra. Therefore, Hartford is responsible for claimant's right knee condition.

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[4] Hartford also argues that claimant has not adequately explained his history of playing basketball. We disagree. In his March 25, 1993 chart note, Dr. Baldwin noted that claimant had played basketball 6 months earlier and had experienced a sore arm. (See Ex. 4-1). At hearing, claimant was unclear about when he had last played basketball. (See Tr. Day II, at 27-28, 30-33, 35-36). Because Baldwin was aware of claimant's basketball activities, and because there is no persuasive evidence that those activities had significant bearing on his current right knee condition, we reject Hartford's argument.

In sum, we conclude that claimant's right knee condition is compensable and that Hartford is responsible for that condition. Consequently, we affirm the Referee's order reaching the same conclusions.

Claimant's counsel is entitled to an assessed attorney for prevailing against Hartford's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Hartford Insurance Company. In reaching this conclusion, we have consider the complexity of the issues, the time devoted to the case (as represented by claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated February 17, 1994 is affirmed. For services on review, claimant's counsel is awarded $1,000, payable by Hartford Insurance Company.

February 2, 1995 Cite as 47 Van Natta 186 (1995)

In the Matter of the Compensation of
MINA G. COOK, Claimant
WCB Case No. 94-00633
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig and Turner-Christian.

The SAIF Corporation requests review of that portion of Referee Baker's order that set aside its denial of claimant's occupational disease claim for herpetic keratitis in the left eye. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had established compensability of her herpetic keratitis condition. We disagree.

In order to prove the compensability of an occupational disease, claimant must show that "employment conditions were the major contributing cause of the disease or its worsening." ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

Claimant, a high school teacher, first developed herpetic keratitis in 1977. Two medical experts give opinions concerning the cause of claimant's left eye herpetic keratitis.

Dr. East is claimant's treating opthalmologist. He explained that herpetic keratitis is generally considered a childhood or adolescent disease, although adults can be infected. Dr. East indicated that the disease is ubiquitous and that claimant could have been infected from innumerable sources. However, based on claimant's history, Dr. East believed that the most likely cause of claimant's herpetic keratitis infection was exposure from one of her students in 1977, even though other potential causes could not be excluded. (Ex. 11). Dr. East indicated that claimant recalled many instances of students with "red eye" or "pink eye," which are known symptoms of the herpes virus, although they can be caused by other infections of the eye.

Dr. Fellman also gave an opinion concerning causation. He indicated that 85 to 90 percent of adult Americans have antibody to the herpes simplex virus. He explained that the infection usually occurs in childhood and that the virus generally goes into dormancy. He explained that varied stimuli seem to be capable of reactivating the virus producing assorted infections including "fever blisters" or "cold sores" on the lip or nose and corneal infections or keratitis. Dr. Fellman indicated that aerosol of fomite transmission of the disease is likely (i.e., someone sneezes and broadcasts the virus, someone soils a towel or cloth and another wipes his face on the towel and contracts the infection).

Dr. Fellman opined that given the ubiquitous nature of this disease, it was hard to make a connection between claimant's infection and exposure to her students. In addition, Dr. Fellman noted that it was not documented that students that claimant recalled with "red eye" or facial lesions had herpes infections. Dr. Fellman concluded that the source of claimant's infection is not clear and that it is just as likely that the infection did not come from the students. Finally, Dr. Fellman also noted that there was literature which suggested that most herpes simplex infections were acquired in childhood. (Ex. 10).

ORS 656.266 requires claimant to establish affirmatively that her disease is work-related. See Lynne C. Gibbons, 46 Van Natta 1698 (1994), Ruben G. Rothe, 45 Van Natta 369 (1993); Tamara D. Hergert, 45 Van Natta 177 (1993); Robin R. Wilson, 42 Van Natta 2882 (1990). Here, the physicians have indicated that there are innumerable sources of the herpes simplex infection which could have caused claimant's left herpetic keratitis infection. Under the circumstances, we are not persuaded that claimant has established that her condition is, in fact, related to her work environment.

In reaching this conclusion, we note that evidence that a claimant's work environment placed her at an increased risk of contracting a disease is insufficient by itself to establish compensability. Lynne C. Gibbons, supra; see also John A. Hoffmeister, 46 Van Natta 1689 (1994) (physician's assumption that Hepatitis C was a significant occupational infectious disease risk for law enforcement personnel insufficient to establish that the claimant contracted Hepatitis C through his work activities). Here, we interpret Dr. East's opinion to mean that claimant's job put her at increased risk of infection with the herpes simplex virus since it exposed her to students who might have that virus. We do not find this opinion sufficient to establish that claimant's work exposure was, in fact, the major contributing cause of the herpetic keratitis. See ORS 656.266.

Moreover, it cannot be established that any of claimant's students in 1977 had a herpes simplex infection. Claimant gave testimony to the effect that there had hardly been a year in which one of her students had not had pink eye or facial blisters. However, the medical evidence established that these conditions can be caused by infections other than the herpes simplex virus. On this record, we are unable to determine whether claimant's work exposure to her students in 1977 was the major contributing cause of her herpetic keratitis condition. Accordingly, claimant has failed to establish compensability of her herpetic keratitis of the left eye.

ORDER

The Referee's order dated May 5, 1994 is reversed in part. SAIF's denial is reinstated and upheld. The Referee's award of a $3,500 attorney fee is also reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MICHAEL R. HECKARD, Claimant
WCB Case No. 93-13684
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of those portions of Referee Menashe's order which: (1) found that claimant had established good cause to explain the untimely filing of his request for hearing from SAIF's denial of his thoracic and low back condition; and (2) set aside SAIF's denial. In his respondent's brief, claimant contests that portion of the Referee's order which found that a Claim Disposition Agreement (CDA) limited claimant's benefits arising from his compensable conditions to medical services. On review, the issues are good cause, compensability, and the effect of the CDA.

We adopt and the affirm the Referee's order with the following comments regarding the CDA issue.

After finding the disputed conditions compensable, the Referee determined that claimant was only entitled to medical services resulting from those conditions. The Referee relied on a prior CDA which had released claimant's rights to "non-medical services" benefits "for all past, present, and future conditions resulting directly or indirectly" from his August 1990 injury claim.

On review, claimant contends that the CDA has no effect on his entitlement to benefits arising from his thoracic and low back conditions. We disagree.

Subsequent to the issuance of the Referee's order, we issued our decision in Jeffrey B. Trevitts, 46 Van Natta 1767 (1994). In Trevitts, we were called upon to determine the effect a CDA had on a claimant's rights to "non-medical services" benefits resulting from a condition which had not been expressly listed as an accepted condition under the CDA. In determining that the claimant had released his rights to such benefits, we reasoned that, had the parties intended that the claimant would retain such rights, the CDA would have specifically provided that the claimant's release of rights and benefits was partial. Noting that the CDA contained no such exclusionary language, we further concluded that other sections of the disposition indicated that no such exclusion was intended. Specifically, we highlighted the following sections of the CDA: (1) the first or "summary" page listed the disposition as a "full release" of all temporary and permanent disability benefits, as well as vocational assistance; (2) a provision in which the claimant released "all other benefits except for medical services"; and (3) an express provision that "claimant retains his right to medical services for the compensable injury."

In reaching our conclusion in Trevitts, we emphasized that we were not holding that parties may never dispose of only one condition (and its benefits) in a CDA if they so desired. However, in order to do so, we declared that the CDA should clearly state the parties' intent to effect a partial release of the claim and benefits, including a provision clearly stating the intent to preserve and retain "non-medical service" benefits.

Here, as in Trevitts, the CDA does not list the conditions which are presently in dispute (thoracic and low back conditions) as accepted conditions. Nevertheless, again as in Trevitts, there is no indication that the CDA was intended as a partial release of claimant's benefits under his injury claim. To the contrary, the CDA expressly provides that it was a full release of claimant's "claim for compensation and payments of any kind due or claimed for all past, present, and future conditions, except medical services . . ." Moreover, the CDA specifies that "[c]ompensation and payments of any kind due or claimed" includes all past, present, and future "non-medical services" benefits "for any and all past, present and future conditions resulting directly or indirectly from this claim . . ."

In light of such circumstances, we find that, pursuant to the CDA, claimant released his rights to all past, present, and future "non-medical service" benefits resulting directly or indirectly from his August 1990 injury claim. Thus, notwithstanding the omission of claimant's thoracic and low back conditions as "accepted conditions" in the CDA, the other aforementioned provisions in the CDA establish that claimant's rights to "non-medical service" benefits resulting from the thoracic and low back conditions were released. Consequently, we agree with the Referee's conclusion that the benefits to which claimant is entitled for his compensable thoracic and low back conditions are limited to medical services.

Claimant is entitled to an assessed attorney fee for his counsel's services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the good cause and compensability issues is $1,750, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issues (after considering claimant's respondent's brief and claimant's counsel's statement of services, as well as SAIF's objections), the complexity of the issues, 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 counsel's services devoted to the "scope of the CDA" issue.

ORDER

The Referee's order dated February 24, 1994 is affirmed. For services on Board review, claimant's attorney is awarded $1,750, to be paid by the SAIF Corporation.

Board Member Hall specially concurring.

I offer this special concurrence to express my opinion concerning the issue raised by claimant on review. Specifically, I address the effect that the CDA has on claimant's rights to benefits for his compensable thoracic and low back conditions.

First, I refer the parties to my dissenting opinion in Jeffrey B. Trevittts, supra. I stand by that opinion. If I were writing on a clean slate, I would be authoring the same opinion in this case as I did in Trevitts. However, I recognize the effect of the doctrine of stare decisis and that I am currently bound by the majority opinion in Trevitts.

February 2, 1995 Cite as 47 Van Natta 189 (1995)

In the Matter of the Compensation of
FLOR IRAJPANAH, Claimant
WCB Case No. 93-12048
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members en banc.[1]

Claimant requests review of Referee Hoguet's order that: (1) admitted Exhibit 6A, a "medical arbiter report"; and (2) affirmed an Order on Reconsideration which decreased claimant's unscheduled permanent disability for a back condition from 15 percent (48 degrees) to zero. On review, the issues are evidence and extent of unscheduled permanent disability. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant has a compensable back condition, including thoracic and lumbar strains. In May 1993, a Determination Order awarded 15 percent unscheduled permanent disability. Claimant requested reconsideration by filing the appropriate form with the Department. On this form, claimant checked "No" to each box except Box No. 7, relating to disagreement with the rating of age, education and adaptability for unscheduled permanent disability, and Box No. 8 for "Other," adding "Claimant permanent & totally disabled." (Ex. 6-1). An accompanying letter from claimant's attorney also stated that claimant was permanently totally disabled and that this matter was noted in Box No. 8 with the intent to "raise and preserve this issue." (Id. at 2). The letter further noted that claimant was not "requesting a Medical Arbiter." (Id).

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[1] Because claimant is represented by the law firm from which Member Hall previously practiced, Member Hall has not participated in this review. OAR 438-11-023.

At the Department's request, claimant was evaluated by Dr. Washington, orthopedic surgeon. The Department's Order on Reconsideration stated that, "[i]n order to obtain the objective findings necessary to rate impairment due to the accepted conditions and sequelae, a medical arbiter examination was scheduled and carried out on 9-22-93 by Eleby R. Washington, III, as provided for in ORS 656.268(5)." (Ex. 7-3). The order further noted that "ranges of motion of the thoracic spine were not provided in the record at the time of claim closure." (Id). Based on Dr. Washington's report, the Order on Reconsideration found no impairment due to claimant's accepted conditions and, thus, reduced claimant's permanent disability award to zero. (Id. at 4).

At hearing, claimant objected to the admission of Exhibit 6A, Dr. Washington's report, on the basis that the Department lacked authority to appoint a medical arbiter since there had been no request for such by either claimant or the insurer pursuant to ORS 656.268(7). The Referee agreed with the Department that the record lacked evidence regarding claimant's thoracic spine and, therefore, "ORS 656.268(5) provided the legal basis for the generation of Exhibit 6A." Accordingly, the Referee admitted the document.

On review, claimant objects to this ruling. Claimant reiterates her assertion that, because there was no request for a medical arbiter by either party, ORS 656.268(7) does not provide authority for the Department's action in requesting an examination of claimant by Dr. Washington. Claimant further contends that ORS 656.268(5) does not relate to the medical arbiter process and, therefore, also is not applicable. According to claimant, because Dr. Washington did not qualify as a medical arbiter and is not the attending physician, his report is not admissible.

ORS 656.268(7) provides in relevant part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director."

The Court of Appeals recently examined this provision in Sedgwick James of Oregon v. Hendrix, 130 Or App 564 (1994). In that case, a Notice of Closure awarded no permanent disability based on a medical opinion that the claimant had no impairment. The claimant requested reconsideration and the appointment of a medical arbiter by the Department. The employer objected to the Department's subsequent appointment of a medical arbiter, asserting that, in order to disagree with impairment, the claimant was required to present medical evidence rebutting the determination of no impairment.

The court found the text of ORS 656.268(7) to be "quite plain." In particular, the court found that the appointment of a medical arbiter was required "when there is a 'disagreement with the impairment' used to rate claimant's disability." Id. at 668. Finding that there had been some determination of impairment with which the claimant disagreed, the court held that the obligation to appoint a medical arbiter was triggered. Id.

Therefore, in order to determine whether ORS 656.268(7) is applicable to this case, we examine whether claimant disagreed with the impairment used to rate her permanent disability. First, we find no disagreement to impairment from claimant's objection to the rating of her age, education and adaptability inasmuch as such factors are separate from impairment. However, claimant also asserted that she was permanently totally disabled. According to the employer, claimant put impairment at issue by seeking such benefits.

Permanent total disability can be proved based on permanent physical incapacity or the "odd lot" doctrine, which consists of proof that a combination of medical and nonmedical disabilities effectively foreclose the worker from performing gainful and suitable employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985). The employer's position would have some basis if claimant had been contending that she is permanently totally disabled (PTD) based only on physical incapacity since her impairment necessarily would be the only factor at issue. However, we do not interpret claimant's request for reconsideration in such a manner.

Inasmuch as claimant, with regard to her unscheduled permanent disability, challenged only non-impairment factors and specifically requested no medical arbiter, we find that the request is most reasonably construed as alleging PTD based on the "odd-lot" doctrine. Because such a theory concerns consideration of non-physical disabilities, we do not conclude that claimant necessarily challenged or expressed "disagreement" with impairment when she raised the PTD issue. See EBI Companies v. Hunt 132 Or App 128 (1994) (Board did not err in relying on opinion of nonattending physician in determining whether to award permanent total disability for unscheduled disability since such a decision does not require the Board to make impairment findings).[2] Therefore, we find the Department's obligation under ORS 656.268(7) to appoint a medical arbiter was not triggered in this case.

Our conclusion is not changed by ORS 656.268(5), upon which the Referee relied. The pertinent portion of that statute provides:

> "If necessary the department may require additional medical or other information with respect to the claim, and may postpone the determination or reconsideration for not more than 60 additional days."

We initially note that, when construing a statute, we first look to its text and context to ascertain the intention of the legislature. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). We agree with the Referee that ORS 656.268(5) applies to the medical arbiter proceedings described in subsection (7) since such a process is a means for the department to "require additional medical * * * information with respect to the claim" and, otherwise, the department would be unable to postpone their reconsideration. However, such language is prefaced by the term "if necessary." Furthermore, the statute must be construed in the context of subsection (7), which expressly relates to medical arbiter examinations and requires "disagreement with the impairment used in rating of the worker's disability."

In order to give effect to both provisions, we construe that the necessity for requiring additional medical information under ORS 656.268(5) is contingent upon a party expressing disagreement with impairment.[3] In other words, we hold that it only becomes "necessary" for the Department to require additional medical information via a medical arbiter examination "if" there is disagreement concerning impairment. Furthermore, we find no indication in the statutes giving the department discretion to appoint medical arbiters and require workers to undergo examinations by such physicians even if no party disagrees with impairment.

As discussed above, claimant did not disagree with impairment. As such, the Department had no obligation or discretion to appoint a medical arbiter under ORS 656.268(7) and Dr. Washington's report does not qualify as "findings of the medical arbiter" under that statute. Moreover, it was not "necessary" for the Department to require additional medical information under ORS 656.268(5) by appointing a medical arbiter. Finally, claimant's attending physician did not concur in Dr. Washington's report. Consequently, finding no statutory basis supporting its admission, we conclude that Dr. Washington's report is not admissible and we do not consider it on review.

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[2] We emphasize that this portion of our decision is based on the record in this case. If the facts in other cases, including those where the claimant alleges permanent total disability, support a finding that the request for Director review constitutes an objection to impairment, then the Department's obligation under ORS 656.268(7) to appoint a medical arbiter would likely be triggered.

[3] As previously discussed, the Department interpreted ORS 656.268(5) in a different manner, finding that it was "necessary" to appoint a medical arbiter because claimant's treating physician failed to address impairment of claimant's thoracic spine in his closing examination report. Although this order holds that there must be an expression of disagreement with impairment before it becomes "necessary" to appoint a medical arbiter, we note that ORS 656.268(5) appears to allow the Department to request additional information from the attending physician if it considers the record to be insufficiently developed. Such further development of the medical evidence from the attending physician would be consistent with the statutory scheme which limits consideration of impairment findings to those rendered by the attending physician. See ORS 656.245(2)(b)(B); Roseburg Forest Products v. Owen, 129 Or App 442 (1994).

Extent of Unscheduled Permanent Disability

The remaining admissible evidence of impairment consists of a report from Dr. Wong, claimant's treating physician. Based on that report, we agree with claimant that she proved 7 percent impairment for loss of forward flexion, OAR 436-35-360(19) (WCD Admin. Order 6-1992); 2 percent impairment for loss of extension, OAR 436-35-360(20); and 6 percent for loss of bilateral flexion, OAR 436-35-360(21). These values result in 15 percent impairment. OAR 436-35-360(22).

Claimant asserts that she is entitled to an adaptability factor of 5 because, at the time of injury, she worked as a retail department manager, which has a strength rating of medium, and she was released only to sedentary work. See OAR 436-35-310(3). We disagree. First, claimant testified that, when she was injured, she worked as a manager at Vista Optical. (Tr. 24). We find that this job most appropriately falls under Supervisor (optical goods), DOT 716.130-010, which has a strength requirement of light.

Furthermore, claimant testified that she now works as an optician. (Tr. 24). That job also has a strength requirement of light. DOT 716.280-014. We find this evidence to be more persuasive than Dr. Wong's report, which was generated many months prior to the issuance of the Order on Reconsideration. Therefore, because we find that claimant's prior strength and RFC are both light, the adaptability factor is 0. OAR 436-35-360(3).

Although the parties stipulated at hearing that claimant's age and education values added together is 1, because adaptability is 0, claimant's unscheduled permanent disability award is 15 percent (based on her impairment). OAR 436-35-280(6), (7).

Finally, we note claimant's argument that, if we find that she was released or returned to regular employment, her adaptability factor should be 1 based on England v. Thunderbird, 315 Or 633 (1993). For the reasons discussed in Michelle Cadigan, 46 Van Natta 307 (1994), we conclude that claimant's adaptability is 0.

Attorney Fee

Because we have reinstated the unscheduled permanent disability awarded by the Determination Order, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation, not to exceed $3,800. See ORS 656.382(2). The parties stipulated at hearing that the employer had paid the award made by the Determination Order. Thus, if claimant's attorney was not paid his fee, he may seek recovery in the manner prescribed by Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994).

ORDER

The Referee's order dated February 7, 1994 is reversed in part and modified in part. That portion of the order finding Exhibit 6A admissible is reversed. In lieu of the Referee's order and Order on Reconsideration, both of which awarded no unscheduled permanent disability, the Determination Order award of 15 percent (48 degrees) is reinstated and affirmed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation of this order, not to exceed $3,800. If the compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed by Jane Volk, supra.

In the Matter of the Compensation of
JOB G. LOPEZ, Claimant
WCB Case No. 93-08872
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Nichols' order that affirmed a Director's order upholding a managed care organization's (MCO's) disapproval of his attending physician's request for authorization of back fusion surgery. In its brief, the SAIF Corporation contends that the Referee erred in denying its motion to dismiss claimant's hearing request for lack of jurisdiction.[1] On review, the issues are jurisdiction and medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his low back in October 1988. The injury eventually led to two low back surgeries in 1989. The claim was accepted by SAIF and closed by Determination Order in June 1990 with a permanent disability award, which was increased to 32 percent by a subsequent stipulation. (Exs. 12, 13).

Claimant continued to have symptoms in his back and legs, and eventually came under the care of Dr. Grewe, a neurosurgeon and a member of CareMark Comp, an MCO. Dr. Grewe recommended L4-5 spinal fusion surgery.

On October 23, 1992, Drs. Peterson, orthopedist, and Reimer, neurologist, examined claimant on SAIF's behalf. They concluded that claimant would not benefit from fusion surgery because of his history of prior back surgeries and because there was no evidence of spinal stenosis or instability. (Ex. 17-9).

On December 9, 1992, Dr. McCarthy, psychiatrist, examined claimant on SAIF's behalf. She concluded that claimant had mild depression caused, in major part, by his October 1988 injury. (Ex. 23-8). She also recommended that surgery be approached with caution, because of claimant's psychological problems. (See id. at 9).

Thereafter, Dr. Grewe requested authorization for L4-5 spinal fusion surgery. CareMark Comp disapproved the request on the basis that surgery was not medically necessary or appropriate. (Ex. 24). Dr. Grewe appealed the disapproval. (Ex. 25). CareMark Comp's Medical Advisory Council unanimously upheld the disapproval. (Ex. 27). After Dr. Grewe requested reconsideration of the disapproval, CareMark Comp's Medical Management Committee upheld the disapproval. (Ex. 32).

Dr. Grewe appealed the disapproval of surgery to the Director. The Director appointed Dr. Melgard, neurologist, to review claimant's case. On June 8, 1993, Dr. Melgard examined claimant and determined that claimant probably had a protruded intervertebral disc; he recommended that claimant undergo a myelogram/CT scan to determine whether the suspected defect was a surgical lesion. (Ex. 35-4, -5).

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[1] On September 30, 1994, we notified the participants that the case had satisfied the criteria for granting oral argument, and invited the Workers' Compensation Division of the Department of Consumer and Business Services (Department) to submit an amicus curiae brief addressing the jurisdictional issue. Subsequently, the Department, by and through the Department of Justice, filed a motion to intervene in the matter. In an Interim Order, we concluded that the Department is not entitled to intervene in this matter. Job J. Lopez, 46 Van Natta 2305 (1994). Particularly, we noted that the Department has no pecuniary interest in the outcome of this case. Id.; compare Trojan Concrete v. Tallant, 107 Or App 429, rev den 312 Or 151 (1991); Richard A. Colclasure, 46 Van Natta 1246 (order on remand), 46 Van Natta 1667 (1994) (second order on remand). Furthermore, we concluded that, in contrast to Kelsey v. Drushella-Klohk, 128 Or App 53 (1994), this was not a matter in which the Department participated at hearing, nor is the issue whether the Department was a "party" entitled to be served with notice of the claimant's hearing request. Job J. Lopez, supra, 46 Van Natta at 2306.

Notwithstanding our denial of the motion to intervene, we recognize the Department's general interest in this dispute. Therefore, we will treat the Department's written argument as an amicus curiae brief. See, e.g., Al S. Davis, 44 Van Natta 931 (1992); see also Jeffrey B. Trevitts, 46 Van Natta 1100 (interim order), 46 Van Natta 1767 (1994) (order on review).

On July 21, 1993, the Director issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute under ORS 656.327, upholding CareMark's disapproval and concluding that the proposed surgery was not appropriate for claimant's condition. (Ex. 36). The order contained a notice of hearing rights indicating that a party aggrieved by the order may request a hearing by the Hearings Division of the Workers' Compensation Board. (Id. at 5).

On August 6, 1993, claimant underwent a myelogram/CT scan. The myelogram was essentially normal, except for revealing the missing L4 facet. (Exs. 37, 38). However, the CT scan revealed a soft tissue density at L4-5 that could represent either localized scarring or a localized disc herniation into the foramen. (Ex. 38). Dr. Grewe subsequently concluded that claimant had a far lateral L4-5 disc herniation that would benefit from the proposed internal fixation and fusion.

Meanwhile, on July 29, 1993, claimant requested a hearing to contest the Director's order. At hearing, SAIF moved for dismissal of the hearing request for lack of jurisdiction. The Referee denied the motion, but concluded that claimant had failed to establish that the requested L4-5 spinal fusion surgery was either reasonable or necessary.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee denied SAIF's motion to dismiss, finding that the reasonableness and necessity of the proposed surgery was a matter concerning a claim over which the Hearings Division has jurisdiction. On review, SAIF contends that, under ORS 656.260(4)(d) and (6), and 656.704(3), the Director has exclusive jurisdiction over this dispute. We disagree.

ORS 656.260(4)(d) provides:

> "(4) The director shall certify a health care provider or group of medical service providers to provide managed care under a plan if the director finds that the plan:
>
> "* * * * *
>
> "(d) Provides adequate methods of peer review, service utilization review and dispute resolution to prevent inappropriate or excessive treatment, to exclude from participation those individuals who violate treatment standards and to provide for the resolution of such medical disputes as the director considers appropriate."

ORS 656.260(6) provides, in part:

> "Utilization review, quality assurance and peer review activities pursuant to this section and authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245(3) shall be subject solely to review by the director or the director's designated representatives."

ORS 656.704(3) provides:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." (Emphasis added).

We first address whether ORS 656.260(4)(d) or 656.260(6) authorize Director review of an MCO's disapproval of an attending physician's request for authorization of medical services. If not, then the last sentence of ORS 656.704(3) does not, by virtue of ORS 656.260, exclude the dispute from matters concerning a claim for which a claimant may request a hearing under ORS 656.283(1). See Martin v. City of Albany, 320 Or 175, 180 (1994). At its very essence, the jurisdictional issue in this case boils down to how the terms "[u]tilization review, quality assurance and peer review" are defined, and whether the medical authorization dispute here falls in or out of the scope of those defined terms.

To resolve this issue, we must ascertain what the legislature intended when it enacted ORS 656.260. ORS 174.020. We begin with the text and context of the statute. ORS 174.020; Porter v. Hill, 314 Or 86, 91 (1992). If those sources do not reveal the legislature's intent, we resort to legislative history and other extrinsic aids. See PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993).

ORS 656.260 provides a comprehensive scheme for the certification of MCOs. ORS 656.260(1) - (5).[2] Under the statute, a health care provider or group of medical service providers may apply to the Director for certification to provide managed care to injured workers for compensable injuries or diseases. ORS 656.260(1). ORS 656.260(3) authorizes the Director to prescribe the form and manner of the application for certification, including information regarding the proposed plan for providing medical services. Certification of the MCO requires a finding by the Director that the plan meets statutory requirements and complies with any other requirement that the Director determines is necessary to provide quality medical services and health care to injured workers. ORS 656.260(4).

SAIF argues that ORS 656.260(4)(d) and 656.260(6) support its position that the Director has exclusive jurisdiction over the medical services dispute in the present case. Specifically, SAIF contends that, under ORS 656.260(4)(d), "peer review" and "service utilization review" are designed to prevent "inappropriate and excessive treatment." Therefore, it argues, because CareMark Comp's decision to deny authorization of claimant's spinal fusion surgery was designed to prevent "inappropriate and excessive treatment," that decision necessarily was a "utilization review, quality assurance [or] peer review activit[y]" under ORS 656.260(6), review of which falls solely under the Director's purview. We disagree.

SAIF's reliance on ORS 656.260(4)(d) is misplaced. On its face, ORS 656.260(4) concerns the certification of MCOs, not the administrative review of disputes regarding the services provided by MCO participants.[3] See, e.g., Minutes of Interim Special Committee on Workers' Compensation, May 3, 1990, pp 23-24 (discussing certification of MCOs). ORS 656.260(4)(d) requires that a health care provider (or a group of medical service providers) that seeks certification as an MCO provide adequate methods of dispute resolution; however, that subsection says nothing about the administrative review of disputes after an MCO has (unsuccessfully) attempted to resolve a dispute. See OAR 436-15-030(1)(n) (MCO plan must include procedure for internal dispute resolution, to include a method to resolve complaints by injured workers, medical providers and insurers). Accordingly, we reject SAIF's argument under ORS 656.260(4)(d).[4]

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[2] ORS 656.260 also establishes the confidentiality of information generated by an MCO's utilization review, quality assurance or peer review activities (and with respect to review of request for authorization of services of other than attending physicians under ORS 656.245(3), see discussion in text, infra), as well as the immunity from liability for persons who participate in good faith in the formation of MCO contracts. ORS 656.260(6) - (9).

[3] No one has raised any issue regarding CareMark Comp's certification.

[4] We disagree with SAIF's characterization of ORS 656.260(4)(d). That section provides that the purposes of an MCO's peer review, service utilization review and dispute resolution activities are: (1) preventing inappropriate and excessive treatment; (2) exclusion from participation in a plan of those individuals who violate treatment standards; and (3) providing for the resolution of such medical disputes as the Director considers appropriate. Given the organization of that subsection, it appears to us that the legislature intended that peer review be designed to serve the first purpose; service utilization review, the second purpose; and dispute resolution, the third purpose. In light of that interpretation, we disagree with SAIF that, as those terms are used in ORS 656.260(4)(d), "peer review" and "service utilization review" are designed only to prevent inappropriate or excessive treatment.

The dissent's reliance on ORS 656.260(4)(d) ignores the overall purpose of subsection (4), i.e., to establish an MCO's qualifications for certification. Moreover, the dissent overemphasizes one clause of ORS 656.260(4)(d) -- "to prevent inappropriate and excessive treatment" -- in its attempt to find footing for its conclusion that an MCO's decision to authorize certain medical services is within the scope of "utilization review, quality assurance and peer review activities" under ORS 656.260(6). When subsection (4)(d) is read in its entirety, it becomes apparent that that subsection was designed to assure that MCOs generally provide high quality, appropriate care that conforms to established treatment standards. Contrary to the dissent's assertions, that section says nothing about a worker's right to challenge an MCO's conclusions regarding the propriety and/or necessity of an individual worker's medical services.

As an aside, we note that there is no contention that claimant (or Dr. Grewe) did not exhaust CareMark Comp's internal dispute resolution procedures before claimant requested a hearing. Under ORS 656.260(4)(d) and the Director's rules, an MCO must establish internal methods of dispute resolution. Because, in our view, the "dispute resolution" methods that must be established concerns disagreements between MCOs and their service providers, but see OAR 436-15-030(1)(n), we are persuaded that an exhaustion argument, even if raised, would likely fail.

ORS 656.260(6) likewise does not support SAIF's position. That subsection provides that an MCO's utilization review, quality assurance and peer review activities under ORS 656.260 "and authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245 (3)" are subject solely to the Director's review. (Emphasis added.) The statute is silent, however, regarding the administrative review of MCO activities regarding the authorization of medical services to be provided by an attending physician.[5]

SAIF argues that authorization of an attending physician's medical services fall under the rubric of "utilization review, quality assurance [or] peer review activit[y]." We disagree. By specifying that the Director has exclusive jurisdiction over the authorization of a non-attending physician's medical services in the MCO context, it is apparent that the legislature considered authorization of medical services, regardless of who provides (or will provide) them, to involve something different than utilization review, quality assurance and peer review activities. ORS 174.010; Nolan v. Mt. Bachelor, Inc., 317 Or 328, 333 (1993) (whenever possible, provisions of a statute are to be construed so as to give effect to each). Had the legislature intended "utilization review, quality assurance and peer review activities" to include an MCO's actions regarding an attending physician's request for authorization of medical services, it would have said so. Or, put another way, if the legislature had intended that all MCO-related requests for authorization of medical services fall within the Director's exclusive jurisdiction, it would not have specified such jurisdiction over only non-attending physicians' requests. Therefore, we conclude that, by its silence, the legislature manifested its intent not to grant the Director exclusive jurisdiction over disputes involving an MCO-related attending physician's request for authorization of medical services. See Perlenfein and Perlenfein, 316 Or 16, 22 (1993) (when legislature uses particular term in one provision of statute, but omits same term in parallel and related provision, court infers that legislature did not intend that term to apply in provision from which term was omitted).

This reasoning is supported by the general meanings of the terms "utilization review," "quality assurance," and "peer review." Because our focus is on the meaning of specific statutory terms, we follow the methodology set forth in Springfield Education Assn. v. School Dist., 290 Or 217, 223-30 (1980).

> "In Springfield, th[e Supreme C]ourt discussed the allocation between administrative agencies and courts of responsibility for giving specific meaning to statutory terms. Id. at 221-30. The opinion divided statutory terms into three classes, each of which conveys to the agency different responsibilities for definition. The first class, terms of precise meaning, requires the agency only to apply the terms to the facts. The second class, inexact terms, comprises a complete expression of legislative policy and requires the agency to interpret the legislature's meaning, either by rule or by a decision in a contested case. The third class, terms of delegation, is incomplete legislation that the agency is authorized to complete, by making rules within the range of discretion established by the statutes. [Springfield, supra, 290 Or] at 223." Tee v. Albertsons, Inc., 314 Or 633, 637-38 (1992).

We conclude that, as used in ORS 656.260, the terms "utilization review, quality assurance and peer review" are statutory terms within the second class described in Springfield. That is, they are statutory terms that embody a complete expression of legislative meaning, even though their exact meanings are not obvious. See Tee, supra, 314 Or at 638 (reaching same conclusion regarding term "gainful occupation" in ORS 656.206(1)(a)). To determine the meanings of those terms, we "look[] to extrinsic indicators such as the context of the statutory term, legislative history, a cornucopia of rules of construction, and [our] own intuitive sense of the meaning of the particular word or phrase." Springfield, supra, 290 Or at 224; see also 2A Sutherland Statutory Construction, § 48.01, 2B §§ 51.01, 52.01, 53.03 (5th ed 1992) (Sutherland) (extrinsic aids to statutory interpretation include legislative

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[5] SAIF argues that the phrase "pursuant to ORS 656.245(3)", in ORS 656.260(6), indicates that the legislature intended the Director only to have exclusive jurisdiction over medical service providers who are not members of MCOs and who do not qualify as attending physicians, in accord with ORS 656.245(3)(b). We disagree. In ORS 656.260(6), the legislature specified that "authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245(3)" is subject to the Director's exclusive review. (Emphasis added). ORS 656.245(3)(a) establishes a claimant's right to choose an attending physician, while ORS 656.245(3)(b) addresses the compensability of services provided by medical services providers who are not members of MCOs and who do not qualify as attending physicians. Had the legislature intended what SAIF envisions, it would have indicated as much by a reference to ORS 656.245(3)(b), not ORS 656.245(3).

history, related statutes, similar statutes from other states and unrelated statutes concerning similar persons, things or relationships). The ultimate inquiry is what the legislature intended by using the term. ORS 174.020; Tee, supra, at 638.[6]

Reading ORS 656.260(6) together with ORS 656.260(4)(d), we conclude that "utilization review" means that process by which an MCO evaluates the necessity, quality, effectiveness or efficiency of medical services provided by its care providers. It, in effect, is a mechanism for assuring the compliance of an MCO's participants with certain medical standards pertaining to quality, utilization and efficiency. See Testimony of Tony Feranado, representing Liberty Northwest Insurance Corporation, Interim Special Committee on Workers Compensation, May 3, 1990, Tape 3, Side B at 035 (discussing establishment of "utilization review committee to evaluate the quality of care that [is] being provided.").

Similarly, based on our own intuitive sense of its meaning, we conclude that "quality assurance" is a mechanism for assuring that quality services are provided generally to the populations served by MCOs. See ORS 656.260(4)(h).

In view of this reasoning, we conclude that neither "utilization review" nor "quality assurance" activities are mechanisms for resolving disputes regarding the reasonableness or necessity of a particular injured worker's medical services; rather, they concern an MCO's internal procedures for assuring that the persons it serves receive uniformly high quality care from its care providers that meet particular medical standards.

Last, we consider the definition of "peer review" activities. That term is defined in OAR 436-15-005(15) as

> "the evaluation of the care provided to a worker by review of the pertinent record and/or personal interview with the attending physician or consultant. Such evaluation shall be conducted by a group designated by the MCO or the director which must include, but is not limited to, members of the same healing art." (Emphasis added).

At the onset, we note that, under this rule, "peer review" concerns only the evaluation of care that has already been "provided"; it does not concern the evaluation of the reasonableness or necessity of proposed or future care. For that reason alone, we conclude that CareMark Comp's disapproval of Dr. Grewe's request for authorization of the proposed L4-5 spinal fusion surgery did not constitute "peer review" activity under OAR 436-15-005(15).

In our estimation, "peer review"[7] is a mechanism by which physicians evaluate each other's performances to assure that medical services have been provided in a competent and efficient manner. As we said in James A. Kinslow, 44 Van Natta 2119, 2120 (1992):

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[6] It is arguable that "utilization review, quality assurance and peer review" are precise terms. In Springfield, the Supreme Court defined "precise" terms as those terms with precise meaning "whether of common or technical parlance." 290 Or at 223 (emphasis added); see 2A Sutherland, § 47.29 (in absence of contrary legislative intent, technical terms or terms of art used in a statute are presumed to have their technical meaning).

The legislative history of ORS 656.260 discusses "utilization review, quality assurance and peer review" as if they were terms of common understanding, at least to the members of the legislative committee and the witnesses that testified before it. Consequently, it is arguable that they are terms of art that have a precise, technical meaning to medical professionals. If that is the case, their technical meanings would apply in ORS 656.260. See Anthony v. Veatch, 189 Or 462, appeal dismissed 240 US 923 (1950) (absent evidence of contrary legislative intent, commercial terms are presumed to have been used in their ordinary trade or commercial meanings).

The problem with this argument is that the record contains no evidence of those terms' technical meanings. Therefore, we conclude that the result is the same whether we find that "utilization review, quality assurance and peer review" are precise, technical or inexact terms: We must to resort to the panoply of intrinsic and extrinsic aids to ascertain the meaning of those terms.

[7] Indeed, on its face, "peer review" suggests just that -- review by one's peers. A claimant is not (necessarily) a physician's "peer." It is apparent, then, that "peer review" cannot be a mechanism by which an injured worker challenges the reasonableness or necessity of medical services.

> "[P]eer review activities, such as those performed by the Medical Review Staff of CareMark Comp, are meant to be an internal review process only and are intended to be a way for the MCO or insurer to insure that member physicians are following accepted standards of care. See ORS 656.260(4)(d) and (6)."

See ORS 441.055(3)(d) (the purposes of peer review are the reduction of morbidity and mortality and for the improvement of health care); see also Patrick v. Burget, 486 US 94, 108 S Ct 1658, 1661 (1988) ("peer review" activities are designed to determine whether a physician's care meets the standards of the facility in which the physician practices).[8]

This conclusion is supported by the legislative history of ORS 656.260. See Testimony of Tom Cooney, representing the Oregon Medical Association, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 5, Side A at 364 ("Peer review in the Oregon setting in the Astoria Clinic Case [Patrick v. Burget, supra] was a bunch of doctors trying to peer review someone on the hospital staff and remove him."). Accordingly, we discern that, as that term is used in ORS 656.260, "peer review" is an intradisciplinary, internal review process to enable an MCO to evaluate the competency and efficiency of a physician's performance, not a mechanism for allowing persons who receive medical services to contest the reasonableness or necessity of those services, past, present or future.[9]

For these reasons, we conclude that, as those terms are used in ORS 656.260(6), "utilization review, quality assurance and peer review activities" do not include actions respecting a request for authorization of an attending physician's medical services, proposed or otherwise, concerning a particular injured worker. Accordingly, we hold that by its terms ORS 656.260(6) does not vest the Director with exclusive jurisdiction to review an MCO's decisions regarding an attending physician's request for authorization of medical services for an injured worker.

In sum, we conclude that the text of ORS 656.260 reveals the legislature's intent not to vest the Director with exclusive jurisdiction over this dispute. Having so concluded, we need not inquire further. However, we briefly note that the context of ORS 656.260, which includes related statutes, supports our conclusion.

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[.]" ORS 656.245(2) provides, in part, that "[i]f a claim for medical services is denied, the worker may submit to the Board a request for hearing pursuant to ORS 656.283."

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[8] At least two states have established statutory definitions for "peer review" activities. Texas defines "medical peer review committee" or "professional review body" as a decision-making entity that is "authorized to evaluate the quality of medical and health care services or the competence of physicians." Tex.Rev.Civ.Stat.Ann. art. 4495b (Vernon Supp.1993). Rhode Island defines "peer review board" as a committee that functions "to evaluate and improve the quality of health care rendered by providers of health care services or to determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health care services in the area * * *." R.I. Gen. Laws § 5-37-1(g) (1987). Those definitions support our conclusion that "peer review" is designed to assure the general adherence to the applicable standards of care, not to give persons a right of action or mechanism for contesting the quality or propriety of the care that they have received.

[9] Our conclusion is also supported by ORS 656.262, which governs a carrier's claims processing obligations. ORS 656.260 does not, by its terms, affect a carrier's duties under ORS 656.262. Therefore, it is some evidence that the legislature intended claimants who receive medical care from MCO providers to have the same rights as claimants who receive care from non-MCO providers. ORS 656.245(5), which provides that injured workers who receive care from MCO providers are to do so in the manner provided by the MCO contract, does not warrant a different conclusion.

We note the dissent's lengthy recitation of Senator Cohen's testimony regarding the "gatekeeping" function of MCOs. That testimony does nothing to answer the primary question posed by this case, viz., what the legislature meant by the terms, "utilization review, quality assurance and peer review." In any event, our interpretation of ORS 656.260 reaffirms the value and necessity of utilization review, quality assurance and peer review as tools designed to reduce health care costs, the primary concern the Senator sought to address.

By their terms, those provisions (which preexisted ORS 656.260) concern all workers, regardless of where they receive medical services. Because the legislature did not amend those subsections when it created the MCO statutory scheme, logic dictates that it intended workers to continue to have the right to request a hearing on denied medical services claims, unless expressly indicated otherwise. Because ORS 656.260 lacks such an express indication, we find that ORS 656.245(1)(a) and (2) are additional support for the conclusion that the Hearings Division had jurisdiction to resolve this dispute.

SAIF argues that, in view of ORS 656.260's confidentiality provisions, the legislature must have intended that the Director have exclusive jurisdiction over disputes regarding an MCO's disapproval of an attending physician's request for authorization of medical services. We disagree.

ORS 656.260(7) provides for the confidentiality of data generated pursuant to utilization review, quality assurance and peer review activities pursuant to ORS 656.260. Subsection (8) protects persons to participate in these activities from being examined regarding the activities or from being subject to civil damages for such participation. Subsection (9) establishes the confidentiality of MCO contracts.

We understand the confidentiality provisions ORS 656.260(7), (8) and (9) to concern only those activities over which the Director has been granted exclusive jurisdiction. It is clear that ORS 656.260(6) vests in the Director exclusive jurisdiction over "[u]tilization review, quality assurance and peer review activities pursuant to this section and authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245 (3) * * *."[10] Because we have concluded that actions regarding an attending physician's request for authorization of medical services does not constitute "utilization review, quality assurance or peer review activities," and because an attending physician is not "other than an attending physician pursuant to ORS 656.245 (3)", it follows that ORS 656.260(7), (8) and (9) have no bearing on this matter.[11]

Since we have determined that ORS 656.260 did not grant the Director exclusive jurisdiction over a dispute regarding an MCO's disapproval of an attending physician's request for authorization of medical services, we conclude that the last sentence of ORS 656.704(3) does not, by virtue of ORS 656.260, exclude the dispute from the matters concerning a claim for which a claimant may request a hearing under ORS 656.283(1). See Martin v. City of Albany, supra, 320 Or at 180.

SAIF argues that, because the Director's rules pursuant to ORS 656.260 establish a procedure by which the Director may review unresolved MCO medical services disputes, see OAR 436-15-008, 436-15-110(1), a procedure for resolving the dispute exists.[12] Therefore, it argues, under ORS 656.704(3), this is not a matter concerning a claim over which the Board and its Hearing Division may exercise jurisdiction.

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[10] In acknowledging the Director's exclusive jurisdiction over and the confidentiality of utilization review, quality assurance and peer review activities, we wish to assure the medical community that our decision today seeks to respect the confidentiality of those activities. Future cases may present issues concerning the confidentiality provisions of ORS 656.260. However, at this juncture, our primary hope is that, by construing ORS 656.260 as we have today, the evaluation of the propriety and necessity of an injured worker's medical services will be kept separate from the internal, confidential processes whereby an MCO seeks to maintain the high quality of its medical services. If our hope is realized, the confidentiality provisions of ORS 656.260 will not be implicated in routine cases concerning the reasonableness or necessity of medical services.

[11] The thrust of SAIF's argument is that, if the Hearings Division has jurisdiction over these matters, a referee may determine, under ORS 656.283(7), that disclosure of an MCO contract is necessary. An analogous issue has arisen in cases in which a claimant has sought by subpoena the disclosure of an MCO contract. We fail to see what bearing an MCO contract would have on a medical services dispute such as that present here. In any event, that issue is not before us in this case.

[12] SAIF relies on Haynes v. Weyerhaeuser, 75 Or App 262 (1985), wherein the Court of Appeals held that ORS 656.248 (since amended by Or Laws 1987, ch 884, § 42, Or Laws 1990, ch 2, § 14), which concerned the resolution of medical fee disputes, vested exclusive jurisdiction in the Director. In so concluding, the court noted, "The administrative rules provide a framework for resolution by the Director of medical fee disputes." Id. at 265. SAIF argues that, because the Director's rules pursuant to ORS 656.260 provide a framework for resolution of disputes regarding the authorization of services provided by MCO participants, under ORS 656.704(3), only the Director has jurisdiction to resolve those disputes. SAIF's reliance on Haynes is misplaced. There, a statute authorized the Director to promulgate the administrative framework for resolving fee disputes. Here, no such authorization is forthcoming in ORS 656.260 with respect to the issues presented by this case.

SAIF misses the point. A provision in ORS chapter 656, not the administrative rules, must establish a procedure for resolving the medical services dispute. See ORS 656.704(3); see also Meyers v. Darigold, Inc., 123 Or App 217, 222 (1993). In other words, the lack of a statutory procedure cannot be saved by the provision of a procedure in the Director's rules that purports to establish a mechanism of administrative review of MCO medical treatment disputes.[13]

Having reached these conclusions, we are still left with the question of who has jurisdiction to review an MCO's disapproval of an attending physician's request for authorization of medical services. On the basis of our review of the statutory scheme as a whole, we conclude that the answer depends on the type of medical services at issue. To resolve this question, we resort to the statutes in ORS chapter 656 governing medical services disputes generally. Those statutes reveal the following:

If the request concerns a palliative care dispute, review is governed by ORS 656.245(1)(b), which authorizes an attending physician to request Director review of a denied request for such care. The Director is then required to appoint a panel of physicians pursuant to ORS 656.327(3) to review the carrier's decision not to reimburse of the palliative care. ORS 656.245(1)(b).

If the issue is whether disputed care is palliative versus curative, review depends on whether the worker "is receiving", has received, or will receive the care. With the former (is receiving and has received), ORS 656.327 applies. Therefore, if one of the parties "wishes" Director review in a case where the substantive issue is whether the disputed treatment that a claimant is receiving or has received is palliative or curative, the Director has exclusive jurisdiction over the matter. Theodore v. Safeway Stores, Inc., 125 Or App 172, 176 (1993). However, if no one "wishes" Director review in such a case, jurisdiction lies with the Board and its Hearings Division. Id. If the case involves proposed palliative care, review is conducted pursuant to ORS 656.283, as with any other matter concerning a claim. Id.

If the request concerns the reasonableness or necessity of curative care that an injured worker "is receiving", review is governed by ORS 656.327(1). That statute authorizes an injured worker, a carrier or the Director to "wish" review by the Director, in which case exclusive jurisdiction vests with the Director. Meyers v. Darigold, Inc., supra, 123 Or App at 222. Review of the Director's order is through ORS 656.283's expedited hearing procedures, except that the Director's order may be modified only if it is not supported by substantial evidence in the record. ORS 656.327(2). If no one "wishes" for Director review under ORS 656.327(1), the Hearings Division has jurisdiction to review the matter ab initio pursuant to ORS 656.283. Meyers v. Darigold, Inc., supra, 123 Or App at 222.

Finally, if the request concerns the reasonableness or necessity of proposed curative treatment, jurisdiction to review the request is vested solely with the Hearings Division pursuant to ORS 656.283. Martin v. City of Albany, supra; Jefferson v. Sam's Cafe, 123 Or App 464 (1993).[14]

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[13] ORS 656.260(11) authorizes the Director to "adopt such rules as may be necessary to carry out the provisions of this section." That grant of authority does not imbue the Director with authority to promulgate rules that exceed the scope of the statute itself. Because ORS 656.260 does not concern the administrative review of MCO decisions regarding attending physicians' requests for authorization of medical services, it follows that the Director lacks authority to promulgate rules regarding that subject.

We recognize that, to some extent, the Director's rules may not comport with our conclusions. OAR 436-15-030(1)(l) requires an MCO to provide adequate methods of "peer review and utilization review" to prevent inappropriate treatment, including the requirement that physicians obtain prior approval of all elective surgeries prior to surgery being performed. This suggests that "peer review" includes an evaluation of the reasonableness and necessity of proposed medical treatment. We disagree. Under OAR 436-15-005(15), "peer review" includes only evaluation of care that has already been provided. The prior approval requirement of OAR 436-15-030(1)(l) does not follow from that definition.

SAIF also relies on OAR 436-10-046(1), which provides, in part, that "[d]isputes relating to treatment provided through a[n] MCO contract shall be processed through the MCO dispute resolution procedures established in accordance with OAR 436-15." Because we have concluded that ORS 656.260 does not govern attending physicians' requests for authorization of medical services, we conclude that OAR 436-10-046(1) has no bearing on this case.

[14] The Director's order in this matter issued before the decisions in Martin and Jefferson issued. The petitions for review in Jefferson and Meyers v. Darigold, supra, currently are being held pending a decision in Niccum v. Southcoast Lumber Co., 123 Or App 472 (1993), which recently issued. 320 Or 189 (1994).

Here, the issue concerns claimant's attending physician's request for authorization to perform spinal surgery. Because the request involves proposed curative medical services, under Martin and Jefferson, jurisdiction to review the proposed surgery request is vested solely in the Hearings Division.[15]

Before we address the medical services issue, we consider several matters raised by the dissent. First, we disagree with the dissent that this decision has "effectively unravelled" the reforms anticipated by the enactment of ORS 656.260. We have simply followed the traditional path of statutory construction, going from the text, to the context, to the legislative history, of ORS 656.260. The dissent's real problem is that it wishes to avoid the conclusions that inevitably flow from the proper analysis of those sources.

Next, we disagree with the dissent that, in interpreting the terms "utilization review, quality assurance and peer review", we have unduly restricted the Director's authority and ignored the confidentiality provisions of the ORS 656.260. The definitions we have adopted comport with the definitions common in the medical service community, and are supported by the statute itself. Furthermore, we have reaffirmed that the Director has exclusive jurisdiction over an MCO's utilization review, quality assurance and peer review activities and that those activities are, and should be, wholly confidential. See note 10, supra. This belies the dissent's arguments to the contrary.

Last, we take exception to the dissent's assertion that our decision has created a conflict between ORS 656.260(6) and ORS 656.283(7). The latter statute requires referees to conduct hearings "in any manner that will achieve substantial justice." The dissent believes that, under our decision, referees will be required to order the disclosure of confidential MCO review activities if they hope to satisfy the "substantial justice" requirement. We disagree, because an MCO's quality assurance, utilization review and peer review activities have no bearing on the processing of an individual worker's request for medical services. See note 10, supra.

In conclusion, we note that, were we to adopt SAIF's arguments regarding ORS 656.260, serious equal protection and other constitutional questions likely would have arisen, because we would have concluded that ORS 656.260 created a two-tiered system under which workers who received services from MCO health care providers would be entitled to fewer appellate rights than those workers who received services from non-MCO providers. We are unwilling to assume that the legislature intended to create such a constitutionally-suspect system. See Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526, 537 (1993). Accordingly, for the reasons stated herein, we affirm the Referee's decision denying SAIF's motion to dismiss the hearing request for lack of jurisdiction.

Medical Services

The Referee concluded that, based on the medical reports of Drs. Peterson, Reimer, McCarthy and Melgard, as well as CareMark's disapproval letters, claimant had failed to prove that the proposed L4-5 spinal fusion surgery was either reasonable or necessary. We disagree.

At the Director's behest, Dr. Melgard examined claimant on June 8, 1993. He determined that claimant might have a disc protrusion, and recommended a myelogram/CT scan. (Ex. 35-4, -5). Thereafter, on August 6, 1993, claimant underwent a myelogram/CT scan. Based on the CT scan, which revealed a soft tissue density at L4-5 (ex. 38), Dr. Grewe, treating surgeon, concluded that claimant had a far lateral L4-5 disc herniation that would benefit from the proposed internal fixation and fusion.

SAIF offered no evidence to controvert Dr. Grewe's final conclusion; instead, it relied on reports that preexisted the August 1993 myelogram/CT. Particularly, it relies on CareMark Comp's reports disapproving Dr. Grewe's request for surgery on the ground that the surgery was not medically necessary or appropriate. (Exs. 24, 27, 32). SAIF also relies on the October 1992 report of Drs. Peterson and Reimer, in which they concluded that claimant would not benefit from additional spinal surgery because of his history of back surgeries and because there was no evidence of spinal stenosis or instability. (Ex. 17).

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[15] Because the Director was without authority to rule on the propriety of claimant's proposed surgery, we perform our review without regard to the Director's order.

The August 1993 myelogram/CT reveals an L4-5 disc herniation that, according to Dr. Grewe, warrants surgical intervention. Because neither CareMark Comp nor the examining physicians were aware of this particular condition, their reports are entitled to little weight. Accordingly, in view of Dr. Grewe's status as one of claimant's treating physicians, and the lack of any timely evidence to the contrary, we conclude that claimant has established the reasonableness and necessity of the proposed L4-5 spinal fusion surgery. Accordingly, we reverse the Referee's decision upholding the Director's order to the contrary.

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 is $4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs and oral arguments), 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 November 10, 1993 is affirmed in part and reversed in part. The Referee's conclusion that claimant's proposed L4-5 spinal fusion surgery is not reasonable or necessary is reversed and the claim is remanded to the SAIF Corporation for processing in accordance with law. The remainder of the Referee's order is affirmed. The Department's motion to intervene is denied. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $4,500, to be paid by SAIF.

Board Member Gunn, specially concurring:

I concur and agree with the majority's well-reasoned decision. However, I am not sure that the statute and the court's previous holdings require the extensive analysis applied by the majority.

The main inquiry is who has jurisdiction? ORS 656.704 gives the Board exclusive jurisdiction over those matters concerning a claim. In SAIF v. Allen, 320 Or 192 (1994), the Supreme Court held that a request for medical services constituted a "claim" for compensation. In preceding cases pertaining to the "medical treatment / jurisdiction" question, the courts have determined that Director jurisdiction over disputes under ORS 656.327 is contingent on "wishing" such review, provided that the dispute does not pertain to a proposed treatment. Martin v. City of Albany, 320 Or 175 (1994); Meyers v. Darigold, Inc., 123 Or App 217 (1993). For disputes involving noncompensable palliative treatment, exclusive jurisdiction rests with the Director. Hathaway v. Health Future Enterprises, 320 Or 383 (1994).

This case concerns a request for proposed medical treatment. I find nothing in the language of ORS 656.245, 656.327, or 656.260 which would wrest such a matter from our jurisdiction. Even if we were to relinquish it, the court would only resettle this jurisdictional question by determining that this dispute constitutes a matter concerning a claim. Why waste all our time with so little profit and appear deaf to the court's previous instructions?

Board Members Neidig and Haynes dissenting.

This case presents one of the most complex and important jurisdictional issues this Board has had to face in years. It is no overstatement to say that the impact of our decision will be felt throughout the workers' compensation system in Oregon. For this reason, we are dismayed that the majority has misinterpreted legislative intent and effectively unraveled what the legislature sought to accomplish when it introduced managed care organizations (MCO's) as part of its comprehensive workers' compensation reform in 1990.

Under the Workers' Compensation Law prior to 1990, an injured worker's entitlement to medical services for a compensable injury was clearly, and without exception, a "matter concerning a claim" subject to the jurisdiction of the Board and its Hearings Division. That changed in 1990, however, when the rising costs of workers' compensation prompted calls for sweeping reform by the legislature. Rising costs of medical services, in particular, sparked controversy and engaged carriers/employers and medical service providers in a political tug-of-war. After the dust had settled, the legislature passed Senate Bill 1197, a comprehensive reform bill which, among other things, placed limitations on an injured worker's right to medical services.

Senate Bill 1197 also amended the statutory definition of "matters concerning a claim" to exclude "any proceeding for resolving a dispute regarding medical treatment...for which a procedure is otherwise provided in this chapter." ORS 656.704(3). In conjunction with that amendment, the legislature adopted ORS 656.260, which permits medical service providers to apply for MCO certification to provide managed care to injured workers. Subsection (6) of ORS 656.260 provides:

> "Utilization review, quality assurance and peer review activities pursuant to this section and authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245(3) shall be subject solely to review by the director or the director's designated representatives." (Emphasis supplied.)

The dispositive issue in this case is whether the disapproval by Caremark Comp, a certified MCO, of claimant's proposed back surgery falls within "[u]tilization review, quality assurance and peer review activities" which are subject to the Director's exclusive review authority. If so, we must then conclude that ORS 656.260(6) provides a procedure for resolving this medical treatment dispute, and this proceeding is excluded from "matters concerning a claim" pursuant to ORS 656.704(3).

The majority holds that an MCO's disapproval of proposed surgery is not a "utilization review, quality assurance or peer review" activity, reasoning that such activities do not involve the approval or disapproval of treatment proposed for an injured worker. The majority's reasoning is flawed; it overlooks both the context of ORS 656.260 and the legislature's conception of MCO's as "gatekeepers" in the delivery of medical services.

Although the terms "utilization review," "quality assurance" and "peer review" are not defined in the Workers' Compensation Law, their meanings can be discerned from the context of ORS 656.260. Subsection (4)(d), for example, uses the terms "peer review" and "utilization review" in setting forth the requirements for MCO certification; it states that the MCO plan must provide:

> "adequate methods of peer review, service utilization review and dispute resolution to prevent inappropriate or excessive treatment, to exclude from participation in the plan those individuals who violate these treatment standards and to provide for the resolution of such medical disputes as the director considers appropriate." ORS 656.260(4)(d) (Emphasis supplied.)

This subsection establishes that an objective of MCO peer review and service utilization review is to prevent inappropriate or excessive treatment. The plain meaning of "prevent" is "to keep from occurring; stop." Random House Webster's College Dictionary 1071 (Glencoe Ed., 1991). Hence, the prevention of inappropriate or excessive treatment requires that treatment be subject to review and approval (or disapproval) prior to its performance. That review would, in our view, necessarily require an evaluation of the appropriateness of proposed treatment under the particular circumstances of the individual worker. In this context, the legislature must have contemplated that an MCO's peer review and utilization review would result in the approval or disapproval of treatment proposed for individual workers.

The legislative history supports our view. During Senate Floor Debate on Senate Bill 1197 in 1990, Senator Cohen discussed the need for MCO's as "gatekeepers" in the delivery of medical care to workers:

> "[O]ne of the items frequently judged as contributing to the increased costs of workers' compensation has been increased costs in medical care. **** Everybody has their own idea of what's caused it, whether it's overutilization or cost shifting that has gone on by specific medical providers. The fact is that yes our costs to the workers' compensation system have increased greatly in the medical delivery area. The people who worked on this bill have acknowledged I think that there is a need for gatekeepers, that we have to restructure the way we at least provide medical care for workers. There is an effort in this bill to provide encouragement for those medical providers to organize themselves as managed care organizations. I add it has some clear directions as to what their mission ought to be: That they have quick, appropriate choice of doctors for injured workers and that the medical care is delivered in a reasonable, convenient way for the injured workers. ****

> "[T]he mission has to be a timely, effective, convenient health care delivery service for the workers and they, it should provide appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service. The criteria also provides adequate methods of peer review, service utilization review and dispute resolution in order to become a managed care organization." Testimony of Senator Cohen, Tape Recording, Senate Floor Debate on Workers' Compensation, May 7, 1990, Tape 3, Side A at 266-87, 425-60. (Emphases supplied.)

Senator's Cohen's comments reveal that the statutory MCO scheme was created for the purpose of controlling rising medical service costs and the overutilization of medical care for injured workers. MCO utilization review serves that purpose by disapproving excessive or otherwise inappropriate treatment, thereby carrying out the MCO's acknowledged role as a "gatekeeper" in the delivery of medical care to injured workers.[1]

Our construction of ORS 656.260 is supported by the Director's administrative rules, which require the MCO to provide adequate methods of "peer review and utilization review" to prevent inappropriate treatment, including the requirement that physicians obtain prior approval of all elective surgeries before surgery is performed. OAR 436-15-030(1)(l). That is precisely the MCO review activity which gave rise to the medical treatment dispute now before us. Under the Director's rules, therefore, the MCO's disapproval of claimant's proposed surgery is subject to the Director's exclusive jurisdiction pursuant to ORS 656.260(6).

Despite the statutory objective of MCO peer review and utilization review to prevent inappropriate and excessive treatment, the majority concludes that the authorization (or disapproval) of treatment involves something other than peer review or utilization review. The majority relies on the portion of ORS 656.260(6) which grants to the Director exclusive jurisdiction over the "authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245(3)." The majority reasons that, by listing the authorization of medical services provided by a non-attending physician separately from "utilization review, quality assurance and peer review activities," the legislature must have intended those activities to mean something other than the authorization (or disapproval) of treatment provided by a physician. The majority misreads ORS 656.260(6).

The language "authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245(3)" must be construed to give effect to the phrase "pursuant to ORS 656.245(3)." Under the majority's construction, that phrase merely refers to the worker's limited right to select and change an attending physician under ORS 656.245(3)(a). However, inasmuch as the term "attending physician" has already been used in ORS 656.260(6), why would the legislature then add the reference to ORS 656.245(3)? The majority has no explanation for that addition. Under its construction, the phrase "pursuant to ORS 656.245(3)" adds nothing to "attending physician"; it is superfluous and without significance.

We disagree. In our view, the phrase "pursuant to ORS 656.245(3)" has a very significant meaning; it refers to ORS 656.245(3)(b), which sets forth the worker's limited right to choose a medical service provider who is neither an attending physician nor a member of an MCO. Subparagraph (A) of that statute provides that a medical service provider who is not qualified to be an attending physician may provide compensable medical services to an injured worker for 30 days from the date of injury or for 12 visits, whichever first occurs, without authorization from the attending physician. Thereafter, the attending physician must provide written authorization for the services.

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[1] Our interpretation is consistent with the legislature's use of the term "utilization review" in the health maintenance organization (HMO) context. In the statute governing group health insurance coverage for treatment of chemical dependency and mental and nervous conditions, "utilization review" is defined to include "prior approval [of treatment], concurrent review of the continuation of treatment, post-treatment review or any combination of these." ORS 743.556(16)(b)(D). The Court of Appeals has interpreted that language as permitting an HMO to pre-authorize treatment. Oregon Psychological Assn. v. Physicians Assn., 108 Or App 541, 546 (1991). Similarly, we believe that MCO "utilization review" activities to prevent inappropriate or excessive treatment also involves pre-authorization review of treatment proposed for workers.

Under our construction, therefore, ORS 656.260(6) grants to the Director exclusive jurisdiction over both: (1) the authorization (or disapproval) of medical services for an accepted condition, to be provided by a non-MCO, non-attending physician under the limited circumstances set forth in ORS 656.245(3)(b)(A); and (2) the authorization (or disapproval) of medical services for an accepted condition, to be provided under an MCO plan by an MCO-enrolled physician or an attending physician (pursuant to the "primary care physician" exception under ORS 656.260(4)(g)). Our construction, unlike the majority's, gives effect to every word of ORS 656.260(6). See ORS 174.010.

Furthermore, our construction is consistent with the regulatory scheme of ORS 656.260 which grants to the Director exclusive authority to regulate MCO activities. Under those provisions, the Director is authorized to review the proposed MCO plan for the provision of services, ORS 656.260(3)(a); to certify a qualified MCO, ORS 656.260(4); to monitor medical and health care service cost and utilization under the MCO plan, ORS 656.260(4)(f); to prescribe any other requirements necessary for the MCO to provide quality medical services and health care to injured workers, ORS 656.260(4)(h); to suspend or revoke certification of the MCO, ORS 656.260(5); and to adopt such rules as may be necessary to carry out the provisions of the statute, ORS 656.260(11). We believe it is consistent with this regulatory scheme for the Director to have exclusive jurisdiction over an MCO's authorization (or disapproval) of medical treatment.

Our construction is also consistent with the confidentiality provisions of ORS 656.260, which grant to the Director discretionary authority over the disclosure of information relating to MCO review activities. ORS 656.260(6) provides that data generated by or received in connection with utilization review, quality assurance and peer review activities is confidential and shall not be disclosed except as considered necessary by the Director. ORS 656.260(7) further provides that no data generated by utilization review, quality assurance or peer review activities can be used in any action, suit or proceeding except to the extent considered necessary by the Director.[2] Inasmuch as MCO review activities have the express purpose of preventing inappropriate or excessive treatment, see ORS 656.260(4)(d), information generated by or received in connection with those activities would likely be considered by the MCO in approving/disapproving treatment proposed for a particular worker. That information could be relevant to any subsequent review of an MCO decision to disapprove treatment. The legislature's grant to the Director of authority over the disclosure of that information supports our conclusion that the legislature also intended to grant exclusive review authority to the Director.

Under the majority's decision, however, the confidentiality provisions in ORS 656.260 will either be compromised or ignored. The conclusion that the hearings referee has jurisdiction to review an MCO's disapproval of treatment will bring the confidentiality provisions directly into conflict with the hearings referee's duty to "conduct the hearing in any manner that will achieve substantial justice." ORS 656.283(7). The hearings referee cannot achieve substantial justice in reviewing an MCO's disapproval of treatment without having some authority over the disclosure of information generated by the MCO's review activities, particularly given the statutory requirement that workers subject to an MCO contract "receive medical services in the manner prescribed in the contract." See ORS 656.245(5). The absence of such authority supports our conclusion that it is the Director, rather than the hearings referee, who has jurisdiction over an MCO's disapproval of treatment. In short, our construction of ORS 656.260(6) achieves the statutory objective of MCO review activities to prevent inappropriate or excessive treatment, and gives effect to the confidentiality provisions in ORS 656.260 without impairing the hearings referee's ability to achieve "substantial justice" pursuant to ORS 656.283(7). See Vaughn v. Pacific Northwest Bell Telephone, 289 Or 73, 83 (1980) (Court will avoid a statutory construction which creates a conflict between statutes or renders one statute ineffective).

The majority states that "serious equal protection and other constitutional questions" would arise if ORS 656.260(6) was interpreted to grant to the Director exclusive jurisdiction of an MCO's disapproval of treatment. Reasoning that that interpretation would create a two-tiered system under which workers subject to an MCO contract would receive fewer appellate rights than those workers who are not subject to such a contract, the majority concludes that such a "constitutionally suspect" system could not have been intended by the legislature. However, inasmuch as claimant did not exhaust his remedies under the Director's review procedures, but instead, requested a hearing before the hearings referee, we find

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[2] The confidentiality provisions of ORS 656.260 do not, however, affect the confidentiality or admission in evidence of a claimant's medical treatment records. ORS 656.260(10).

the majority's constitutional concerns to be speculative and premature.[3] In any event, non-MCO treatment disputes are already subject to different tiers of appellate rights, depending on various factors, including whether the treatment is a palliative care dispute subject to ORS 656.245(1)(b). See Martin v. City of Albany, 320 Or 175 (1994). If different tiers of appellate review are permissible for non-MCO treatment disputes, why are they not permissible in the MCO context? Finally, even if we assumed, for the sake of argument, that the Director's review procedures were unconstitutional, that fact alone would not invest the Hearings Division with jurisdiction over MCO's treatment disputes; rather, it would be up to the Director to promulgate rules and implement procedures to ensure a constitutional review of such disputes.

Claimant contends that, because SAIF did not timely accept his claim for the proposed surgery, SAIF had "de facto" denied his surgery claim, and the Hearings Division had jurisdiction to review the "de facto" denial. Claimant overlooks ORS 656.245(5) which provides that "workers who are subject to the [MCO] contract shall receive medical services in the manner prescribed in the contract." Although SAIF has the general duty to process medical services claims, see ORS 656.262(1), inasmuch as claimant was subject to the contract between SAIF and its certified MCO, Caremark Comp, we believe SAIF fulfilled its claim processing duty by referring claimant's surgery request to Caremark Comp for review. Because Caremark Comp's disapproval of the surgery request fell within its utilization review, quality assurance and peer review activities, its decision was "subject solely to review by the director or the director's designated representatives." ORS 656.260(6) (Emphasis supplied). Under these circumstances, a ruling that the Hearings Division has jurisdiction of this medical treatment dispute on a "de facto" denial theory, despite the MCO's involvement, would circumvent the legislature's intent to grant exclusive jurisdiction of the dispute to the Director.

In conclusion, we find that ORS 656.260(6) provides for exclusive Director review of an MCO's disapproval of proposed treatment as excessive or inappropriate for an accepted condition. Here, Caremark Comp determined that claimant's proposed surgery was inappropriate for his accepted back condition. Because there is a procedure "otherwise provided" under ORS 656.260(6) for resolving this medical treatment dispute, we conclude this is not a matter concerning a claim over which the Board and its Hearings Division have jurisdiction. See ORS 656.704(3). Accordingly, we would grant SAIF's motion to dismiss claimant's hearing request for lack of jurisdiction.

Finally, we are mindful of the Board's decision in James A. Kinslow, 44 Van Natta 2119 (1992), wherein it was stated that peer review activities "are meant to be an internal review process only and are intended to be a way for the MCO or insurer to insure that member physicians are following accepted standards of care." Id. at 2120. However, the issue in Kinslow was whether the claimant's hearing request, which was filed one day prior to his physician's request to the MCO for pre-certification for surgery, was premature. The Board concluded that it was premature. The subsequent discussion of MCO "peer review" activities was unnecessary to the decision and was, therefore, dicta. Insofar as Kinslow is inconsistent with our opinion and the Director's rule defining "peer review," it should be disavowed.

Because the majority's decision strips ORS 656.260 of its intended meaning and undercuts the role of MCO's as "gatekeepers" in the delivery of medical services to injured workers, we respectfully dissent.

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[3] The Director's rules provide contested case procedures for the resolution of MCO-related disputes. Any party may challenge the final decision rendered by an MCO concerning a medical treatment dispute by requesting Director review. OAR 436-15-110(1). The Director may resolve the dispute by issuing an order. Id. A party who disagrees with the Director's order may obtain a contested case hearing. OAR 436-15-008(2), (3). Under the Administrative Procedures Act, the contested case order is appealable to the Court of Appeals. ORS 183.482. Given the Director's contested case procedures and the right to judicial review of the Director's decision, we disagree with the majority's characterization of the Director's review procedures as "constitutionally suspect."

In the Matter of the Compensation
EWELL McCRAE, Claimant
WCB Case No. C4-03204
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gatti, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On December 21, 1994, 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, pro se, releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

As submitted, the CDA provided claimant's signature and the signature of the insurer's attorney. Subsequent to our acknowledgment of the parties' CDA, the insurer advised the Board that it had received notice of an attorney fee lien from claimant's former counsel. Upon receipt of the insurer's letter, the Board requested that claimant, claimant's former counsel, and the insurer provide written responses, by January 31, 1995 explaining their respective positions on the attorney fee issue. In response to our request, we have received replies from the insurer and claimant's former attorney. As the time for receiving responses has now expired, we proceed with our review of this matter.

Claimant's former counsel has submitted an attorney fee lien and affidavit in support, claiming entitlement to 25 percent ($750) of the total CDA proceeds ($3,000). Claimant's former counsel asserts that, originally, former counsel recommended claimant accept a $10,500 CDA offered by the insurer. Former counsel contends that, after being fired by claimant, claimant and the insurer entered into a disputed claim settlement (DCS) for $9,000, and a CDA for $3,000.

The insurer's response provides that the "overall settlement" obtained between claimant and the insurer is different from the settlement proposed by claimant's former counsel. The insurer contends that claimant's former counsel negotiated only a CDA, whereas claimant and the insurer subsequently agreed to both a DCS and a CDA for more money than was originally offered when claimant's counsel was involved. In light of such circumstances, the insurer asks that the CDA "be approved without further consequences" to it, leaving claimant and his former attorney "with options outside the workers' compensation arena."

No response has been received from claimant, and claimant's former counsel has not submitted a response to the insurer's contentions. For the following reasons, we approve the CDA, but decline to approve an attorney fee for claimant's former counsel.

Because we have not received a response from claimant, we conclude that claimant wishes approval of the CDA as drafted. In other words, we construe claimant's lack of a response as a disagreement with the attorney fee lien asserted by former counsel. Accordingly, we find this case distinguishable from Billy Lemons, 46 Van Natta 2428 (1994). In Lemons, the claimant's former counsel filed a notice of lien seeking an attorney fee from the CDA proceeds as payment for services rendered during negotiations which preceded the CDA. However, in Lemons, the claimant raised no objection to his former counsel's request, as long as the amount of the attorney fee to be approved was the same as agreed to in prior negotiations. Under such circumstances, we approved the CDA and directed that a portion of the proceeds be distributed by the carrier to the claimant's former counsel.

In the present case however, we have not received claimant's agreement that former counsel is entitled to the attorney fee asserted. Moreover, as noted by the insurer, the CDA currently before the Board, from which former counsel requests an attorney fee, is apparently not the same as the settlement previously negotiated by claimant's former counsel. Additionally, former counsel has not disagreed with the insurer's contention that the current CDA is not the same settlement as was previously reached by former counsel on claimant's behalf. Therefore, we are unable to find that claimant's former counsel rendered services on behalf of claimant in reaching this particular CDA..

Finally, we note that claimant's former counsel has not filed an executed attorney retainer agreement as required by the Board's rule. OAR 438-15-010. Accordingly, for the aforementioned reasons, we decline to approve an attorney fee as requested by claimant's former counsel.

The parties' CDA, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

In the Matter of the Compensation
LORI R. NEVEAU, Claimant
WCB Case No. 93-12297
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Crumme's order that: (1) found that claimant's psychological condition claim had not been prematurely closed; and (2) upheld the self-insured employer's "back-up" denial of her temporomandibular joint [TMJ] 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 exception of paragraph 22 (finding that claimant's accepted psychological condition was medically stationary as of June 1, 1993).

CONCLUSIONS OF LAW AND OPINION

Claimant was sexually harassed by a male coworker, Mr. Velmere, on more than one occasion between April and June of 1992. Claimant states that she developed tension headaches as a result of that harassment. Following a meeting with the employer's representatives investigating the matter, claimant's headaches worsened and she sought medical treatment, for which she subsequently filed a workers' compensation claim. On January 29, 1993, the employer accepted claimant's psychological condition claim as generalized anxiety disorder.

Thereafter, claimant was diagnosed as suffering from TMJ syndrome. Claimant filed a second workers' compensation claim on March 24, 1993, asserting that her TMJ symptoms began after she was "violently" shaken about the neck and shoulders by Mr. Velmere that previous April. (Ex. 24). The employer accepted this condition on May 12, 1993. (Ex. 27AA).

On June 1, 1993, the employer closed claimant's psychological condition claim pursuant to a Notice of Closure. Claimant requested reconsideration, arguing that her psychological condition was not medically stationary. An August 27, 1993 Order on Reconsideration agreed with claimant and set aside the Notice of Closure as premature. Also on June 1, 1993, the employer had issued a "back-up" denial of claimant's TMJ condition based on insufficient evidence of a causal connection between that condition and the sexual harassment she suffered at work. (Ex. 29).

Premature Closure

It is claimant's burden to prove that her 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 June 1, 1993 Notice of Closure, considering claimant's condition at the time of closure and not 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).

Claim closure is premature if any compensable condition is not medically stationary. Rogers v. Tri-Met, 75 Or App 470 (1985); cf. Michael L. Millican, 45 Van Natta 1738 (1993). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). 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).

In issuing its Order on Reconsideration that set aside the employer's June 1, 1993 Notice of Closure as premature, the Appellate Unit of the Department of Consumer and Business Services[1] relied upon the July 23, 1993 opinions of the medical arbiters, Dr. Klecan (psychiatrist) and Dr. Bellville (psychiatrist). (Ex. 33-4). Conversely, finding claimant's psychological condition to be medically stationary and reinstating the Notice of Closure, the Referee relied upon the opinions of Dr. Turco (psychiatrist), Dr. Bergstrom and an "addendum" opinion from Dr. Klecan. As discussed below, we find that the July 1993 opinions of the medical arbiters are the most persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

On July 23, 1993, claimant was examined separately by the two medical arbiters concerning her accepted psychological condition. Dr. Klecan stated that claimant "continues to have some anxiety symptoms related to the work stress," and that she required further treatment. (Ex. 31C-6). Similarly, Dr. Bellville (psychiatrist) recommended possible therapies (e.g., biofeedback, panic attack support group, assertiveness training), and cautioned that claimant's anxiety symptoms "might continue" without therapy and a change in the "stressor at work." (Ex. 31D-4).

On May 24, 1993, the employer received a letter from Dr. Bergstrom, who treated claimant for her TMJ syndrome. It was his opinion that claimant's generalized anxiety disorder was medically stationary at that time. (Ex. 28). However, Dr. Bergstrom provided no reasoning or explanation for his opinion. Furthermore, he is not a psychiatrist and has not treated claimant for her psychological condition.

At the request of the employer, claimant was also examined by Dr. Turco. (Ex. 36). Dr. Turco opined that claimant's generalized anxiety disorder was medically stationary in June 1993. (Ex. 36-6). Notably, Dr. Turco examined claimant only once, in November 1993, yet he provides no explanation for his conclusion that claimant was medically stationary five months earlier. Dr. Bergstrom subsequently concurred with the opinion of Dr. Turco, but offered no explanation. (Ex. 37).

On November 10, 1993, the employer's counsel solicited an "addendum" letter from one of the medical arbiters, Dr. Klecan. (Ex. 35). The Referee considered this report in determining claimant's medically stationary date. As an initial matter, claimant argues that Exhibit 35 was solicited in violation of administrative guidelines and, therefore, the Referee was precluded from relying upon it. (App. Br. at 9). We agree, but for the following reason.

A "supplemental" or "clarifying" report from the medical arbiter or panel of arbiters, which is generated after the initial arbiter report and the Order on Reconsideration, is not admissible under ORS 656.268(7) and 656.268(6)(a). Daniel L. Bourgo, 46 Van Natta 2505(1994); cf. Ryan F. Johnson, 46 Van Natta 844 (1994).

As we discussed in Bourgo, the implementation of the medical arbiter process during the 1990 legislative session was intended as a significant step toward providing a nonlitigious, less costly administrative forum for resolving extent of disability issues. To permit the parties to solicit supplemental opinions from the medical arbiters would tend to further the very same "dueling doctors" and litigious system the legislature was attempting to avoid. Daniel L. Bourgo, supra.

Pursuant to our de novo review, we conclude that Exhibit 35 is not admissible for the purpose of establishing whether claimant was medically stationary as of June 1, 1993. Dr. Klecan's "addendum" letter was authored after the initial medical arbiters' reports of July 23, 1993, and after the August 27, 1993 Order on Reconsideration that set aside the June 1993 Notice of Closure as premature. Consequently, that supplemental report cannot be considered. Daniel L. Bourgo, supra.

Furthermore, as discussed above, we find that the opinion of Drs. Bergstrom and Turco are not fully explained and, therefore, are less persuasive than the complete and well-reasoned opinions of the medical arbiters. See Somers v. SAIF, supra. Based upon the July 23, 1993 opinions of Drs. Klecan and Bellville, we find that claimant's generalized anxiety disorder was not medically stationary as of June 1, 1993. Thus, we find that claimant's psychological condition claim was prematurely closed. Rogers v. Tri-Met, supra. Accordingly, we reinstate the August 27, 1993 Order on Reconsideration, which set aside the June 1, 1993 Notice of Closure as premature.

[1] We note that the Department of Consumer and Business Services was formerly the Department of Insurance and Finance.

"Back-Up" Denial

The Referee found that claimant misrepresented certain material circumstances surrounding the sexual harassment she suffered at the hands of Mr. Velmere. Primarily, the Referee focused on claimant's consistent representation to the employer and her physicians that, while at work, Mr. Velmere came running up behind her and shook and/or choked her "violently." (Exs. 24, 25B-1, 25C, 26-1). Claimant attributed the onset of her TMJ symptoms to that April 1992 incident. On her Form 801, she stated:

> "I was sitting down at a table and. Dave Velmere ran up behind me and put his hands on my shoulders[,] neck and throat and shook me violently[.] I told him to stop it[.] He ran around the large table and ran up to me again and shook me very violently[.] Again I told him to stop it." (Ex. 24).

Later testimony from an eyewitness, Ms. Fong, substantially contradicted claimant's version of events. Specifically, Ms. Fong testified that Mr. Velmere walked around a table and lightly shook claimant by the shoulders for a couple seconds. (Tr. 63-64). Ms. Fong also testified that it was a friendly atmosphere, claimant was laughing at the time, did not protest Mr. Velmere's actions, did not exhibit any discomfort, nor was her head jerked back. (Tr. 65). Based on the consistency of the witnesses' testimony, their potential biases and their demeanor, the Referee found Ms. Fong was the more credible historian.

Under these circumstances, the Referee concluded that claimant made a material misrepresentation and, therefore, ORS 656.262(6) did not apply. See Randy G. Harbo, 45 Van Natta 1676 (1993). Instead, the standard applied by the Referee was whether claimant's misrepresentation was sufficiently material so that it could have reasonably affected the employer's decision to accept her claim for the TMJ condition. See Ebbtide Enterprises v. Tucker, 303 Or 459 (1987). Concluding that the misrepresentation was material, and that the employer's "back-up" denial was proper, the Referee found that claimant failed to prove the compensability of her TMJ syndrome. See Tony N. Bard, 45 Van Natta 1225 (1993).

Arguing that her characterization of the shaking incident as "violent" does not rise to the level of a misrepresentation, claimant contends that the Referee erred in applying the Ebbtide standard. Alternatively, claimant contends that if the characterization was a misrepresentation, it was not material because the information necessary to reach such a conclusion was available at all times prior to the employer's decision to accept the claim. See SAIF v. Abbott, 103 Or App 49 (1990). We disagree with both assignments of error.

Contrary to claimant's assertions, we note that her misrepresentation extended beyond the use of the adverb "violent" on her Form 801. (App. Br. at 12). The employer's claims examiner, Ms. Worley, testified that the decision to accept claimant's TMJ condition was based upon her description of the incident on her Form 801 and her contemporaneous statements to her medical providers. (Tr. 130-131). Furthermore, Ms. Worley stated (without contradiction) that the employer had no knowledge of Ms. Fong's observations until after accepting the claim. (Tr. 133-134).

Prior to the employer's May 12, 1993 acceptance of claimant's TMJ condition, it received separate medical reports from Dr. Yanney (dental surgeon), Dr. TenHulzen (dental surgeon) and Dr. Ironside, MD, indicating that the incident with Mr. Velmere was considerably more physically traumatic than reflected by Ms. Fong's recollection. Specifically, on April 9, 1993, Dr. Ironside noted that claimant had been choked and shaken by Mr. Velmere. (Ex. 25B-1). Also on April 9th, Dr. Yanney received a history from claimant that Mr. Velmere had "assaulted her from behind, put a choke hold on her neck, and shook her several times forward and back." (Ex. 25C). Similarly, the history claimant gave Dr. TenHulzen on April 21, 1993, indicated that she had been violently shaken by Mr. Velmere. (Ex. 26). Drs. Yanney and TenHulzen both indicated that a very violent episode of shaking could have caused the traumatic onset of claimant's TMJ syndrome. (Exs. 25C & 26-4).

The Referee found that claimant's recollection of the incident with Mr. Velmere was inconsistent and unreliable. Instead, the Referee found Ms. Fong to be the more credible historian. We defer to that finding because of the Referee's opportunity to observe the witnesses. See Humphrey v. SAIF 58 Or App 360 (1982). Furthermore, based on the substance of the witnesses' testimony, we conclude that Ms. Fong was credible, while claimant was not. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Considering Ms. Fong's credible testimony that claimant was not in fact violently shaken or choked by Mr. Velmere, we conclude that claimant misrepresented the circumstances of that April 1992 incident. Thus, we turn to the issue of whether those misrepresentations were material.

Based upon the reports from Drs. Ironside, Yanney and TenHulzen, and claimant's statements, the employer accepted her TMJ syndrome. However, upon receiving the information from Ms. Fong, the employer issued its "back-up" denial. The eyewitness account from Ms. Fong provided previously unknown grounds that could have reasonably affected the employer's decision to accept the claim. Ebbtide Enterprises v. Tucker, supra.

In light of such circumstances, we are persuaded that the new information provided by Ms. Fong, which indicated that claimant was neither choked nor shaken violently (as claimant represented to both her physicians and her employer), could have reasonably affected the employer's decision to accept the claim. Ebbtide Enterprises v. Tucker, supra. Accordingly, we find that the employer's "back-up" denial is proper; and, therefore, the burden shifts to claimant to prove the compensability of her injury claim for TMJ syndrome. Tony N. Bard, supra.

Compensability

We adopt and affirm that portion of the Referee's order that found claimant had failed to prove the compensability of her TMJ condition.

Attorney Fees

Inasmuch as we found that claimant's occupational disease claim was prematurely closed, we conclude that claimant's attorney is entitled to an attorney fee payable from any increased compensation created by this order, not to exceed $3,800, and payable directly to claimant's counsel. ORS 656.386(2); OAR 438-15-055.

Claimant is also entitled to an assessed attorney fee for services at hearing regarding the self-insured employer's request for hearing of the August 27, 1993 Order on Reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing concerning the premature closure issue is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by 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 March 3, 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 August 27, 1993 Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded 25 percent of the increased compensation resulting from this order, not to exceed $3,800, payable by the self-insured employer directly to claimant's attorney. For services at hearing regarding the employer's unsuccessful appeal of the Order on Reconsideration, claimant's attorney is awarded $1,000, to be paid by the employer. The remainder of the Referee's order is affirmed.

February 2, 1995 Cite as 47 Van Natta 211 (1995)

In the Matter of the Compensation of
RICHARD J. TASKINEN, Claimant
WCB Case No. 93-10255
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of that portion of Referee Emerson's order which: (1) found that the Director lacked jurisdiction to resolve a dispute regarding a proposed surgery; and (2) found that claimant's medical services claim for proposed low back surgery was appropriate. In his brief, claimant contends that the Referee erred in not awarding an assessed attorney fee under ORS 656.386(1). Claimant also moves for a remand for consideration of additional evidence. On review, the issues are

medical services, attorney fees and remand. We deny the motion for remand and affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing concerning the Director's August 18, 1993 Proposed and Final Order Concerning a Bona Fide Medical Services Dispute, which found that proposed low back surgery was not reasonable and necessary. The Referee held that the proposed surgery, consisting of a L4-5 fusion, was reasonable and necessary. In reaching this conclusion, the Referee reviewed the hearing record de novo in accordance with Jefferson v. Sam's Cafe, 123 Or App 464 (1993); and Niccum v. Southcoast Lumber Co., 123 Or App 472 (1993). The Referee was correct. Martin v. City of Albany, 320 Or 175 (1994); Niccum v. Southcoast Lumber Co., 320 Or 189 (1994). Moreover, we agree with and adopt the Referee's reasoning and conclusion that the proposed surgery was reasonable and necessary. Given this conclusion, we deny claimant's request for remand for the taking of additional evidence.

Citing SAIF v. Allen, 124 Or App 183 (1993), the Referee held that he was unable to award an attorney fee under ORS 656.386(1). Subsequent to the Referee's order, however, the Supreme Court reversed the Court of Appeals' decision in Allen. SAIF v. Allen, 320 Or 192 (1994). The Court held that a claim for medical benefits is a "claim for compensation" within the meaning of ORS 656.386(1). Id. at 203.

In Lois J. Schoch, 47 Van Natta 71 (1995), we awarded an attorney fee under ORS 656.386(1) when the claimant finally prevailed over a Director's order declaring medical treatment not compensable and a referee's decision affirming the Director's order. Here, inasmuch as claimant finally prevailed at hearing over the Director's order in this case, he is entitled to an attorney fee award under ORS 656.386(1). Lois J. Schoch, supra.

Moreover, in Roy Stoltenburg, 46 Van Natta 2386 (1994), we affirmed a referee's order awarding an attorney fee under ORS 656.386(1), where we agreed with the referee's determination that proposed surgery was reasonable and necessary. Inasmuch as the insurer had appeared at the hearing to contest the reasonableness and necessity of the proposed surgery, we found the insurer's conduct amounted to a decision denying a claim for compensation. 46 Van Natta at 2387.

In this case, the insurer also contested the reasonableness and necessity of the proposed surgery at hearing. We, therefore, find the insurer's conduct in this case amounted to a denial of a claim for compensation. In accordance with our decisions in Schoch and Stoltenburg, we conclude that claimant's counsel was entitled to an assessed attorney fee under ORS 656.386(1) for services at the hearing level. We, thus, reverse the Referee's decision on this 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 attorney fee for claimant's counsel's services at hearing 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) , the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee award for services on review devoted to the attorney fee issue.

ORDER

The Referee's order dated April 29, 1994, as amended on July 26, 1994, is affirmed in part and reversed in part. That portion which declined to award claimant's counsel an assessed attorney fee is reversed. Claimant's counsel is awarded an attorney fee of $3,000 for services at hearing, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ROBYN BYRNE, Claimant
Own Motion No. 94-0751M
INTERIM OWN MOTION ORDER CONSENTING TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Craine & Love, Claimant Attorneys

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under this claim with Liberty Northwest Insurance Corporation (Liberty) expired July 27, 1987. Thus, that claim is subject to ORS 656.278.

We provide the following background information. By Own Motion Order dated September 28, 1994, the Board denied consent to the designation of a paying agent under ORS 656.307 because there was no evidence of a worsening of claimant's compensable low back condition with Liberty that required surgery or hospitalization. As a result of that own motion order, on September 30, 1994, the Department issued an order designating a paying agent solely for payment of medical benefits pursuant to ORS 656.245.

Subsequently, on November 29, 1994, claimant was hospitalized for treatment of her low back condition. On December 7, 1994, claimant underwent surgery for that condition. Although Liberty initially contended that the hospitalization and surgery were not reasonable and necessary treatment for the compensable low back injury, it has subsequently withdrawn that contention and concedes that the hospitalization and surgery are reasonable and necessary treatment. On December 15, 1994, the Board issued an order postponing action on claimant's request to reopen the own motion claim pending the resolution of the responsibility issue. The arbitrator's hearing to determine the responsibility issue remains pending. (WCB Case Numbers 94-11911, 94-13130).

As a result of the developments regarding claimant's medical treatment, the Benefits Section has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180 for the payment of temporary disability benefits, as well as medical benefits.

Under OAR 438-12-032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. Id.

The record establishes that there has been a worsening of claimant's compensable injury requiring hospitalization on November 29, 1994 and surgery on December 7, 1994. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation commencing November 29, 1994, the date claimant was hospitalized. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307.

The parties shall notify the Board of the arbitrator's decision regarding the responsibility issue. When the responsible carrier has been determined, the Board will either: (1) issue an order reopening the own motion claim, if the own motion carrier is found to be the responsible carrier; or (2) issue an order denying reopening of the own motion claim, if a non-own motion carrier is found to be the responsible carrier.

IT IS SO ORDERED.

In the Matter of the Compensation of
ISIDRO RANGEL-PEREZ, Claimant
WCB Case No. C4-02704
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
H. Galaviz-Stoller, Claimant Attorney
SAIF Legal Department, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On October, 26, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

The CDA contains the signatures of the SAIF Corporation's claims adjuster, SAIF's trial counsel and claimant's attorney, but does not include claimant's signature. On the line provided for claimant's signature, his attorney signed "for" claimant. In addition, claimant's attorney submitted a letter to the Board advising that claimant left for Mexico after authorizing settlement of the claim and that she has no way of contacting him there.

The Board's rules define a "claim disposition agreement" as a written agreement executed by all parties in which a claimant agrees to release rights or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim. OAR 438-09-001(1). In other words, the Board's rules require a CDA to be executed by all parties. See OAR 438-09-001(1); Catherine E. Evans, 45 Van Natta 1043 (1993); Edgar C. Sixberry, 43 Van Natta 335 (1991); Van L. Bloom, 46 Van Natta 2177 (1994).

Therefore, on November 3, 1994, by letter, the Board requested an addendum, providing claimant's original signature and an additional postcard. Claimant's original signature was not provided. Accordingly, because the original CDA does not contain claimant's original signature, it is not in compliance with the Director and Board rules. See OAR 436-60-145(1); OAR 438-09-001(1). Consequently, we disapprove the CDA as unreasonable as a matter of law, see ORS 656.236(1)(a), and return it to the parties. We consider this approach to be particularly appropriate where the record is devoid of a signature from claimant evidencing an understanding regarding the finality and significance of a CDA.

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

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
CELESTE K. CAREY, Claimant
WCB Case No. 94-03138
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Neal's order that upheld the self-insured employer's denial of claimant's psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable August 1990 back injury. In October 1992, claimant sought psychological treatment from Dr Dorsey, psychiatrist. The Referee found that claimant failed to prove compensable her need for psychological treatment. Claimant challenges this conclusion, asserting that her need for psychological treatment is a compensable consequence of her 1990 back injury. See ORS 656.005(7)(a)(A).

Subsequent to the Referee's order, we issued Albert H. Olson, 46 Van Natta 1848 (1994). In that case, following a compensable injury, the employer informed the claimant that it could offer no employment which the claimant was capable of peforming. The claimant then sought treatment for depression. We found that the medical evidence established that the "claimant's injury and its sequelae, including [the] claimant's inability to continue employment because of injury-related disability, were the major contributing cause of his depression." Id. at 1849. Therefore, we concluded that the claimant proved compensable his need for psychological treatment under ORS 656.005(7)(a)(A). Id.

A preponderance of the medical evdience in this case shows that claimant suffered from an adjustment disorder. However, unlike the claimant in Olson, we find insufficient proof that claimant's compensable injury and its sequelae were the major contributing cause of claimant's psychological condition and need for treatment. The Physician in the best position for evaluating causation, claimant's treating psychiatrist, Dr. Dorsey, ultimately stated that "some of [claimant's] symptoms of pathology are of long-standing duration" that were "exacerbated by the psychosocial stress that she is enduring as a result of her joblessness, financial pressures and uncertainty of her future." (Id). Dr. Dorsey also indicated that there was "a component of psychological pathology here as a result of the injury in addition to the physical problems." (Id).

We agree with the Referee that Dr. Dorsey's opinion is insufficient to support a finding that the compensable injury was the major contributing cause of claimant's psychological symptoms. Instead, her opinion shows that the compensable injury, including the resulting sequelae of jobless, financial stress, and uncertainty of the future, was only a factor in her need for treatment.

Claimant's family physician, Dr. Crawford, who extensively treated claimant, also only stated that claimant's psychological condition was "definitely related to her work injury." (Ex. 47). Since Dr. Crawford indicated only that claimant's psychological condition was "related" to the injury, we also find her opinion insufficient to prove causation, especially in view of the other factors cited by Dr. Dorsey as also contributing to claimant's need for psychological treatment.

Therefore, we agree with the Referee that claimant failed to show that her compensable injury, including its sequelae, was the major contributing cause of her need for psychological treatment and, therefore, such treatment is not compensable. See ORS 656.005(7)(a)(A); Albert H. Olson, supra.

ORDER

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

In the Matter of the Compensation of
KERRI A. HOUGHTON, Claimant
WCB Case No. 94-01016
ORDER OF ABATEMENT
Coons, et al., Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Claimant has requested reconsideration of our January 5, 1995 order, as corrected January 6, 1995, which affirmed a Referee's order that had affirmed an Order on Reconsideration award of 7 percent (22.4 degrees) unscheduled permanent disability for a neck condition. In addition to disagreeing with our analysis, claimant contends that our holding is directly contrary to the holding recited in Sara I. Smith, 46 Van Natta 895 (1994).

In order to further consider claimant's arguments, we withdraw our prior orders. The SAIF Corporation is granted an opportunity to respond. To be considered, that 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
JOHN W. HAMMER, JR., Claimant
WCB Case No. 93-10659
ORDER ON REVIEW
Bryant, Emerson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Nichols' order which upheld the insurer's denial of his right shoulder aggravation claim. On review, the issue is aggravation.

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

Claimant sustained a compensable right shoulder injury in January 1991. A February 22, 1991 Determination Order found claimant to be medically stationary as of December 11, 1990, and closed the claim with no award of permanent disability. (Ex. 36). An Order on Reconsideration issued June 24, 1991, increasing claimant's unscheduled permanent disability award to 8 percent, but otherwise affirming the Determination Order. (Ex. 41). An Opinion and Order issued February 28, 1992, increasing the permanent disability award to 10 percent. (Ex. 45). In March 1993, claimant again sought treatment for his right shoulder, alleging an aggravation. (Exs. 46, 47).

The Referee held that the aggravation claim was not compensable because claimant failed to prove that his worsened condition resulted in reduced earning capacity since the last arrangement of compensation. Specifically, the Referee found that claimant had the same work restrictions in 1991 when his claim was closed (no repetitive use of his right shoulder, no overhead work), as he had in March 1993.

On review, claimant contends that the Referee erred by using the wrong baseline medical information for measuring whether claimant's earning capacity had diminished. Specifically, claimant asserts that the correct baseline for measuring earning capacity is the December 11, 1990 chart note by Dr. Price, at which time claimant was declared medically stationary and released to his regular work without restrictions. We disagree.

In Lindon E. Lewis, 46 Van Natta 237 , aff'd mem Morgan Manufacturing v. Lewis, 131 Or App 267 (1994), we reasoned that the "baseline" for determining whether a compensable condition has worsened is the claimant's "medically stationary" condition at or before the last award or arrangement of compensation. 46 Van Natta at 239. In other words, evidence regarding a claimant's "medically stationary" condition up to and including the "last award or arrangement of compensation" that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1). Id. at 240.

Here, claimant was declared medically stationary on December 11, 1990, at which time Dr. Price, his attending physician, released him to his regular work. A Determination Order issued February 22, 1991, declaring claimant to be medically stationary on December 11, 1990. Neither party challenged the medically stationary date on reconsideration or at hearing. Thus, we conclude that claimant remained medically stationary through both the reconsideration and hearing processes. Accordingly, the "baseline" for determining whether claimant's condition worsened in 1993 is his medically stationary condition as it was described at and prior to the last arrangement of compensation (in this case, the February 28, 1992 Opinion and Order).

As noted above, on December 11, 1990, claimant's attending physician released him to return to regular work. However, when claimant returned to his regular work, his shoulder pain increased and he was again periodically disabled from working. (See Ex. 25-2). By February 8, 1991, Dr. Price reported that claimant was released to light duty with no use of his right arm. (Ex. 34). In March 1991, both Dr. Price and Dr. Stack (a prior attending physician) reported that claimant was restricted from repetitively using his right shoulder and from doing overhead work with his right arm. (Ex. 38, 39). Thus, we conclude that claimant's "baseline" medically stationary condition included restrictions on repetitive use of his right shoulder and no overhead work.

In March 1993, claimant sought treatment from Dr. Sulkosky for problems with his right shoulder. (Exs. 46, 47). Dr. Sulkosky also restricted claimant from doing overhead work, and restricted him to light duty. (Exs. 47, 51). In June 1993, Drs. Gritzka and Platt examined claimant at the insurer's request, and they also noted restrictions on overhead and repetitive use of claimant's right shoulder. (Ex. 53). Under these circumstances, we agree with the Referee's determination that claimant did not experience reduced earning capacity in 1993 compared with his "baseline" medical condition in 1991, because his work restrictions in 1993 were the same as his restrictions in 1991. Accordingly, we affirm the Referee's order finding that claimant's right shoulder aggravation claim is not compensable.

ORDER

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

February 6, 1995 Cite as 47 Van Natta 217 (1995)

In the Matter of the Compensation of
ISABEL CAMPA, Claimant
WCB Case No. C5-00047
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorneys
SAIF Legal Department, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

On January 6, 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. Therefore, pursuant to ORS 656.054, claimant's claim was referred to the SAIF Corporation for processing. (P. 2, Lns. 12-14).

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 not previously addressed the issue of whether an NCE is a party to a CDA, thus requiring the NCE's signature. However, the Supreme Court addressed a similar issue in Astleford v. SAIF, 319 Or 225 (1994), holding that, under ORS 656.289(4), an NCE is a "party" who "may * * * by agreement" settle a disputed workers' compensation claim. Id. at 234. After examining the statute to determine whether the context of ORS 656.289(4) requires that the term "parties" be given a different meaning than the one suggested by the general definition of "party," the Court could not identify any reason why the term "party" in ORS 656.289(4) has other than the statutory meaning of ORS 656.005(20). Accordingly, the Court held that an NCE is a "party" who "may * * * by agreement make such disposition of the claim * * *."

We must determine, under ORS 656.236(1), whether an NCE is a "party" to a CDA by examining the statute to determine whether the context of the statute requires that the term "parties" be given a different meaning than the one suggested by the general definition of "party." Astleford, supra. Here, after examining the text and context of ORS 656.236(1), we find no reason why the term "party" in ORS 656.236(1) has other than the statutory meaning of ORS 656.005(20). Accordingly, we conclude that an NCE is a "party" to a CDA agreement.

Having determined that a NCE is a party to the CDA agreement, we address the effect of the lack of the NCE's signature on the instant agreement. Here, the CDA was signed by the Department's Collections Unit supervisor, and was accompanied by a letter that stated:

> "The department has investigated the Noncomplying Employer in this case and determined recovery of costs is economically unfeasible. The NCE is incarcerated * * *. The NCE will not be a party to this agreement nor will DCBS seek recovery of costs from this NCE.
>
> "For these reasons, I have approved the CDA in this matter."

We disagree with the Department's statement suggesting that the NCE "will not be a party to this agreement." As we discussed above, the statutory definition of "party" includes an employer and makes no distinction between an insured employer and a noncomplying employer. Presumably, an employer's status as a "party" arises from its material, pecuniary interest in workers' compensation claims and their disposition. An NCE, for example, is liable for all claim costs to the Industrial Accident Fund. See ORS 656.054(3). The Director is charged with the duty to recover those costs from the NCE. Id.

In this case, however, the Department has represented that it will not seek recovery of claim costs from the NCE, and its representative has signed the CDA. Furthermore, neither SAIF nor claimant object to approval of the CDA without the NCE's signature. Under these circumstances, we find the NCE in this case has no pecuniary interest in the CDA. Therefore, although NCE's are "parties," we conclude that it is unnecessary for this NCE to sign the CDA. See ORS 656.054(3). Based on the aforementioned reasoning, we hold that the proposed CDA is not unreasonable as a matter of law.

Our decision in this case is consistent with our orders disapproving CDA's that were not signed by claimants. See Isidro Rangel-Perez, 47 Van Natta 214 (1995); Marcos Montoya, 47 Van Natta 81 (1995). In those cases, the unsigning party had a material, pecuniary interest in the disposition of his/her future rights relating to an accepted claim. Here, in contrast, the unsigning party (the NCE) lacks a pecuniary interest by virtue of the Department's announcement not to pursue a claim reimbursement procedure.

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. An attorney fee of $1,250, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILL H. DAVIS, Claimant
Own Motion No. 89-0660M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant, pro se, requests review of the SAIF Corporation's August 2, 1994 Notice of Closure which closed his claim with an award of temporary disability compensation from April 3, 1990 through July 26, 1994. SAIF declared claimant medically stationary as of July 26, 1994. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 2, 1994 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. We may consider post-closure medical reports regarding the question of whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

On May 14, 1993, Dr. Mulchin, claimant's treating urologist, requested approval for a surgical procedure to augment claimant's bladder, and noted that claimant's neurogenic bladder condition resulted from the work-related back injury. In a June 13, 1994 letter, Dr. Ryberg, claimant's treating neurologist, opined that claimant was "medically stationary with regard to his chronic pain."

In a July 26, 1994 check-the-box form, Dr. Mulchin indicated that no surgery was scheduled. In that form, SAIF included a paragraph informing Dr. Mulchin that Dr. Ryberg had opined that claimant was medically stationary with respect to his chronic pain condition. In the paragraph, SAIF also properly defined the term "medically stationary" as meaning that "no further material improvement would reasonably be expected from medical treatment or the passage of time." However, the question posed to Dr. Mulchin in the last sentence of that paragraph was: "At this time would it be safe to assume that [claimant's] bladder condition is also medically stationary until such time that he undergoes the proposed bladder augmentation surgery?" In answer to SAIF's question, Dr. Mulchin checked the box marked "YES." The question posed by SAIF to Dr. Mulchin does not constitute a proper legal statement of the definition of "medically stationary." A claimant cannot be medically stationary with respect to a compensable condition if surgery has been recommended which could improve that compensable condition. If there is a reasonable expectation of improvement with surgery, the criteria for being declared "medically stationary" have not been met. ORS 656.005(17).

In a September 12, 1994 letter to SAIF's claims examiner, Dr. Mulchin clarified his position with respect to claimant's proposed surgery and his medically stationary status. He opined that:

> "[i]t appears that [SAIF has] misunderstood the answers to questions you've posed previously. [Claimant] informed me that it is your impression that he can no longer be improved from his present status and that is incorrect.
>
> "As you recall, [claimant] was cleared for a bladder augmentation, a procedure of which I have decided to perform no longer. This complexity would best be handled by Dr. Arthur Sagalowsky. Once evaluated by Dr. Sagalowsky and treated with the appropriate procedure, then I do feel that [claimant] would of [sic] recovered to his fullest extent.
>
> "As it stands right now I feel he can be helped significantly with bladder augmentation. Certainly this would improve his caliber of life and existence."

In order to be medically stationary, all compensable conditions must be medically stationary. Rogers v. Tri-Met, 75 Or App 470 (1985). Although Dr. Ryberg opined that claimant's compensable back condition was medically stationary, and that no further improvement would be anticipated, he gave no opinion as to claimant's neurogenic bladder condition. Dr. Mulchin, who treated claimant for his bladder condition, responded to an improper question regarding claimant's medically stationary status, and he retracted that response in his September 12, 1994 letter. Dr. Mulchin further clarified in that letter that he still recommended bladder augmentation surgery, although he noted that he no longer performed surgery of that type, and referred claimant to a surgeon who was capable of performing this "complex" operation. Additionally, he opined that there was a reasonable expectation of further improvement of the bladder condition with medical treatment. Finally, since Dr. Ryberg gave no opinion as to the status of claimant's bladder condition (except to note that surgery was still planned), Dr. Mulchin's corrected opinion with respect to the status of claimant's bladder condition is medically unopposed. Therefore, we conclude that claimant was not medically stationary when his claim was closed.

In reaching this conclusion, we recognize that, in those cases where a claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if the claimant refuses the surgery. E.g. Stephen L. Gilcher, 43 Van Natta 319, 320 (1991); Karen T. Mariels, 44 Van Natta 2452, 2453 (1992). However, those cases are distinguishable from the present case in that, here, claimant has not refused the proposed surgery. In fact, prior to claim closure, Dr. Ryberg indicated that claimant was still planning on having the bladder surgery. (June 13, 1994 letter from Dr. Ryberg to SAIF's claims examiner). Furthermore, Dr. Mulchin referred claimant to another surgeon to perform the surgery. (September 12, 1994 letter from Dr. Mulchin to SAIF's claims examiner). Therefore, although the performance of the surgery has been delayed, claimant has not refused to undergo the surgery. Accordingly, because the record establishes that this proposed surgery is reasonably expected to materially improve claimant's compensable bladder condition, we conclude that the claim was prematurely closed. ORS 656.005(17); 656.268(1).

Finally, we note that, if claimant's condition remains unchanged and he subsequently decides not to undergo the proposed bladder surgery or does not pursue the surgery, SAIF may make a written request to suspend temporary disability benefits under OAR 438-12-035(5). Pursuant to that rule, claimant would have an opportunity to submit a written response to such a request. Furthermore, SAIF may not suspend temporary disability benefits without prior written authorization from the Board.

We emphasize that claimant is not required to undergo the proposed bladder surgery: that decision is up to him and his physicians. However, should claimant fail to pursue the proposed surgery or decide not to undergo the surgery, the consequences of those actions could include suspension of his temporary disability benefits pursuant to OAR 438-12-035. In addition, if claimant is otherwise medically stationary and he refuses the proposed surgery, SAIF could close the claim under the reasoning in Gilcher, supra, and Mariels, supra, as discussed above.

Accordingly, because we find that claimant's claim was prematurely closed, SAIF's August 2, 1994 Notice of Closure is set aside. When appropriate, SAIF shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT A. JARVILL, Claimant
WCB Case No. 93-01835
ORDER ON REVIEW
Edward Harri, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Baker's order that upheld the SAIF Corporation's denial of claimant's claim for a psychological condition. On review, the issue is compensability.

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

To establish a compensable psychological condition claim, claimant must prove that the employment conditions producing his mental disorder were 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. ORS 656.802(3)(b). Claimant argues, inter alia, that the employer engaged in unreasonable disciplinary actions and, therefore, that such actions may be considered in evaluating the compensability of his psychological condition. We disagree.[1]

For many years, claimant was the principal for SAIF's insured (the employer), a state school for incarcerated youth. During that time, he was supervised by several superintendents. Claimant asserts that at least two of these superintendents' disciplinary actions were unreasonable.

The evidentiary record reflects that, since the late 1970's, claimant received both favorable and unfavorable performance appraisals; the record also contains numerous memoranda and Letters of Caution addressing certain performance deficiencies on claimant's part. The testimonial record reveals that claimant had varying degrees of difficulty communicating with others. The memoranda and Letters of Caution focused primarily on inadequacies in claimant's communication methods.

On this record, we are unable to conclude that the employer's disciplinary actions, as a whole, were unreasonable. Our review of the evidence convinces us that, although some of the documentation concerning claimant's performance was pugnacious, the employer's actions over the years were designed to correct specific deficiencies in claimant's performance. We do not find that goal, or the actions selected to achieve it, generally unreasonable.

More importantly, even if we were to find some of the employer's particular disciplinary actions unreasonable, the medical evidence on which claimant relies does not sufficiently identify the purportedly unreasonable conduct, or factor out those actions in the process of ascertaining the cause of claimant's psychological condition. See Mary A. Murphy, 45 Van Natta 2238 (1993) (medical experts' reliance on a condition generally inherent in every working situation basis for upholding carrier's denial of the claimant's mental disorder). For these reasons alone, we conclude that claimant's stress claim fails.

Claimant argues that, because he received inconsistent performance appraisals, the employer acted unreasonably. As an example, claimant refers us to a favorable review that he received in late May 1992 (Ex. 56), which was followed on June 3, 1992 by a Letter of Caution criticizing claimant for failing accurately to record minutes of an administrative meeting. (Ex. 57). Because we find that the employer's actions were reasonable responses to the varying quality of claimant's performance, we conclude that any "inconsistency" in the employer's appraisals did not constitute unreasonable disciplinary action. Furthermore, to the extent that some of these actions may be found to be unreasonable, they were not sufficiently identified or factored out in the medical opinions that address causation. See Mary A. Murphy, supra.

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[1] Claimant also asserts that the Referee misunderstood his compensability theory, which is that his current psychological condition is related to his approximately 20-year history of employment with the employer. (See Claimant's Appellant's Brief at 12). We have considered that theory in reviewing the record.

Much of claimant's unreasonable disciplinary action argument rests on the relationship he had with Mary Ellen Eiler, who became the employer's superintendent in April 1990. Claimant maintains that Eiler "harassed" him with inconsistent performance reviews and requests about when he could return from sick leave related to a surgical procedure. (Claimant's Reply Brief at 11-12).

Our review of the record reveals no such "harassment." To the contrary, the documentary record shows that Eiler closely tracked claimant's performance, commending him when he performed well, and criticizing him when he did not. We conclude that Eiler's requests for information regarding claimant's sick leave status, albeit somewhat repetitious, resulted from the inability of claimant or his physicians to predict when claimant could return to work.[2] Finally, witnesses for both claimant and SAIF testified that Eiler always treated claimant respectfully and professionally. (E.g., Tr. Day I at 59, 109-110, Day III at 85, 140, 172). In view of this evidence, we reject claimant's "harassment" argument.

Last, claimant argues that his psychological condition was caused by conditions not generally inherent in every working situation. We have concluded that the medical evidence is insufficient because it did not factor out those of the employer's disciplinary actions that were not unreasonable in ascertaining the cause of claimant's psychological condition. In view of such legally insufficient medical evidence, we need not determine whether the other employment conditions claimant faced were not generally inherent in every working situation.[3]

ORDER

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

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[2] Many of the requests for information regarding claimant's sick leave status were actually authored by Assistant Superintendent Larry Lissman. (Exs. 99, 105, 108, 111, 114, 117AA1, 125a). Board Member Hall finds that, considering both the number and tenor of the requests, Lissman's conduct rises very nearly to the level of harassment. However, because the requests issued after claimant had become disabled as a result of his mental stress condition, and because the medical evidence fails to meet claimant's burden of proof, see text accompanying note 3, infra, Board Member Hall declines to consider the harassing nature of Lissman's conduct in analyzing the cause of claimant's condition.

[3] Claimant argues that the employer's failure to comply with a variety of state and federal mandates applicable to state institutions that house incarcerated youth, particularly with respect to staffing and administration, is not a condition generally inherent in every working situation. Board Member Hall is not convinced that the degree to which the employer failed to comply with government mandates in this case is common to all employments. However, because the medical evidence fails to separately factor out this particular element from non-compensable factors, the medical evidence fails to meet claimant's burden of proof, and Board Member Hall agrees that the Board need not address that issue.

February 9, 1995 Cite as 47 Van Natta 222 (1995)

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

Claimant requests reconsideration of our January 11, 1995 order 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 (2) declined to award an attorney fee under ORS 656.386(1). Specifically, claimant asks us to reconsider that portion of our order which found that substantial evidence supports the Director's order.

In order to allow sufficient time to consider the motion, we withdraw our January 11, 1995 order. The self-insured employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSE M. ADAMS, Claimant
WCB Case No. 94-03908
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Lane, Powell, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Herman's order that upheld the insurer's denial of claimant's aggravation claim for a left shoulder condition. On review, the issue is aggravation.

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

Claimant argues that the Referee erred in finding that she failed to establish that she has suffered a diminished earning capacity. We disagree.

Before closure of her left shoulder claim, Dr. Freudenberg, claimant's then-treating physician, limited claimant to sedentary work, and indicated that claimant could not perform repeated lifting with her left hand of over three to five pounds, carry more than 10 pounds with her left hand, or perform any overhead activity with her left upper extremity. (Ex. 17-2). Thereafter, a medical arbiter concluded that claimant could perform no over-shoulder work and could not lift over seven to eight pounds with her left arm. (Ex. 21-3). Following claimant's current left shoulder exacerbation, Dr. Bert, her current treating physician, imposed similar restrictions (no overhead work or lifting over 20 pounds). (Ex. 29). In view of this medical evidence, we conclude that claimant has failed to establish that her current worsening resulted in a diminished earning capacity.[1]

ORDER

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

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[1] Claimant cites Barbara A. Fleming, 46 Van Natta 1026 (1994) for the proposition that diminished earning capacity may be temporary. Claimant then refers us to Dr. Freudenberg's opinion in which he states his believe that claimant may require further left shoulder surgery. (Ex. 31). To the extent that claimant is asserting that a prediction of future disability may serve as a basis for a finding of current diminished earning capacity, we reject that argument.

In the Matter of the Compensation of
KENNETH L. CALLEY, Claimant
WCB Case No. 94-01543
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys

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

Claimant requests review of Referee Mongrain's order that upheld the self-insured employer's denial of his claim for a right inguinal hernia. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, we do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to prove compensability of his right indirect inguinal hernia by a preponderance of the evidence. We disagree.

Under ORS 656.005(7)(a)(B), when the disability or need for treatment is due to the combination of the injury and a preexisting condition, the injury is compensable only if it is the major contributing cause of the disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, 594, rev den 318 Or 27 (1993). On review, claimant contends that the work related lifting incident is the major contributing cause of his disability and need for treatment

Three physicians address the causation of claimant's indirect right inguinal hernia. Dr. Battalia reviewed claimant's records on behalf of the employer. He explained that the indirect hernia is a congenital defect which consists of a sac which opens into the internal abdomen. When abdominal contents enter the sac, an individual becomes aware of the presence of a bulge. There is frequently discomfort when abdominal contents are in the sac. In claimant's case, Dr. Battalia opined that the major contributing cause of claimant's need for treatment was the preexisting congenital hernia. Dr. Battalia did not believe that there was a tearing or worsening of the preexisting hernia due to the work incident.

Dr. Edwards is claimant's attending physician and surgeon. He agreed with Dr. Battalia that an indirect inguinal hernia is a congenital defect. However, he opined that increased abdominal pressure and stretching of the surrounding abdominal wall can allow the preexisting sac to dilate and accept intra-abdominal contents such as the omentum and small bowel. He explained that there can be a congenital potential herniation with the hernia sac present, but chronic or acute lifting can cause a stretching or acute tearing of the surrounding tissues leading to a symptomatic herniation of intra-abdominal contents. Dr. Edwards explained that this scenario was consistent with claimant's history and findings. Initially, Dr. Edwards stated that he could not determine whether the major contributing cause of the hernia was the acute lifting or chronic, repeated lifting, or the congenital defect. He believed that this was a question for the Referee to address. However, he later explained that the lifting incident on October 22, 1993, was the major contributing cause of claimant's need for surgery.

Dr. Blumberg also reviewed claimant's records on behalf of the employer. Dr. Blumberg agreed with Dr. Edwards that there can be a potential hernia with a hernia sac present and chronic or acute lifting can cause stretching or acute tearing of the surrounding tissues and lead to a symptomatic herniation of intra-abdominal contents. However, Dr. Blumberg opined that the most likely cause for appearance of this hernia in people in their 50's, 60's and 70's is frequently not any specific lifting episode, but aging. Dr. Blumberg agreed with Dr. Battalia that claimant's work activities did not constitute the major contributing cause of claimant's indirect inguinal hernia. Dr. Blumberg also agreed that there was no objective evidence that claimant's work materially caused or worsened his preexisting hernia. Dr. Blumberg opined that the work activities may have made the preexisting hernia symptomatic. However, Dr. Blumberg opined that once the indirect inguinal defect is present, herniation can occur at any time in life and more often than not occurs simply with the aging process.

After reviewing the record, we find no persuasive reasons not to defer to the opinion of Dr. Edwards, claimant's attending physician and surgeon. Weiland v. SAIF, 64 Or App 810 (1983). As the

physician who performed the surgery to correct the hernia condition, Dr. Edwards is in the best position to provide an opinion regarding the cause of claimant's hernia. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Although Dr. Edwards initially sought to defer to the Referee, he subsequently explained that claimant's work injury was the major contributing cause of claimant's disability and need for treatment. Dr. Edwards explained that claimant's history and findings were consistent with a scenario where increased abdominal pressure and stretching of the surrounding abdominal wall allowed the preexisting sac to dilate and accept intra-abdominal contents such as the omentum and small bowel. This would in turn lead to a herniation of intra-abdominal contents.

Based on this record, we conclude that Dr. Edwards' opinion supports the conclusion that claimant's work injury is the major contributing cause of his disability and need for surgery. Under such circumstances, we conclude that claimant has established compensability of his disability and need for treatment.

In reaching this decision, we note that we are not concluding that claimant's congenital indirect hernia is itself compensable. Rather, we are persuaded by Dr. Edwards' opinion that the work incident caused the intra-abdominal contents to be pushed into the preexisting hernia sac. In other words, we conclude that Dr. Edwards' opinion supports a conclusion that the injury and the preexisting hernia condition combined and that the work incident was the major contributing cause of the resultant disability and need for treatment. ORS 656.005(7)(a)(B).

Claimant is entitled to an assessed attorney fee for prevailing against the employer's denial of the hernia condition. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the 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 June 30, 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 Board review, claimant's attorney is awarded $3,000, payable by the insurer.

Board Member Haynes dissenting.

I disagree with the majority's analysis of the medical evidence in this case and would agree with the Referee's conclusion that claimant failed to meet his burden. All three physicians, Edwards, Battalia and Blumberg agree that claimant's indirect inguinal hernia is a congenital defect. Dr. Edwards' medical opinion contains two serious flaws which renders it unpersuasive. First, without explanation, Dr. Edwards retreated from his initial conclusion that he could not determine what the major contributing cause of claimant's hernia was. He initially stated:

> "As to whether the 'major contributing cause' was the acute injury or chronic, repeated lifting with increased intraperitoneal pressure, or the congenital defect that has been present since birth, I cannot determine and I think this should be settled by a referee at the hearing."

In spite of his statement that he could not determine which of the three causes of the hernia was the major contributing cause, Dr. Edwards, was later able to make this connection without an explanation for his earlier inability.

The second flaw in Dr. Edwards' opinion is that when he does causally relate the hernia to the injury, he relies solely on the temporal relationship between the appearance of symptoms and the work incident. Dr. Edwards stated that he believed that the October 22, 1993 work incident was "a major contributing cause" of claimant's surgery since claimant's symptoms had begun on that date. (Ex. 11B). He explained that claimant "did not have pain or bulging prior to lift [sic] the pipe at work. He lifted the pipe at work and felt pain in his groin." (Ex. 14).

Because the hernia symptoms necessitating surgery occurred after the lifting incident, Dr. Edwards believed that the major contributing cause of the disability and need for treatment was the lifting incident. It is well settled that an inference of causation should not be drawn based upon a temporal relationship between the injury and the appearance of the symptoms. Allie v. SAIF, 79 Or App 284 (1986). However, this is the only basis for Dr. Edwards' opinion that claimant's condition is work-related.

Because of the flaws in Dr. Edwards' opinion, I believe that the majority erred in relying on this opinion. Accordingly, because I would rely on the more persuasive opinions of Drs. Battalia and Blumberg to conclude that claimant failed to meet his burden of proof, I respectfully dissent.

February 10, 1995 Cite as 47 Van Natta 226 (1995)

In the Matter of the Compensation of
CRAIG E. CHAMBERLIN, Claimant
WCB Case No. 94-02548
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Daughtry's order that awarded an assessed attorney fee of $750 for claimant's counsel's services in connection with the insurer's alleged "de facto" denial of claimant's injury claim for a left anterior pectoral muscle strain. On review, the issues are scope of acceptance and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed a claim for "strained chest wall" related to a lifting incident at work on November 1, 1993. (Ex. 1). The insurer accepted a claim for costochondritis on January 21, 1994. (Ex. 13). On February 28, 1994, claimant requested a hearing, alleging a "de facto" denial. Before the hearing, the parties agreed to clarify the scope of the insurer's acceptance. The insurer agreed to "amend" the accepted condition to include left anterior pectoral muscle strain. The only issue before the Referee was whether claimant's counsel was entitled to an assessed attorney fee.

The insurer contends that the Referee erred in awarding an assessed fee because there was no "de facto" denial. According to the insurer, claimant's left anterior pectoral muscle strain is the same condition as the costochondritis condition accepted by the insurer. See Teresa A. Olson, 45 Van Natta 1765 (1993) (despite the different terminology used by each doctor, there was no medical evidence that claimant sought treatment for a new or different condition from the one accepted by the employer). We disagree.

We find that the left anterior pectoral muscle strain condition was not included in the insurer's January 21, 1994 acceptance. The scope of acceptance is a factual determination. SAIF v. Tull, 113 Or App 449 (1992). For purposes of determining the applicability of a backup denial, 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); see SAIF v. Allen, 320 Or 192, 215 (1994).

Here, the insurer specifically accepted costochondritis. The specific language of the acceptance does not include a left anterior pectoral muscle strain. The insurer relies on Dr. French's April 7, 1994 explanation of claimant's condition to argue that they are the same condition. Dr. French reported:

> "The injury was to the left anterior chest, pectoral muscles costochondral junction in the left shoulder. These are all one functional mechanism. I do not feel that it is possible in this case to separate the shoulder and the muscles about the shoulder from the junction of the sternum and ribs." (Ex. 15).

We find that the insurer's reliance on Dr. French's April 7, 1994 report is misplaced. Although Dr. French reported that it was not possible to separate the shoulder and shoulder muscles from the junction of the sternum and ribs, two of his earlier reports referred separately to claimant's costochondritis and left shoulder sprain. (Exs. 11 & 12). Both of those reports were issued before the insurer had accepted claimant's costochondritis on January 21, 1994. Dr. French's January 25, 1994 report referred to "[l]eft shoulder strain, some pectoralis fibromyalgias." (Ex. 14). On April 27, 1994, Dr. French agreed with the insurer's letter that "[claimant] has two diagnoses separate and distinct, i.e., costochondritis and left shoulder strain of unknown cause and possibly not related to our injury but related to a separate incident." (Ex. 16).

Under these circumstances, we conclude that the insurer's acceptance of costochondritis did not constitute an acceptance of a left anterior pectoral muscle strain. Although the insurer did not accept a claim for a left shoulder strain, it did agree to "amend" the accepted condition to include a left anterior pectoral muscle strain. We agree with the Referee that the insurer's amended acceptance identified a previously unaccepted condition for which claimant is entitled to claim present and future compensation.

Under the Supreme Court's recent opinion in SAIF v. Allen, supra, the reports showing that claimant was in need of medical treatment for "left shoulder strain" and "pectoralis fibromyalgias" were "claims" for compensation for purposes of ORS 656.386(1). The insurer's conduct in failing to expressly accept or deny the claims within the required statutory period were "de facto" denials of those claims. See SAIF v. Blackwell, 131 Or App 519 (1994).

When a claimant's attorney is instrumental in gaining acceptance of a "de facto" denial before a hearing, claimant is entitled to a carrier-paid attorney fee pursuant to ORS 656.386(1). SAIF v. Blackwell, supra. Here, claimant's attorney filed a request for hearing that resulted in acceptance of claimant's left anterior pectoral muscle strain. Accordingly, since his counsel was instrumental in a obtaining compensation without a hearing, claimant is entitled to an assessed attorney fee under ORS 656.386(1).

The insurer contends that the $750 fee awarded by the Referee is excessive. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the fee awarded by the Referee is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Finally, we note that claimant is not entitled to an attorney fee for services on review. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 6, 1994 is affirmed.

In the Matter of the Compensation of
RAYMOND L. DeGRANDE, Claimant
WCB Case No. 93-10149
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

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

Claimant requests review of Referee Mills' order that upheld the insurer's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

On April 24, 1989, Dr. Noall performed a follow-up examination of claimant. Claimant complained of very mild residual symptoms in the low back. Dr. Noall measured 70 percent of normal forward flexion, normal extension and normal lateral bending right and left. Dr. Noall predicted intermittent soreness in the low back which might limit repetitive bending, stooping and prolonged sitting in the future. (Ex. 31).

By a May 30, 1989 Stipulation, claimant received an additional 5 percent unscheduled disability. The stipulation provided that the award contemplated future waxing and waning of symptoms. (Ex. 34).

On October 26, 1989, claimant sought treatment from Dr. Torres for back symptoms. He had some low back tenderness. (Ex. 35). On November 17, 1989, Dr. Noall treated claimant with physical therapy for a symptomatic flare-up. Dr. Noall found claimant medically stationary on January 2, 1990. (Ex. 36). Claimant filed an aggravation claim which was denied and settled by a June 8, 1990 DCS. (Ex. 40).

Claimant continued to work as a busdriver until March 1, 1990, when his union went on strike. Claimant was unemployed until August or September 1991, when he started his own yard maintenance company in the state of Washington. Claimant carried Washington workers' compensation insurance for his employees. Claimant himself was not covered. (Tr. 12). Claimant avoided performing heavy yard maintenance work. He hired others to do the heavy lifting, such as the removal of sod. Clamant did not do landscaping, plant trees or build walks. The heaviest lifting claimant performed was to lift a bag of wet grass weighing 30 to 40 pounds or to lift an edger into his truck. (Tr. 6, 7).

On October 23, 1992, claimant sought treatment for low back pain and radiation into his right thigh and calf that had worsened since October 17, 1992. Dr. Noall reported a positive straight leg raising test and positive Lasegue's on the right. X-rays showed no changes from 1988. Dr. Noall diagnosed recurrent right sciatica/post-laminectomy syndrome for which he prescribed a four-week course of physical therapy and placed claimant on light duty work. (Exs. 41 and 42).

On April 15, 1993, Dr. Noall noted that claimant had completed a course of physical therapy, but that his condition had not markedly improved. He found pain across the lumbosacral junction, no tenderness, minimally positive straight leg raising test on the right, with pain in the right thigh. He permanently limited claimant to sedentary work. On June 28, 1993, Dr. Noall evaluated claimant, found him medically stationary, and continued the sedentary work limitation. (Exs. 42 and 49).

On July 30, 1993, Drs. Peterson and Snodgrass examined claimant for the insurer. (Ex. 50).

The insurer denied claimant's aggravation claim on the basis that his low back condition had not materially worsened and that his current condition and need for treatment was the result of his employment in landscape maintenance, employer and insurance carrier unknown. (Ex. 51).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant established by medical evidence supported by objective findings that he experienced a symptomatic worsening. However, the Referee also concluded that claimant had failed to prove that his worsened condition resulted from the 1987 injury or that the worsening of his condition was greater than the waxing and waning of symptoms contemplated by the last arrangement of compensation. Accordingly, the Referee upheld the insurer's denial of claimant's aggravation claim.

On review, claimant contends that his 1987 injury was a material cause of his worsened condition and that his worsened condition was greater than the waxing and waning contemplated at the time of the last arrangement of compensation. We agree.

In order to establish a compensable aggravation claim for an unscheduled condition, claimant must prove that his compensable condition has worsened, by medical evidence supported by objective findings, since his last award or arrangement of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition

resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687, rev den 312 Or 150 (1991). Furthermore, because claimant received a previous permanent disability award for his injury, he must establish that any worsening is more than waxing and waning of symptoms, if such was contemplated by the previous permanent disability award. See ORS 656.273(8).

A compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition. Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994); Robert E. Leatherman, 43 Van Natta 1677 (1991). Moreover, because claimant's landscaping work was not subject to Oregon law, the insurer's aggravation denial is more properly interpreted as a contention that the major contributing cause of claimant's alleged worsening was an injury not occurring within the course and scope of employment. See ORS 656.273(1). Therefore, once claimant establishes that his compensable injury is a material contributing cause of his worsened condition, in order to prevail, the insurer must prove that the major contributing cause of claimant's alleged low back worsening was claimant's work in landscape maintenance. 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) (The insurer has the burden of establishing under ORS 656.273(1) that the major cause of worsening is an off-work injury).

Here, claimant must establish that his compensable condition has worsened since the May 30, 1989 Stipulation, in which claimant received an additional 5 percent unscheduled permanent disability and which provided that the award contemplated future waxing and waning of symptoms.

We begin by adopting that portion of the Referee's opinion establishing that claimant's worsened condition was established by objective evidence of a symptomatic worsening of his low back condition.

Furthermore, we agree with the Referee that the opinion on causation provided by Drs. Peterson and Snodgrass, who performed an examination for the insurer, was based on incorrect assumptions about the work claimant performed. We accordingly defer to the opinion of claimant's attending physician, Dr. Noall, who opined that claimant's 1987 injury was the major cause of claimant's worsened condition. See Weiland v. SAIF, 64 Or App 810 (1983) (We give the greatest weight to the opinion of the treating doctor, absent persuasive reasons to do otherwise). We do not find that Dr. Noall's opinions are inconsistent or unexplained. In this regard, we do not share the dissent's interpretation of Dr. Noall's deposition. When questioned about whether there was any worsening caused by claimant's activites as a landscaper, Dr. Noall merely indicated that he could not identify a worsening due to that cause as opposed to the original injury. (Ex. 52-15). Consequently, claimant has carried his burden to prove that the 1987 injury is a material contributing cause of his worsened condition.

However, the inquiry does not end here. In order to defeat claimant's aggravation claim, the insurer must prove that the major contributing cause of claimant's worsened low back condition was claimant's work in landscape maintenance. As noted above, we do not find the insurer's doctors' opinion to be persuasive as to the cause of claimant's condition. Accordingly, we conclude that the insurer has failed to prove that an off-the-job injury is the major contributing cause of the worsened condition. See Fernandez v. M & M Reforestation, supra; Roger D. Hart, supra.

Our final inquiry is whether claimant's worsening is more than waxing and waning of symptoms as contemplated by the May 30, 1989 Stipulation. At that time, claimant was able to perform full time work at his regular job as a bus driver, which entailed occasional lifting of 100 pounds. Prior to the stipulation and after a reopening for temporary disability following an episode of increased pain after claimant moved freight, Dr. Noall stated that claimant had very mild residual symptoms from his laminectomy. Dr. Noall predicted intermittent soreness in claimant's low back that might result in limitation of repetitive bending, stooping and prolonged sitting. Claimant was not prescribed drugs to control pain or inflamation. (Ex. 31).

In contrast, following this recent worsening of his low back condition, Dr. Noall permanently restricted claimant to sedentary work and prescribed a pain-killer and anti-inflamatory drug and activity limitation to control his symptoms. We find that claimant has proven that his worsened condition is greater than the waxing and waning of symptoms as contemplated by May 30, 1989 Stipulation. Consequently, claimant has proven the compensability of his aggravation claim.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved, and the risk that counsel's efforts might go uncompensated.

ORDER

The Referee's order dated February 15, 1994 is reversed. The insurer's denial is set aside and claimant's aggravation claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the insurer.

Board Member Haynes dissenting.

The majority concludes that claimant established the compensability of his aggravation claim. Because I do not agree that claimant met his burden to prove that his worsened condition resulted from the 1987 injury, I respectfully dissent.

Although Dr. Noall, claimant's attending physician, originally indicated in a check-the-box letter that the 1987 injury was the major contributing cause of claimant's worsened condition, Noall provided no analysis to support his opinion. Moreover, in his deposition, Noall indicated that he was unable to say whether claimant's worsened back condition was a result of his activities as a landscaper or some other cause. Again, he provided no explanation for his opinion or for the apparent change from his initial opinion. This admission of his inability to identify the cause of the worsening is inconsistent with his conclusory check-the-box opinion. I thus conclude that claimant has failed to sustain his burden of proof.

In addition, the medical evidence indicates that claimant's symptoms follow a pattern of waxing and waning that was contemplated by the language of the 1989 Stipulation.

For these reasons, I would affirm and adopt the Referee's order.

February 10, 1995 Cite as 47 Van Natta 230 (1995)

In the Matter of the Compensation of
JAMES EDMONDS, Claimant
WCB Case No. 93-11930
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Cowling, Heysell, et al., Defense Attorneys

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

The self-insured employer requests review of Referee Spangler's order that: (1) found claimant entitled to temporary total disability benefits for the period from September 1, 1993 to November 8, 1993; and (2) awarded a penalty for its allegedly unreasonable termination of temporary disability. On review, the issues are entitlement to temporary disability and penalties.

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

Under ORS.656.268(3)(c), temporary total disability may be terminated if the "attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment." We have previously concluded that, in stating that modified emplyment must be "offered," the statute contemplates that the worker is available for such work. Douglas G. Reed, 44 Van Natta 2427, 2428 (1992). Furthermore, in stating that the worker must "fail to begin such employment," we have concluded that the statute contemplates that it must be within the worker's discretion not to accept the employment. Id.

Here, as in Douglas Reed, supra, the employer did not "offer" modified employment to claimant, but merely informed him of a job that would have been available had he not been fired. Furthermore, claimant did not "fail" to begin employment because, having been fired, he had no choice as to whether he would actually perform such work. The fact that modified work was never actually offered is determinative; the reason for the "pre-offer" firing is irrelevant. Accordingly, we conclude here, as we did in Reed, that the requirements of ORS 656.268(3)(c) were not satisified, and the employer was not justified in unilaterally terminating payment of temporary disability.

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

ORDER

The Referee's order dated January 10, 1994, as reconsidered February 22, 1994, is affirmed. For services on review, claimant's counsel is awarded a $500 attorney fee, payable by the self-insured employer.

Board Member Neidig dissenting.

Inasmuch as I disagree with the majority's conclusion that the employer improperly terminated claimant's temporary disability, I respectfully dissent. I base my decision on the following reasoning.

The majority adopts the Referee's conclusion which relied on Douglas G. Reed, 44 Van Natta 2427 (1992). In Reed, following a claimant's compensable injury and his termination from employment, a carrier "offered" him a modified position which satisfied the criteria set forth in ORS 656.268(3)(c). In extending the "offer," the carrier also stated that because of the claimant's termination, he was not eligible to work. Consequently, in conjunction with extending the "offer," the carrier also terminated the claimant's temporary disability.

In disapproving of the carrier's conduct, the Reed Board concluded that no "offer" was made because no job was available to the claimant due to his firing. Moreover, the Reed Board reasoned that the claimant could not "fail" to begin employment that he was precluded from actually performing.

I consider the present case to be distinguishable from Reed. In Reed, there is no indication why the claimant was terminated from his employment. Here, it is uncontested that claimant was discharged as a result of a positive drug test in violation of his employer's express drug policy. Thus, when the employer extended its modified job offer, claimant was physically capable of performing the requisite work activities. However, as a result of his violation of the employer's drug policy, claimant was no longer eligible to perform those activities.

Unlike the situtation in Reed, claimant had a choice concerning whether he could actually perform the modified job. He made that choice when he violated the employer's drug policy. The fact that such a violation preceded the employer's job offer does not alter my analysis. Claimant "fail[ed] to begin such [modified] employment" as required by ORS 656.268(3)(c) by virtue of his "drug-related" termination. Consequently, the employer was authorized to terminate claimant's temporary disability once he received the modified job offer which had been approved by his attending physician.

In the Matter of the Compensation of
EDWARD M. ELLISON, Claimant
WCB Case No. 93-04321
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of that portion of Referee Thye's order that set aside its June 30, 1993 denial of claimant's "current condition" and need for surgery. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

The employer issued two denials, the first an April 7, 1993 denial of claimant's request to reopen his claim as of February 26, 1993, and the second a June 30, 1993 denial of the compensability of claimant's knee replacement surgery and claimant's request to reopen his claim as of the surgery date. The Referee concluded that claimant's condition had not worsened during the period between claim closure and surgery and, accordingly, upheld the April 7, 1993 denial. The Referee characterized the employer's June 30, 1993 denial as an aggravation denial, which he set aside. See Order on Reconsideration at 1. The parties do not dispute this characterization. Therefore, we analyze claimant's claim as an aggravation claim.[1]

Compensability/Aggravation

The Referee, applying ORS 656.005(7)(a)(B) and U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), concluded that claimant had proven that his compensable left knee injury was the major contributing cause of his disability and need for treatment and had therefore established the compensability of his aggravation claim as of the date of his knee replacement surgery.

The employer contends that claimant's compensable injury is not the major contributing cause of his need for total knee replacement surgery. In addition, citing ORS 656.273(1)(b), the employer contends that the Referee erred in presuming that claimant's in-patient hospitalization established a worsened condition that was not supported by medical opinion. We agree that ORS 656.273(1)(b), by its terms, prohibits the presumption of a worsened condition by inpatient hospitalization of a worker. However, we do not agree that claimant failed to prove an aggravation on the merits.

To establish a compensable aggravation of a scheduled condition, claimant must show a worsened condition resulting from the compensable condition. ORS 656.273(1) and (3); Perry v. SAIF, 307 Or 654 (1989). An aggravation has two components: causation and worsening.

Subsequent to the Referee's order, the Court of Appeals issued Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994). In Jocelyn, the claimant had experienced a compensable low back injury that was superimposed on a preexisting low back condition. The claimant filed an aggravation claim for the worsening of his accepted condition, which the employer denied. We applied the major contributing cause standard of proof pursuant to ORS 656.005(7)(a)(B) to establish causation.

The court concluded that the legal standard of ORS 656.005(7)(a) (B) for conditions resulting from a combination of a compensable condition and a preexisting condition does not apply to a claim for

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[1] Because this is an aggravation claim rather than a medical services claim, we agree with the Referee's conclusion that Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994), is not controlling. Nevertheless, the standard of proof in Beck for "conditions resulting from the injury" under ORS 656.245(1) is material contributing cause, the same standard as is applied to the causation element of an aggravation claim. See Jocelyn, supra.

aggravation. Instead, the court held that 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. That standard applies even if, as here, the claimant had a condition that preexisted the compensable injury. Thus, in order to establish an aggravation claim, claimant must establish that the compensable injury is a material contributing cause of the worsening. Iocelyn, supra.

After reviewing the record, we affirm and adopt the Referee's opinion that the compensable left knee strain injury is the major contributing cause of claimant's current left knee condition, which requires surgery in order to alleviate claimant's disability. We supplement as follows.

Dr. Bald, who treated claimant prior to claim closure, opined that claimant's preexisting arthritic condition is the major contributing cause of claimant's preexisting knee joint deterioration and an eventual need for knee replacement surgery (which had been avoided for ten years, during which period claimant remained asymptomatic). However, Dr. Bald also concurred with the examiners' opinion that claimant's arthritic knee had been significantly worsened by the compensable injury. (Exs. 22 and 23; Tr. 23). It is this resultant, highly symptomatic condition for which claimant continues to seek treatment.

Dr. Dorr, claimant's current treating surgeon, noted that the arthritic changes in claimant's knee had been aggravated by his injury. (Ex. 28). Dr. Dorr opined that claimant's ligament injury and subsequent instability made it impossible for claimant to function, despite conservative treatment, bracing and arthroscopic surgery. (Exs. 28B and 36). He further opined that the injury was the major contributing cause of claimant's current need for knee replacement surgery. (Ex. 36). Inasmuch as Dr. Dorr performed claimant's recent surgery, we find his observations more persuasive than Dr. Bald's. Consequently, we conclude that the compensable injury is, at the least, a material contributing cause of claimant's current condition and need for surgery. Thus, claimant has established the causation element of an aggravation claim. Iocelyn, supra.[2]

We next determine whether the compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove the worsening of a scheduled body part, claimant must show that he is more disabled, i.e., has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988). Finally, because claimant received a previous permanent disability award for his condition, he must establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

We conclude that claimant has satisfied each of these elements. Claimant experienced an increased loss of use or function of his knee shortly after claim closure that resulted in knee replacement surgery, which in turn resulted in increased loss of use or function of the knee. (Exs. 28, 28B, 29A and 36). Finally, claimant's need for surgery in June 1993 constitutes more than a waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8). For these reasons, we conclude that claimant has established a compensable aggravation of his accepted left knee condition.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated April 8, 1994, as reconsidered and modified April 29, 1994, is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the self-insured employer.

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[2] Were the legal standard for establishing an aggravation claim to be major contributing cause, we would conclude that claimant has established his claim under that standard, based on the same medical evidence.

In the Matter of the Compensation of
LARRY G. FALLS, Claimant
WCB Case No. 94-00240
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of those portions of Referee Spangler's order which: (1) set aside its denial, on behalf of August Construction Company (August), of claimant's left upper rib injury claim; and (2) assessed penalties against SAIF/August for its allegedly unreasonable claim processing. On review, the issues are subjectivity and penalties. We reverse.

FINDINGS OF FACT

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

We do not adopt the last sentence of the Referee's second paragraph under "Ultimate Findings of Fact." Instead, we make the following findings.

R and R Painting (a subcontractor for August, the general contractor) was not an Oregon subject employer when labor commenced on the contract with August. (See Exs. 4A-2, 5).

R and R Painting (a Washington employer) had adequate coverage for its Washington crew prior to the time labor under the contract commenced. (Ex. 4A-2).

Claimant was an Oregon subject worker when he was hired by R & R to work on the "August - R & R" contract. (Ex. 1-2). R & R became an Oregon subject employer when it hired claimant.

Claimant was hired after work under the "August - R & R" contract had commenced. (Exs. 1-1, 4-2).

CONCLUSIONS OF LAW AND OPINION

The Referee held that August, as general contractor, was liable for claimant's left rib injury claim under ORS 656.029 because the subcontractor (R & R) failed to provide coverage for claimant. We disagree.

First, we summarize the pertinent facts. Subcontractor R and R Painting (R & R) entered into a contract with August, the general contractor, to paint a building in Oregon. The first contract period was a few days in July 1992, and the second contract was for the period September 19, 1992 to September 24, 1992.

R & R hired claimant to do painting in Oregon during the second contract period. Claimant began working September 22, 1992, and he sustained an injury on September 24, 1992.

Pursuant to a Director's order, R & R was held to be a noncomplying employer (NCE) during the period from September 22, 1992 to September 25, 1992. The Director's November 20, 1992 NCE order was not appealed.

On August 9, 1993, claimant filed a claim against August. On January 10, 1994, claimant resolved his claim against R & R by entering into a Disputed Claim Settlement (DCS) with SAIF (on behalf of R & R). On January 21, 1994, SAIF denied claimant's 1993 claim on behalf of August Construction Company (its insured).

ORS 656.029 provides, in pertinent part:

> "(1) If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer."

In Liberty Northwest Ins. Corp. v. Hegerberg, 118 Or App 282 (1993), the court explained that the critical time for determining who must provide workers' compensation coverage is the time when the contract is awarded and labor under the contract commences. If the subcontractor has adequate workers' compensation coverage before labor under the contract commences, then the general contractor is not responsible for providing coverage. On the other hand, if the subcontractor does not have workers' compensation coverage prior to the time that labor under the contract commences, the general contractor is responsible for providing coverage. 118 Or App at 286-87.

Here, the parties do not dispute that the subcontractor (R & R), had Washington workers' compensation coverage prior to the time when labor under the contract commenced. (See also Exs. 1-2, 4A-2). Washington coverage was adequate because R & R had no Oregon subject employees at that time. Therefore, at the time the contract was let (either the July 1992 or the September 1992 contract), R & R was a nonsubject employer and exempt from the provisions of Oregon workers' compensation law. See ORS 656.126(2). Consequently, the general contractor, August, was not responsible for workers' compensation coverage for R & R's employees. ORS 656.029(1).

Under ORS 656.029(1), if a worker is not covered, the person responsible for providing coverage is treated as a noncomplying employer. Because R & R had adequate workers' compensation coverage at the time labor under the contract began, R & R assumed responsibility for providing coverage for all its employees while working on the August contract, including employees hired after the contract is let. See Wood v. Dunn, 109 Or App 204, 211 (1991).

Here, we find that the subcontractor (R & R) was charged with the responsibility of providing coverage for claimant, since it certified to the general contractor that it had adequate coverage before labor under the contract began. Thus, claimant's remedy was with SAIF, in its capacity as claims processor for the noncomplying employer (R & R). The general contractor (August) was not obliged under ORS 656.029(1) to provide coverage for the subcontractor's (R & R's) employees. Accordingly, we conclude that August, the general contractor, is not responsible for claimant's work injury. ORS 656.029(1); Wood v. Dunn, supra. Consequently, SAIF's denial on behalf of August is reinstated and upheld.

In light of this conclusion, we need not address SAIF's remaining contentions. Furthermore, because we are upholding SAIF's denial on behalf of August, there is no basis for assessing penalties or attorney fees against SAIF.

We note that, although the general contractor is not responsible for providing coverage, claimant's remedy was with the subcontractor, R & R, and SAIF, as claims processor for the noncomplying employer.

ORDER

The Referee's order dated May 13, 1994 is reversed. The SAIF Corporation's January 21, 1994 denial is reinstated and upheld. The Referee's penalty and attorney fee awards are reversed.

In the Matter of the Compensation of
JANET A. GASS, Claimant
WCB Case Nos. 92-10461, 92-05647 & 92-06765
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys
Beers, Zimmerman, et al., Defense Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Care Center East/Crawford & Company (Crawford) requests review of those portions of Referee Quillinan's order which: (1) set aside its denials of claimant's neck, upper back and left shoulder aggravation claim; and (2) upheld Security Insurance Company's/EBI's (EBI) denials of claimant's new injury claim for the same condition on behalf of Rose City Nursing Home. EBI cross-requests review of the order, contending that claimant's neck, upper back, and left shoulder condition is not compensable. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A certified nurses assistant, claimant sustained a compensable trapezius strain as a result of transferring a patient on January 14, 1991. At the time, claimant was employed by Care Center East, a self-insured employer whose claims were processed by Crawford. The claim was closed without permanent disability on August 16, 1991 by Notice of Closure, but claimant continued to seek medical treatment.

On September 28, 1991, claimant sustained another compensable injury transferring a patient, this time involving the left shoulder and back. Claimant was still employed at Care Center East and her claim was again closed without permanent disability by Notice of Closure issued on January 8, 1992. At hearing, the parties agreed to treat the January and September 1991 injuries as one under the September 28, 1991 injury date.

Claimant began treatment with an osteopath, Dr. Trostel, on October 3, 1991 for left shoulder, neck and low back symptoms. Dr. Trostel released claimant for work at the end of October 1991 with improvement in muscle spasms and increased range of motion. Claimant began employment in November 1991 at Rose City, insured by EBI.

In January 1992, claimant again sought treatment from Dr. Trostel for muscle spasm and tenderness in the upper back and cervical area. Dr. Trostel's treatment continued into February 1992, with claimant still evidencing considerable upper intercostal muscle spasm as of February 21, 1992. This was Dr. Trostel's last treatment prior to March 6, 1992, when claimant sought additional treatment after experiencing two "real bad pinches" during two separate incidents of transferring a patient.

Dr. Trostel reported acute pain in the left low back and left upper back. There was marked muscle spasm in the left lumbosacral area. Dr. Trostel removed claimant from work and she remained off work for approximately eight weeks.

Although claimant testified that she reported the March 6, 1992 incidents to Dr. Trostel, his chart note does not contain a history of the alleged incidents. Nor is a history of those incidents contained in the medical report of another osteopath, Dr. Baum, to whom Dr. Trostel referred claimant on March 11, 1992. Dr. Baum diagnosed cervical-dorsal and left shoulder strain. Claimant did tell a physical therapist on March 17, 1992 about a "pinch" in the middle back she experienced after reaching forward for a patient on March 6, 1992. (Ex. 107).

On March 18, 1992, Dr. Trostel confirmed that claimant had demonstrated marked muscle spasm in the left lumbosacral and thoracic areas, with reported pain in the left low back and left upper back. (Ex. 108). Dr. Trostel requested reopening of the 1991 claim.

Both Crawford and EBI denied compensability and responsibility. In a statement given to EBI, claimant said that her symptoms had remained the same since 1991. Claimant testified at hearing that

her symptoms after the 1991 injury at Care Center never completely went away but that she was able to work. (Tr. 24). Claimant further testified that her symptoms in February 1992 were basically the same as she had previously experienced and that her symptoms after the March 6, 1992 incidents felt the same. (Tr. 74). She considered her problem in March 1992 to be part of an ongoing condition beginning in 1991, only that her symptoms were of considerably greater intensity and appeared to affect a larger area. Claimant agreed that the March 1992 incidents were the "worst injury." (Trs. 79, 80).

At hearing, claimant agreed that she was making no claim against EBI for a low back injury. Liberty Northwest, on behalf of another employer, agreed to continue to be responsible for claimant's low back condition under a 1988 low back injury claim and was dismissed from the proceedings.

Although there was medical evidence in the record that attributed claimant's pain complaints to a preexisting, noncompensable psychogenic pain disorder, the Referee determined that claimant's current condition was compensable. Reasoning that the medical evidence supported a conclusion that claimant sustained a flare-up of the 1991 injury, not a new injury in March 1991, the Referee concluded that Crawford remained responsible for claimant's neck, upper back and left shoulder complaints.

On review, both EBI and Crawford contend that claimant's current condition is not compensable. Both assert that the diagnosed psychogenic pain syndrome is the major contributing cause of claimant's current disability and need for medical treatment pursuant to ORS 656.005(7)(a)(B). Moreover, even if claimant's current condition is compensable, Crawford asserts that it is the responsibility of EBI. We disagree.

Compensability

The Referee determined that ORS 656.005(7)(a)(B) was not applicable, reasoning that the medical evidence did not establish that claimant's preexisting psychogenic pain disorder "combined" with her compensable 1991 injury to cause her need for treatment in March 1992. Finding that claimant's disability and need for medical treatment in March 1992 was materially related to her 1991 injury, and constituted a continuation of that injury, the Referee concluded that claimant sustained a compensable aggravation that was the responsibility of Crawford and Care Center East.

Based on our de novo review of the record, we find no clear evidence that claimant's diagnosed psychogenic pain disorder combined with either claimant's compensable 1991 injury or the reported lifting incidents in March 1992 to cause claimant's need for treatment. Assuming that there was the required combination, such that ORS 656.005(7)(a)(B) was applicable to the compensability issue, we still find that the psychogenic pain disorder was not the major contributing cause of claimant's need for treatment in March 1992.

Dr. Trostel provided the most persuasive medical evidence on the compensability issue. He treated claimant in connection with her compensable 1991 injuries and also in regard to her March 1992 incidents. While his opinion has fluctuated somewhat on the responsibility issue, Dr. Trostel has always maintained that claimant's treatment in March 1992 was the result of either the original 1991 injury or the lifting incidents in March 1992. Inasmuch as he treated claimant both before and after the March 1992 incidents, we find his opinion to be persuasive evidence that claimant's need for treatment in March 1992 was work-related. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Moreover, Dr. Baum, who also treated claimant contemporaneously with the March 1992 incidents, has also related claimant's treatment to either the 1991 injury or to the March 1992 incidents. Neither doctor attributed claimant's symptomatology in March 1992 to a psychogenic pain disorder.

The insurers cite evidence from physicians who subsequently treated and/or examined claimant (Drs. Klecan, Steinhauer, Gambee, Duvall and Bald) that the major contributing cause of claimant's present complaints is the psychogenic pain disorder. However, we agree with the Referee that this evidence is not as persuasive as that provided by the physicians who treated claimant contemporaneously with the March 1992 incidents. Both Dr. Trostel and Dr. Baum reported objective findings of injury and clearly related claimant's symptoms to her employment. (Exs. 87-2, 104, 108, 119, 123). We, therefore, conclude that claimant has proved that her disability and need for medical treatment in March 1992 are compensable.

Responsibility

In the responsibility context, ORS 656.005(7)(a)(B) applies in determining whether or not a worker sustained a "new compensable injury" under ORS 656.308. The appropriate standard to determine if claimant sustained a "new compensable injury" under ORS 656.308(1) and ORS 656.005(7)(a)(B) is whether an accidental injury combined with a preexisting compensable condition and whether that injury is the major contributing cause of the need for treatment and/or disability for the resultant condition. See SAIF v. Drews, supra, 318 Or at 9.

Although we do not find that claimant's diagnosed psychogenic pain disorder combined with either her 1991 injury or the claimed "new injury" of March 1992, we conclude that, based on medical evidence from Dr. Trostel and Dr. Baum, the March 1992 incidents did combine with the preexisting compensable 1991 injury to cause disability or a need for treatment. The issue then becomes whether the March 1992 incidents are the major contributing cause of claimant's need for treatment and disability. SAIF v. Drews, supra. If so, then responsibility shifts to EBI. If not, then responsibility remains with Crawford.

We agree with and adopt the Referee's reasoning and conclusion that claimant sustained a flare-up of the 1991 injury in March 1992. Thus, we find that Crawford failed to sustain its burden of proving that the March 1992 lifting incidents are the major contributing cause of claimant's disability or need for treatment. Therefore, claimant did not suffer a new injury sufficient to shift responsibility to EBI under ORS 656.308. Crawford remains responsible for claimant's current upper back, neck and left shoulder condition.

Claimant is entitled to an assessed attorney fee for prevailing over Crawford's request and EBI's cross-request for review. ORS 656.382(2); See Tina R. Flansberg, 44 Van Natta 2380, 2382 (1992). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, one-half to be paid by Crawford and the other half to be paid by EBI. 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 March 4, 1994 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1000, to be paid in equal shares by Crawford and EBI.

February 10, 1995 Cite as 47 Van Natta 238 (1995)

In the Matter of the Compensation of
GENE R. JONES, Claimant
WCB Case No. 94-02817
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Sedgwick James & Company (Sedgwick), requests review of those portions of Referee Davis' order that: (1) declined to reconsider an interim order which had denied Sedgwick's motion to postpone the hearing to join Liberty Northwest Insurance Corporation (an insurer with a prior accepted claim) because Sedgwick had untimely disclaimed responsibility under ORS 656.308(2); and (2) set aside its denial of claimant's injury claim for a cervical, dorsal and lumbar strain condition. Sedgwick requests that this matter be remanded to the Referee for joinder of Liberty. In his respondent's brief, claimant contests those portions of the Referee's order that: (1) declined to assess a penalty and attorney fee for Sedgwick's allegedly unreasonable denial and claim processing; and (2) upheld Sedgwick's "de facto" denial of his injury claim for a right shoulder condition. On review, the issues are the pre-hearing ruling, remand, compensability, penalties and attorney fees. We deny the motion for remand and affirm on the merits.

FINDINGS OF FACT

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

Claimant has an accepted claim for cervical, thoracic and lumbosacral strains he suffered in a June 18, 1993 industrial accident with Liberty's insured. He treated with chiropractor Dr. Platt through November 30, 1993.

On December 1, 1993, while employed with Barrett Business Services (BBS), claimant was involved in a minor motor vehicle accident as he drove a tow truck. The next day, he sought treatment with Dr. Platt for headaches and neck and back pain, and filed an injury claim with BBS. On the 801 claim form he filed with BBS on December 2, 1993, claimant advised that he had previously injured his neck and low back on June 18, 1993.

On March 2, 1994, Sedgwick (BBS's claims processing agent) issued a letter denying the claim for neck and low back strain on the basis that it was a preexisting condition. On March 31, 1994, Sedgwick issued an amended denial which disclaimed responsibility on the basis that the neck and low back condition was the result of the June 1993 claim with Liberty.

By hearing request dated March 3, 1994, as supplemented on April 4, 1994, claimant requested a hearing on Sedgwick's denial and amended denial letters. The hearing was scheduled for May 24, 1994.

On May 18, 1994, Liberty issued a letter disclaiming responsibility for claimant's condition on the basis that the December 1, 1993 incident with BBS was the major cause of the condition.

On May 23, 1994, the day before hearing, Sedgwick moved for postponement of the hearing in order to join Liberty as a potentially responsible carrier. Claimant objected to the motion. Following a telephone conference, Assistant Presiding Referee Schultz denied the motion to postpone on the ground that Sedgwick's disclaimer of responsibility was untimely.

At hearing, Sedgwick did not renew its motion to postpone, but objected to Referee Schultz's finding that its disclaimer was untimely. Referee Davis declined to decide the timeliness issue and, instead, deferred to Referee Schultz's finding on that issue.

FINDING OF ULTIMATE FACT

The December 1, 1993 work incident with BBS was the major contributing cause of claimant's neck and back condition.

CONCLUSIONS OF LAW AND OPINION

Pre-Hearing Ruling

Sedgwick contends that Assistant Presiding Referee Schultz erred in making a pre-hearing ruling that its responsibility disclaimer was untimely and that Referee Davis erred in deferring to that ruling. Sedgwick misconstrues Referee Schultz's ruling.

As the Assistant Presiding Referee in the Portland Hearings Division office, Referee Schultz was acting within his authority to rule on preliminary matters concerning cases scheduled for hearing in that office. See OAR 438-06-050. Such matters include a pre-hearing motion for postponement, which may not be granted unless there is a finding of extraordinary circumstances beyond the control of the moving party. See OAR 438-06-081.

In this case, Sedgwick requested postponement for the purpose of joining Liberty as a potentially responsible carrier. Therefore, in ruling on the motion for postponement, Referee Schultz necessarily had to determine whether Sedgwick could properly join Liberty. In that regard, OAR 438-06-065(3)(b) provides that "an insurer...shall not be joined by another insurer...in any proceeding unless it is established...[t]hat another insurer...has alleged, in compliance with OAR 438-05-053, that it is responsible for a claimant's condition...." (Emphasis supplied.) OAR 438-05-053(1) requires that an insurer which intends to disclaim responsibility "shall, not later than 30 days after being named or joined in the claim, mail to the claimant a notice stating its intent to disclaim responsibility." (Emphasis supplied.)

Hence, in order to determine whether joinder of Liberty was proper, Referee Schultz first had to determine whether Sedgwick disclaimed responsibility "in compliance with OAR 438-05-053," i.e., within 30 days after being named or joined in the claim. Under the applicable rules, therefore, it was necessary for Referee Schultz to consider the timeliness of Sedgwick's responsibility disclaimer before ruling on its motion. Under these circumstances, we conclude that Referee Schultz did not err in considering the timeliness issue before ruling on Sedgwick's motion.

Furthermore, we reject Sedgwick's contention that claimant had no standing to raise the untimeliness of its disclaimer before Referee Schultz. As a party to the proceeding, claimant had standing to object to Sedgwick's motion for postponement of the hearing to join Liberty as a potentially responsible carrier. He had a stake in having the hearing proceed without delay and in any determination regarding which carrier is responsible for his claim. Sedgwick's contention to the contrary is without merit.

Timeliness of Disclaimer

At hearing, the parties were given an opportunity to fully develop the record regarding the timeliness of the responsibility disclaimer. (Tr. 67-69). However, Referee Davis declined to reconsider Referee Schultz's finding on that issue. Sedgwick argues that Referee Davis erred. For the reasons discussed below, however, we find that Sedgwick's disclaimer was, in fact, untimely. In this regard, we find that the record regarding the timeliness issue was sufficiently developed for our review, and we need not remand this case for further evidence taking. See ORS 656.295(5).

ORS 656.308(2) provides, in pertinent part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim....Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection." (Emphases supplied.)

Sedgwick argues that under ORS 656.308(2) the 30-day period for disclaiming responsibility is initiated when either: (1) an employer or insurer issues a responsibility disclaimer and gives notice of the claim to other employers or insurers; or (2) the claimant files claims against other employers or insurers and requests joinder. It cites our recent decision in Paul M. Jordan, 46 Van Natta 1614 (1994), as supporting authority. We disagree with Sedgwick's interpretation of ORS 656.308(2).

This case turns on the meaning of the language "actual knowledge of being named or joined in the claim." In interpreting the statute, our task is to discern the intent of the legislature. PGE v. Bureau of Labor and Industries, 317 Or 606, 608 (1993). In determining the intent of the legislature, we first examine the text and context of the statute. Id. Only if the text and context of the statute are unclear do we then proceed to consider the legislative history. Id.

The legislature's use of the disjunctive term "or" indicates that the 30-day period for disclaiming is triggered by either: (1) actual knowledge that the insurer/employer is being "named" in the claim; or (2) actual knowledge that the insurer/employer is being "joined" in the claim. Both "named" and "joined" are terms of legal art; "named" means the "designation of an individual person, or of a firm or corporation or other entity," while "joined" refers to the act of uniting parties to a proceeding or action. Black's Law Dictionary 432, 533 (Abr 5th ed 1983). Applying those definitions to the text of ORS 656.308(2), we conclude that the 30-day period for disclaiming is triggered by either: (1) actual knowledge that the insurer/employer is being designated as the responsible party (defendant) in an injury or occupational disease claim; or (2) actual knowledge that the insurer/employer is being united with other employers/insurers as a potentially responsible party (co-defendant) in an injury or disease claim. Inasmuch as we find that the text of the statute is plain and unambiguous, we need not resort to the legislative history of ORS 656.308(2).

Our statutory interpretation is consistent with our decision in Paul M. Jordan, supra. There, the claimant had an accepted low back injury claim with carrier #1. After he began working for a new employer, insured by carrier #2, claimant sought treatment with his doctor who issued a written report documenting a new protruded lumbosacral disc, additional low back problems and his new employment. Carrier #1 received the doctor's report. Three months later, carrier #1 received a responsibility disclaimer from carrier #2, naming it as a potentially responsible carrier. We held that carrier #1's duty to disclaim was not triggered until it received carrier #2's disclaimer notice. We reasoned that the doctor's written report did not trigger carrier #1's duty to disclaim because the report primarily suggested that the claimant's condition was related to employment exposure with the second employer. In other words, carrier #1 did not have actual knowledge of its potential responsibility for the claim until it received carrier #2's disclaimer notice in conjunction with the previously received medical report.

The facts of this case compel a different result. We find that BBS had actual knowledge that it was being designated as the responsible party in claimant's neck and back injury claim on December 2, 1993, the date its claims representative received and signed claimant's 801 claim form. That claim form notified BBS that it was being designated as the employer responsible for claimant's neck and back injury which occurred on December 1, 1993. (Ex. 4). Although BBS's designation in the 801 claim form was sufficient to trigger the disclaimer provisions of ORS 656.308(2), the claim form went further, by advising that claimant had previously injured the same body parts while driving a tow truck on June 18, 1993. (Id).

Therefore, BBS or its claim processing agent, Sedgwick, had 30 days from December 2, 1993 to issue a timely disclaimer of responsibility for the claim. However, Sedgwick did not issue its responsibility disclaimer, which named Liberty as a potentially responsible carrier, until March 31, 1994, almost four months after receiving the 801 form. Because Sedgwick's responsibility disclaimer was not "given as provided in [ORS 656.308(2)]," under the terms of the statute, it could not "assert, as a defense, that the actual responsibility lies with another employer or insurer." Lacking that responsibility defense, there was no basis for joining Liberty in the proceeding. See OAR 438-06-065(3)(b). Accordingly, we find no "good cause" or other compelling basis for remanding this case to the Referee. See Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986). Sedgwick's motion for remand is denied.

Compensability - Neck and Back Claim

Sedgwick contends that, even if its responsibility disclaimer was untimely, claimant is still required to establish the compensability of his neck and back injury claim under the "major contributing cause" standard in ORS 656.005(7)(a)(B). Sedgwick reasons that, by virtue of claimant's prior accepted neck and back injury claim with Liberty, he has a "preexisting condition" which combined with the December 1, 1993 industrial accident to cause his subsequent disability or need for treatment. Sedgwick argues, therefore, that claimant must prove that the December 1, 1993 accident was the major contributing cause of his resultant disability or need for treatment. Claimant responds that, even under the "major contributing cause" standard, he has established the compensability of his claim for a neck and back injury on December 1, 1993. We agree.

Because claimant previously injured his neck and back in June 1993 and was continuing to treat for that injury until shortly before the December 1993 accident, the application of the "major contributing cause" standard in this case is a complex medical question requiring expert medical evidence to resolve. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993). Medical opinions were rendered by Drs. Platt, Puziss and Burns. Dr. Platt, claimant's treating chiropractor since June 1993, diagnosed cervical sprain/strain, thoracic sprain/strain and lumbar sprain/strain, and opined that the December 1, 1993 accident was the major contributing cause of claimant's subsequent need for treatment. He reasoned that claimant's gradually worsening symptoms (headaches and neck and back pain) on the day after the accident were consistent with the mechanism of the accident. (Exs. 6, 17).

Dr. Puziss, the consulting orthopedic surgeon, diagnosed mild cervical and dorsal lumbar strains and opined that the December 1, 1993 accident was the major contributing cause of claimant's subsequent need for treatment. He reasoned that the mechanics of the accident were entirely consistent with the injuries he diagnosed and treated. (Exs. 10, 20).

Dr. Burns, an osteopathic physician who examined claimant at Sedgwick's request on January 6, 1994, found mild parathoracic muscle spasm but no objective evidence of any significant injury in the cervical and lumbar spine. Comparing those findings to claimant's treatment records following the June 1993 accident, Dr. Burns felt there was no pathological or material worsening of the thoracic condition. He opined that the December 1 accident most likely increased claimant's thoracic discomfort temporarily, causing the need for treatment. (Exs. 11, 16).

After reviewing these medical opinions, we conclude that Dr. Platt's opinion was most persuasive. As the only physician to treat claimant's neck and back condition both before and after the December 1993 accident, Dr. Platt was in the best position to assess the contribution of the December 1993 accident to claimant's subsequent need for treatment. See Kienow's Food Stores v. Lyster, supra, 79 Or App at 421. He saw claimant on the day after the December 1 accident and found objective findings of a neck and back injury. Although he did not specifically discuss claimant's treatment prior to the December 1 accident, inasmuch as he was the doctor who rendered that treatment, we are persuaded that his opinion concerning causation was based on his first-hand observation and evaluation of claimant's condition both before and after the December 1 accident.

Furthermore, Dr. Platt's opinion was supported by that of orthopedic surgeon Dr. Puziss, who found objective evidence of a mild cervical and dorsal lumbar spine injury and opined that the injury was consistent with the mechanism of the December 1 accident. Even Dr. Burns, who examined claimant five weeks after the accident, found objective evidence of a thoracic injury and opined that the accident caused an increase in thoracic symptoms. Although Dr. Burns did not find evidence of a cervical or lumbar spine injury, the absence of such evidence could be attributed to the five-week interval between the accident and his examination.

Finally, Sedgwick attempted to minimize the significance of the December 1 accident by offering the testimony of the passenger in claimant's tow truck at the time of the accident. The passenger testified that the truck's impact with the rear of the other vehicle was "very slight" and caused her to go "gently forward and back." (Tr. 63). However, based on our review of the photographs of the front bumper of the tow truck after the accident, (Exs. 21A, 21B, 21C), we are persuaded that the impact was more significant than described by the passenger. Consequently, we do not find the passenger's testimony to be persuasive. Accordingly, we conclude that, under the "major contributing cause" standard in ORS 656.005(7)(a)(B), claimant has established the compensability of his claim for injury to his neck, mid-back and low back as a result of the December 1, 1993 accident.

Compensability - Right Shoulder

In his respondent's brief, claimant contends that the Referee erred in concluding that he did not assert a claim for a right shoulder injury as a result of the December 1, 1993 accident. We disagree.

The medical reports in the record do not document any objective findings of a right shoulder injury. At most, the reports indicate that claimant had symptoms of pain and discomfort radiating from the cervical and thoracic spine. In any event, there is no medical opinion which relates a right shoulder condition to the December 1993 accident. Drs. Platt and Puziss diagnosed cervical, thoracic/dorsal and lumbar spine conditions only. (Exs. 6, 10). Therefore, as supplemented herein, we adopt the Referee's opinion on this issue.

Penalties/Attorney Fees

Finally, claimant contends that the Referee erred in declining to assess penalties and attorney fees for Sedgwick's allegedly unreasonable denial and claim processing. Specifically, claimant argues that: (1) there was no reasonable basis for Sedgwick's denial of his claim for cervical and lumbar spine conditions; and (2) there was an unreasonable failure to process his claim for the thoracic spine condition.

We adopt the Referee's opinion on this issue with the following supplementation. At hearing, claimant did not raise Sedgwick's failure to process his claim for the thoracic spine condition as a basis for penalties and attorney fees. The only basis he asserted for penalties and attorney fees was the unreasonableness of Sedgwick's denial, which denied only the cervical and lumbar spine conditions. Because claimant did not raise Sedgwick's failure to process the thoracic spine claim as an issue at hearing, we decline to address it for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Claimant's counsel is entitled to an assessed attorney fee for prevailing against Sedgwick'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 assessed attorney fee for services on review is $1,000, to be paid by Sedgwick. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee award for his counsel's unsuccessful services regarding the right shoulder, penalty and attorney fee issues.

ORDER

The Referee's order dated June 30, 1994 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,000 for services rendered on Board review, to be paid by Sedgwick.

February 10, 1995 Cite as 47 Van Natta 243 (1995)

In the Matter of the Compensation of
SUSAN MAZZA-MELTON, Claimant
WCB Case No. 94-04332
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of those portions of Referee Peterson's order that: (1) set aside its denial of claimant's low back injury claim; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Claimant's attorney is entitled to an assessed attorney fee for prevailing over the insurer's request for review regarding the compensability issue. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

Penalties

Claimant was injured on September 14, 1993, when two boxes fell on her neck and shoulders. On December 8, 1993, the insurer accepted a claim for cervical strain. Following claim closure, claimant was diagnosed with a herniated disc. On March 14, 1994, the insurer denied compensability of any low back condition.

The Referee assessed a penalty, finding that the March 14, 1994 denial did not issue within 90 days of the filing of the low back condition claim and, therefore, was unreasonable. The insurer asserts, first, that there was no claim for a low back condition until January 11, 1994, and, therefore, its denial was not untimely. The insurer further argues that claimant failed to prove "amounts then due" upon which to base a penalty.

A physician's report requesting medical services for a specified work-related condition constitutes a "claim." Safeway Stores, Inc. v. Smith, 117 Or App 219, 227-28 (1993). Claimant's prior treating physician, Dr. Connor, D.O., filed an "829" form with the insurer requesting a change of attending physician. (Ex. 11). The form also indicated a diagnosis of lumbar strain and that claimant had been injured at work when two boxes fell on her. (Id). The insurer received the form on November 4, 1993. (Id).

Based on this report, we find that the insurer had information of a low back condition that was being treated as a result of her work accident. Therefore, a "claim" was filed for claimant's low back condition. Furthermore, because the insurer did not deny the low back condition within 90 days of November 4, 1993, when the insurer received the "829" form, we conclude that its March 14, 1994 denial was not timely. See ORS 656.262(6).

Although the record lacks specific evidence that the insurer did not pay all compensation relating to the low back condition, we also are convinced that there are "amounts then due" upon which to base a penalty. Claimant was not diagnosed with a herniated disc until February 25, 1994, after her cervical condition claim was closed on February 23, 1994. The March 14, 1994 denial stated that the insurer had "received a letter on 3/7/94" indicating claimant's diagnosis of a herniated disc and that it was denying "any low back condition." (Ex. 24). Claimant received additional treatment for her herniated disc following the issuance of the denial, including a MRI scan and physical therapy. (Exs. 25A, 25B).

Such evidence sufficiently shows that, at minimum, the insurer did not provide compensation for claimant's low back treatment following the issuance of the March 14, 1994 denial since the denial explicitly stated that the low back condition did not arise out of claimant's employment or related to her accepted condition. Specifically, in light of such language, we find proof that the insurer considered itself not liable for the low back condition and, therefore, did not provide compensation for its treatment.

Consequently, since we agree with the Referee that the insurer's denial was not timely and there are "amounts then due," we affirm the assessment of a penalty.

ORDER

The Referee's order dated July 8, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
STEVEN H. NEWMAN, Claimant
WCB Case No. 93-10605
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Lipton's order which upheld the SAIF Corporation's denials of claimant's occupational disease claim for bilateral carpal tunnel syndrome. In his brief, claimant also contends that the Referee erred in refusing to admit into evidence a survey of the medical community's opinion regarding a medical theory espoused by Dr. Radecki. On review, the issues are compensability and evidence. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld SAIF's denials of claimant's occupational disease claim for bilateral carpal tunnel syndrome, relying on the opinion of Dr. Ochoa, an examining physician, who concluded that claimant did not have carpal tunnel syndrome. The only condition Dr. Ochoa diagnosed was right C8/T1 radiculopathy, which he could not directly relate to claimant's employment. Finding that Dr. Ochoa presented the best analysis of the etiology of claimant's upper extremity complaints, the Referee concluded that claimant did not have carpal tunnel syndrome and that SAIF's denials should be upheld.

On review, claimant contends that the Referee erred in finding that he did not suffer from a compensable carpal tunnel condition. We agree.

In May 1993, claimant, an electrician, consulted a neurologist, Dr. Edmonds, for complaints of left hand pain of gradual onset. Dr. Edmonds diagnosed left carpal tunnel syndrome based on her clinical examination and bilateral carpal tunnel syndrome based on her nerve conduction studies. (Exs. 1, 2). Dr. Edmonds subsequently referred claimant to a neurosurgeon, Dr. Mason, who concluded on October 5, 1993 that, based on claimant's history and clinical examination, claimant had bilateral carpal tunnel syndrome. (Ex. 5B).

Claimant was also seen by an examining physician, Dr. Radecki, who also concluded that claimant demonstrated mild bilateral median nerve slowing in the carpal tunnel. (Ex. 7-2). This conclusion was based on electrodiagnostic testing. By the time Dr. Ochoa examined claimant on October 28, 1993, however, claimant's bilateral wrist condition was significantly improved. (Tr. 32). Dr. Ochoa could find no evidence of carpal tunnel syndrome at that time. (Ex. 9-7). The only abnormality Dr. Ochoa could detect on examination was cervical radiculopathy, which he could not directly relate to claimant's employment.

We agree with claimant that he need not currently demonstrate evidence of carpal tunnel syndrome in order to have a compensable claim. In light of the diagnoses of three physicians, Drs. Edmonds, Mason and Radecki, all of whom examined claimant prior to Dr. Ochoa, and all of whom diagnosed carpal tunnel syndrome, we are persuaded that claimant suffered, at least initially, from bilateral carpal tunnel syndrome. The fact that claimant may not currently demonstrate evidence of this condition does not require that we find this condition noncompensable.

Nor do we agree with the Referee that Dr. Mason, in his deposition, conceded that claimant never had the condition. Dr. Mason testified that claimant does not currently have clinical evidence of carpal tunnel syndrome. (Ex. 14-14). However, Dr. Mason also testified that, when he examined claimant on October 5, 1993, claimant clearly had carpal tunnel syndrome, although it was not advanced and may have been waxing and waning. (Ex. 14-34). Therefore, the dispositive issue becomes whether or not claimant's carpal tunnel condition is related to his employment as an electrician.

In order to establish the compensability of his occupational disease claim, claimant must prove that work activities were the major contributing cause of his bilateral wrist condition. ORS 656.802. The existence of the disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

Given our conclusion that claimant did suffer from bilateral carpal tunnel syndrome, the electrodiagnostic studies of Drs. Edmonds and Radecki constitute objective evidence of the existence of the disease.

There is a dispute regarding the cause of claimant's bilateral carpal tunnel condition. When there is a dispute between medical experts, we give more weight to medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Only two physicians have expressed opinions on the causation of claimant's carpal tunnel condition: Drs. Mason and Radecki. On November 29, 1993, Dr. Mason concurred with the summary of a telephone conference he had with claimant's counsel. (Ex. 11). Dr. Mason agreed that he was well aware of claimant's work activities as an electrician and that claimant's repetitive use of his hands during that employment was the major contributing cause of his carpal tunnel condition. This opinion was based in part on the assumption that claimant had no comparable off-the-job exposure, an assumption that SAIF does not contest on review.

Dr. Mason further concurred with claimant's counsel's summary of how claimant's repetitive work activity caused swelling in the synovial membranes of the carpal tunnel and that this in turn caused compression of the median nerve, i.e., carpal tunnel syndrome. Although SAIF dismisses Dr. Mason's concurrence letter as merely a "check-the-box" response worthy of little weight, we still find it persuasive because of the detailed explanation contained in the letter. See Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of expert's response depends on explanation that corresponds to medical expert's opinion).

In his deposition, Dr. Mason confirmed that claimant's counsel had accurately summarized his medical opinion. (Ex. 14-25). Dr. Mason was also provided with a description of claimant's job duties at his deposition. Dr. Mason further confirmed that, based on this history, his opinion remained that claimant's work caused his carpal tunnel syndrome. (Ex. 14-28).

Inasmuch as it is well-reasoned and explained, and because it is based on a complete and accurate history, Dr. Mason's opinion is persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Moreover, we find it more persuasive than that of Dr. Radecki, who opined that claimant's carpal tunnel condition is not related to his employment, but rather to factors such as age, obesity and the shape of claimant's wrists. However, Dr. Radecki's opinion is based largely on his review of medical literature, much of which is grounded in a statistical correlation between these idiopathic factors and the occurrence of carpal tunnel syndrome. (Exs. 10-10, 11, 13, 15, 16, 17, 18, 20, 29, 30). Because Dr. Radecki's medical opinion does not adequately address claimant's particular circumstances, we give less weight to Dr. Radecki's conclusions as to the etiology of claimant's carpal tunnel syndrome. See Catherine M. Grimes, 46 Van Natta 1861 (1994); Mark Ostermiller, 46 Van Natta 1556, on recon 46 Van Natta 1785 (1994).

In conclusion, we find Dr. Mason's medical opinion to be the most persuasive on the causation issue. Accordingly, we conclude that claimant has sustained his burden of proving that his employment was the major contributing cause of his bilateral carpal tunnel condition. Thus, we reverse the Referee's decision on the causation issue and set aside SAIF's denials.

In light of our compensability determination based on the evidence admitted by the Referee, it is unnecessary for us to address the Referee's exclusion of the survey.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). SAIF objects to claimant's request for an assessed attorney fee of $5,200 for services both at hearing and on review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, counsel's statement of services, and 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 March 30, 1994 is reversed. SAIF's denials are set aside, and the claim is remanded to it for processing in accordance with law. Claimant's attorney is awarded $4,500 for services at hearing and on Board review, to be paid by SAIF.

In the Matter of the Compensation of
ROBERT D. SCHNELLE, Claimant
WCB Case No. 93-15200
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Referee Garaventa's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for claimant's back condition. On review, the issue is extent of unscheduled permanent disability.

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

The reference to "SAIF" in the last sentence of the "Findings of Fact" is replaced with "the insurer."

On the merits, we note that claimant is entitled to a reevaluation of his entire injury claim following closure of the aggravation claim. We further note that the last award or arrangement of compensation (a March 1, 1988 Notice of Closure) closed claimant's back and right ankle injury claim with no permanent disability. Under these circumstances, in order to prove entitlement to unscheduled permanent disability for his compensable back condition, claimant must establish that the condition has permanently worsened condition since the last award or arrangement of compensation. See Bendix Home Systems v. Alonzo, 81 Or App 450, 452 (1986) (citing Stepp v. SAIF, 78 Or App 438, rev den 301 Or 445 (1986) (a determination of the extent of permanent disability cannot be relitigated in the guise of an aggravation claim).

Claimant contends that he meets the threshold worsening requirement because he had no low back impairment when his initial claim was closed in 1988, but does have such impairment now. Claimant bases his contention on range of motion measurements made by the medical arbiter following closure of the aggravation claim in 1993.

We acknowledge that Dr. Dineen, medical arbiter, examined claimant on November 19, 1993 and recorded right ankle and back range of motion measurements which are arguably ratable under the "standards."[1] (Ex. 24). However, Dr. Schader, treating physician, opined (in contrast) that claimant's lumbar spine demonstrated "totally normal range of motion" at a February 17, 1993 closing examination. (Ex. 19A-1). We further note, as did the Referee, that the record contains no baseline for evaluating whether claimant's back range of motion has changed, because there are no previous measurements. Under these circumstances, and considering Dr. Schader's advantageous position as claimant's treating physician, we find no persuasive reason to discount Dr. Schader's conclusion that claimant's back range of motion is "totally normal." See Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983).

Consequently, based on Dr. Schader's opinion, we conclude that claimant has not established a permanent worsening of his back condition since the last arrangement of compensation. Accordingly, claimant is not entitled to a permanent disability award for his back.

ORDER

The Referee's order dated April 20, 1994 is affirmed.

[1] However, we note that Dr. Dineen did not relate claimant's back measurements to the 1987 work injury or describe them as "permanent impairment.

In the Matter of the Compensation of
DELBERT D. SHUCK, SR., Claimant
WCB Case No. 94-00758
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Hall and Turner-Christian.

Claimant requests review of that portion of Referee McWilliams' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a left shoulder condition. The employer cross-requests review of that portion of the order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant performed heavy work for the employer for 31 years. As of June 1993, claimant, who is right-handed, had worked for about a year as a "rail sticker operator." This position required repetitive lifting of wooden blocks ordinarily weighing 15-20 pounds. Claimant used both arms to perform his job. During the previous 30 years, claimant performed a variety of other heavy jobs, which did not steadily involve both arms or lifting weights. (Tr. 8).

In June 1993, claimant's right shoulder became painful. When he began favoring it, his left shoulder became painful.

On July 1, 1993, claimant sought treatment for his right shoulder from Dr. Guild, family physician. Dr. Guild treated claimant conservatively and ordered modified work. Claimant filed a claim for a right shoulder strain.

Dr. Guild referred claimant to Dr. Panum, an occupational medicine specialist. Dr. Panum ordered x-rays which revealed degenerative changes of the right acromioclavicular joint with spurring. Dr. Panum referred claimant to Dr. Davis, orthopedist. Dr. Davis examined claimant on October 12, 1993 and recorded claimant's history of bilateral shoulder pain, worse on the right, and diagnosed bilateral impingement syndrome and degenerative rotator cuff disease. All three doctors worked in the same clinic.

Shortly thereafter, claimant began working as a "slicer" for a different employer. Dr. Davis reported that claimant could handle this work comfortably.

On November 23, 1993, the employer denied claimant's claim for a bilateral shoulder condition. Claimant requested a hearing.

By December 1993, claimant was working at full capacity at his new "slicer" job.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant proved that his right shoulder condition is compensable, but failed to prove that his left shoulder condition is compensable. We conclude that the bilateral condition is compensable, based on the following reasoning.

Regarding claimant's burden of proof, we note at the outset that the uncontroverted evidence indicates that claimant's degenerative right shoulder condition preexisted the onset of his 1993 right shoulder problems. However, there is no evidence that any shoulder degeneration (involving either shoulder) preexisted claimant's 31 year exposure to heavy work for the employer. Moreover, there is no evidence that claimant had prior shoulder symptoms or treatment. Nevertheless, claimant bears the burden of proving that employment conditions were the major contributing cause of the claimed bilateral shoulder condition. See ORS 656.802(2); see also ORS 656.802(1)(c).

The Referee found that the medical evidence relating claimant's right shoulder condition to his work is uncontoverted. We agree and adopt the Referee's reasoning in this regard. Accordingly, we further agree that claimant has carried his burden regarding his right shoulder.

The Referee found that claimant failed to carry his burden of establishing medical causation regarding his left shoulder condition. We disagree, for the following reasons.

Claimant sought treatment for his right shoulder first because it hurt first. A month later, Dr. Guild reiterated that claimant's right shoulder "problem" is that "he uses it a lot with his work [for the employer] where he has worked for 31 years." (Ex. A). In the same report, Dr. Guild noted, "On the left side, he can get to the belt, though that shoulder is becoming sore, as he overuses that one." (Id). Thus, in our view, Dr. Guild related claimant's left shoulder problems to left shoulder overuse at work, just as he did the right shoulder problems.

In addition, we note that claimant sought and received treatment for both shoulders in 1993, but never before. Like Dr. Guild, Dr. Davis referred to claimant's 31 year history of heavy work for the employer and treated both shoulders similarly. Claimant testified that his left shoulder started getting sore when he was "babying" his right shoulder and using his left shoulder more at work. (Tr. 7). He began noticing left shoulder pain soon after the onset of right shoulder pain. (Id). There is neither argument nor evidence relating claimant's left shoulder problems to off-work activities.

Considering the medical evidence in light of the above-described facts, we conclude that claimant has established that his work conditions as a "rail sticker operator," including the favoring of the right shoulder, were the major contributing cause of the left shoulder condition for which claimant sought treatment in 1993. 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).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of his left shoulder condition. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the left shoulder condition is $1,750, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate brief and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We have also taken into consideration claimant's attorney's awards for services at hearing and on review regarding the right shoulder condition.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's cross-request for review regarding claimant's right shoulder 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 concerning the right shoulder condition is $750, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 10, 1994 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's denial of claimant's claim for a left shoulder condition is reversed. The employer's denial is set aside and the left shoulder claim is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the left shoulder, claimant is awarded a $1,750 attorney fee, payable by the employer. For services on review regarding the right shoulder, claimant is awarded a $750 attorney fee, payable by the employer.

In the Matter of the Compensation of
ALBINA A. SINGH-BOGARIN, Claimant
WCB Case No. 93-13283
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Steven D. Hallock, Defense Attorney

Reviewed by Board Members Hall and Turner-Christian.

The insurer requests review of Referee Michael V. Johnson's order that awarded 40 percent (128 degrees) unscheduled permanent disability for claimant's left shoulder condition, whereas an Order on Reconsideration had awarded none. The insurer argues that Exhibit 20, a "post-reconsideration" report from claimant's attending physician, should not be considered in evaluating claimant's permanent disability because it is not relevant to claimant's condition at claim closure. On review, the issues are evidence and extent of permanent disability.

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

We agree with the Referee that claimant is entitled to a 5 percent impairment factor for a chronic condition which limits repetitive use of her left shoulder. In reaching this conclusion, we defer to the opinion of Dr. Zirschky, claimant's attending physician, regarding claimant's impairment. See Weiland v. SAIF, 64 Or App 810 (1983).

In addition, we acknowledge the insurer's contention that Exhibit 20, a post-reconsideration report from Dr. Zirschky should not be considered in evaluating claimant's permanent disability. However, we need not address the propriety of relying on Exhibit 20, because we would reach the same result without that report, based on Dr. Zirschky's earlier opinion that claimant "shouldn't do repetitive lifting or use of the left arm." (Ex. 10A).

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

ORDER

The Referee's order dated April 5, 1994 is affirmed. For services on review , claimant is awarded a $750 attorney fee, payable by the insurer.

In the Matter of the Compensation of
KIRK J. FINDLAY, Claimant
WCB Case No. 93-09350
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

On January 12, 1995, we withdrew our December 15, 1994 order which had affirmed a Referee's order that upheld the insurer's partial denial of his occupational disease claim for a psychological condition. We took this action in order to retain jurisdiction to consider the parties' proposed revised disputed claim settlement. Having received the revised agreement, we proceed with our reconsideration.

The parties have submitted a proposed "Joint Petition and Order of Bona Fide Dispute Settlement -- Amendment," which is designed to resolve all issues raised or raisable in this matter. Pursuant to the amended settlement, claimant agrees that the insurer's denials "remain in full force and effect." The parties further stipulate that claimant's request for hearing and Board review "shall be dismissed with prejudice."

We have approved the parties' amended agreement, thereby fully and finally resolving this dispute. Accordingly, on reconsideration of our December 15, 1994 order, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
CALUM E. REED, Claimant
WCB Case Nos. 93-14030 & 93-14029
ORDER ON REVIEW
Vera Langer (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Referee Brazeau's order that upheld the SAIF Corporation's partial denials of his fainting condition. On review, the issue is compensability.

We adopt and affirm the Referee's order.

ORDER

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

Board Member Gunn specially concurring.

The doctrine of stare decisis compels the result we have reached in this matter. However, this case provides an excellent example of how the legislative changes over the past few years have frustrated the primary objective of the workers' compensation system: to provide for injured workers. See ORS 656.012(2).

Here, claimant suffers from a condition, termed "neurocardiogenic syncope," that causes a loss of consciousness. Most of the medical experts agree that this condition is probably the result of episodic and excruciating pain related to claimant's compensable right elbow condition. In the past, such evidence would have been sufficient to establish the compensability of claimant's neurocardiogenic syncope condition.

However, under the "major contributing cause" standard, claimant faces the unfair burden of conclusively establishing that his accepted right elbow condition is at least 51 percent to blame for his periodic blackouts. In other words, to meet the major contributing cause standard a compensable injury must be more responsible for a given condition than the combination of all other possible factors. By no fault of claimant, the examining physicians are unable to diagnose the etiology of his blackouts to such a mathematical certainty.

It is unreasonable to deny an injured worker his just compensation for a work-related condition because the medical evidence does not quantify that work-relatedness is at least 51 percent of all possible causes. This increased burden of proof is contrary to the basic purpose of the workers' compensation system. It is even more troubling to observe that, if this worker could sue for damages outside the workers' compensation system, his burden of proof would not be so strict and the recoverable damages would not be fixed by law.[1]

If we are to restore an injured worker physically and economically to a self-sufficient status in a expeditious manner, and to the greatest extent practicable, then the inquiry should simply be (as it was before the 1990 amendments): is the condition for which compensation is sought attributable to a work injury? Here, the answer is "yes." Thus, claimant's neurocardiogenic syncope would be compensable.

This approach is far more equitable, and intuitive, than the strict application of such a rigorous standard as "major contributing cause." Unfortunately, this injustice can only be corrected by the legislature. I encourage them to do so.

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[1] Notably, the Supreme Court recently held in Errand v. Cascade Steel Rolling Mills, Inc., 320 Or 509 (1995), that the employer was not immune from a civil claim where the injured worker did not have a compensable injury. This holding portends better days for some injured workers.

In the Matter of the Compensation of
ELIZABETH E. HELLER, Claimant
WCB Case No. 94-04337
ORDER ON REVIEW
Swanson, et al., Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of those portions of Referee Brazeau's order which: (1) set aside its "de facto" denial of a billing for medical services; (2) awarded an assessed attorney fee of $987.50 for claimant's counsel's services in overturning the denial; and (3) assessed penalties under ORS 656.262(10) for allegedly late payments of medical bills. In its brief, the insurer contends that the Board does not have jurisdiction to address the issue of penalties. Claimant moves to strike evidence submitted with the insurer's appellant's brief. Further, claimant asks that her untimely respondent's brief be accepted. On review, the issues are claimant's procedural motions, jurisdiction, compensability, and penalties and attorney fees.

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

Claimant submitted several medical bills to the insurer. All of the bills but one were paid, although the bills were paid late. Claimant requested a hearing, seeking penalties for late payment of the bills, and claiming that one of the bills was "de facto" denied. The Referee assessed penalties under ORS 656.262(10) for late payment of the medical bills, found compensable the bill that was "de facto" denied, and awarded an attorney fee under ORS 656.386(1) for claimant's counsel's services in overturning the denial.

Motion for Waiver

Claimant moves for a waiver of the rules concerning timely filing of briefs, contending that her brief was one day late due to a miscalculation of the due date by claimant's counsel's legal assistant. Thus, claimant argues there were extraordinary circumstances beyond claimant's control in filing the brief late. The insurer opposes the motion, asserting that such circumstances do not satisfy the requisite administrative standard. See OAR 438-11-030. We deny the motion.

Here, claimant concedes that she untimely filed her respondent's brief. See OAR 438-11-020(3). Nevertheless, attributing her delay to a "calendaring error," she seeks waiver of the aforementioned rule. Such a situation does not constitute an extraordinary circumstance beyond the control of the requesting party. See Lester E. Saunders, 46 Van Natta 1153 (1994). Accordingly, we deny claimant's motion to accept her untimely filed respondent's brief.

Evidence

The insurer has submitted several items as exhibits attached to its appellant's brief. Those items include claimant's request for hearing, a Director's order referring ORS 656.262(10) penalty proceedings to the Hearings Division, the insurer's motion for dismissal, the order denying the motion to dismiss, and the insurer's objection to claimant's attorney fee request. Claimant moves to strike the appendices because the documents have not been admitted into evidence. Although not submitted as evidence at the hearing, each of the aforementioned documents are already present in the record on review. Inasmuch as that record is subject to our review, the insurer's submission is superfluous. Accordingly, we grant the motion to strike.

Jurisdiction

The insurer contends that the sole issue before the Referee was penalties arising from the late payment of medical bills, and that exclusive jurisdiction over the penalty issue is with the Director. We disagree that the Director has exclusive jurisdiction in this case.

ORS 656.262(10) provides, in part, that the Director has exclusive jurisdiction over proceedings regarding solely the assessment and payment of penalties and fees described in that subsection of the statute. Here, in her Request for Hearing and Specification of Issues, claimant listed "failure to pay medical services in a timely manner; 'de facto' denial of medical services; penalties and fees." Because it is apparent from claimant's hearing request that penalties were not the sole issue at hearing, we conclude that we have jurisdiction to address the penalty issue. See James V. Johnston, 46 Van Natta 1198, on recon 1813 (1994).

Compensability

With regard to the issue of compensability of claimant's denied medical services claim, we adopt the Referee's reasoning and conclusion.

Attorney Fees

Asserting that "[t]here is no such thing as a 'de facto' denial," the insurer contends that there is no basis for an attorney fee award under ORS 656.386(1). We disagree.

In SAIF v. Allen, 320 Or 192 (1994), the Supreme Court held that the Board properly applied the term "de facto denial" to an insurer's failure to accept or deny a claim within 90 days, as required by ORS 656.262(6). 320 Or at 214-215. The facts in this case are identical to those in Allen, where the insurer did not issue an acceptance or denial of a claim for medical services within the time period required by ORS 656.262(6). Moreover, as in Allen, there is no indication that the insurer's denial was confined to the issue of the amount of compensation or the extent of disability. See Snowden A. Geving, 46 Van Natta 2355 (1994). Accordingly, we agree with the Referee that the insurer "de facto" denied claimant's claim for medical services, and that claimant was entitled to an assessed attorney fee.

Additionally, the insurer contends that claimant did not raise the issue of an attorney fee under ORS 656.386 at hearing, but rather, based her request for attorney fees only on ORS 656.382. The insurer argues that the Referee, on his own motion, awarded a fee under ORS 656.386(1). Alternatively, the insurer contends that the Referee's attorney fee award is excessive. We disagree with both of the insurer's contentions.

Specifically, at hearing, claimant stated that she was "asking for an attorney fee based on a 'de facto' denial of the January 20, 1994 treatment and/or an attorney fee under ORS 656.382 * * *." (Tr. 2). (Emphasis added). We conclude that, by requesting a fee based on a denial, claimant was requesting a fee authorized by ORS 656.386(1).

Accordingly, claimant is entitled to an assessed attorney fee for prevailing at hearing over the issue of the "de facto" denial of the claim for medical services. ORS 656.386(1). Finally, after considering the factors set forth in OAR 438-15-010(4), we find that the Referee's $957.50 attorney fee award was reasonable. In reaching this 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Inasmuch as claimant's brief was rejected as untimely, no attorney fee pursuant to ORS 656.382(2), for services on Board review, shall be awarded. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

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

In the Matter of the Compensation of
RITA L. JEFFERSON, Claimant
WCB Case No. 90-22070
ORDER ON REMAND
Swanson, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Jefferson v. Sam's Cafe, 123 Or App 464 (1993). The court reversed our order that held that the Hearings Division lacked jurisdiction under ORS 656.327 to consider a medical treatment dispute concerning a proposed wrist surgery. Reasoning that jurisdiction over proposed medical treatment lies with the Hearings Division, the court has remanded for further proceedings.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In May 1989, claimant compensably injured her left and right hands, including the wrist and forearm. Claimant underwent left carpal tunnel release surgery in January 1990. This surgery relieved her numbness, but she continued to experience pain from the thumb into the radial forearm and pain in the shoulder and elbow. (Exs. 2, 8). On November 13, 1990, after conservative treatment failed, claimant's treating physician, Dr. Layman, recommended surgery for left deQuervain's syndrome and left lateral epicondylitis.

On December 12, 1990, the SAIF Corporation requested Director review of the reasonableness and necessity of the proposed treatment. On December 14, 1990, claimant requested a hearing, challenging SAIF's "de facto" denial of the proposed wrist surgery. Dr. Layman performed the surgery on January 30, 1991.

As of the March 4, 1991 hearing, the Director had begun processing the medical review, but had not issued an order. At hearing, the Referee concluded that the Hearings Division had jurisdiction over the issue of the reasonableness and necessity of the proposed treatment. Relying on the opinion of Dr. Layman, the Referee concluded that the surgery was reasonable and necessary treatment for claimant's compensable left wrist condition.

On review, we found that the Referee lacked jurisdiction over the issue of the reasonableness and necessity of the proposed treatment. Relying on Stanley Meyers, 43 Van Natta 2643 (1991), and Kevin S. Keller, 44 Van Natta 225 (1992), we concluded that the medical services dispute was not a matter concerning a claim over which the Hearings Division had jurisdiction.

On appeal, the Court of Appeals reversed our decision. Jefferson v. Sam's Cafe, supra. Reasoning that ORS 656.327 is inapplicable to disputes regarding proposed medical treatment, the court held that the Board and its Hearings Division have exclusive jurisdiction to resolve disputes concerning future medical treatment. Consequently, the court has remanded for reconsideration. In accordance with the court's mandate, we proceed with our reconsideration.

Claimant carries the burden of proving by a preponderance of the evidence that the proposed treatment is reasonable and necessary. West v. SAIF, 74 Or App 317 (1985). The issue of whether the proposed treatment is reasonable and necessary presents a complex medical question, the resolution of which turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Dr. Steinhauer examined claimant on June 26, 1990 as part of a comprehensive disability prevention evaluation. He diagnosed, inter alia , deQuervain's syndrome, but did not consider that condition to be a major contributing factor of claimant's pain and, thus, concluded that surgery would not provide pain relief. He also felt that claimant had somatoform pain disorder with secondary gains contributing to her ongoing pain problems. Dr. Steinhauer recommended EMG studies to rule out ulnar or radial nerve damage. (Ex. 22). Claimant's EMG studies were within normal limits.

Dr. Long disagreed with Dr. Steinhauer that EMG studies would be of any benefit in determining whether surgery would be beneficial. Dr. Long explained that EMG examination of the ulnar muscles is an insensitive way to diagnose mild or moderate ulnar entrapment neuropathy at the elbows. (Ex. 29). Based on his examination findings, Dr. Long diagnosed ulnar compression neuropathy at the elbows, and possible radial neuropathy with some element of deQuervain's tenosynovitis. Dr. Long deferred to Dr. Layman concerning the appropriateness of surgery.

At the request of SAIF, Drs. Radecki and Nye examined claimant on October 25, 1990. Dr. Radecki performed EMG and nerve conduction studies. Based on these studies, he found no evidence of either median or ulnar nerve compromise. Dr. Nye found no evidence of deQuervain's tenosynovitis or lateral epicondylitis. Both doctors felt that claimant had functional overlay. Based on examination findings and on an earlier psychological evaluation, Dr. Nye advised against surgery, believing that it would be of no benefit. (Ex. 37).

Dr. Layman disagreed with Dr. Nye's assessment by noting that Dr. Nye found a positive Finkelstein's test, which was an important test in diagnosing deQuervain's syndrome. Dr. Layman also noted that Dr. Nye failed to perform a test of resisted wrist extension which was an important test for diagnosing lateral epicondylitis. Finally, Dr. Layman reported that claimant experienced considerable relief of symptoms following surgery. (Ex. 41).

The medical evidence is divided. We, therefore, give more weight to the medical opinion that is based on the most complete information and is the most well reasoned. Somers v. SAIF, 77 Or App 259, 263 (1986). We generally give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

Here, there are a number of reasons to defer to Dr. Layman's opinion. As the physician who eventually performed claimant's surgery, Dr. Layman is in the best position to assess claimant's condition. Argonaut Ins. Co. v. Mageske, 93 Or App 698 (1988). Drs. Steinhauer and Nye based their conclusions regarding the necessity of surgery on EMG studies. However, both Drs. Layman and Long explained that the EMG studies are not beneficial in determining the need for surgery. In addition, Dr. Layman persuasively refuted Dr. Nye's contrary opinion that claimant does not have deQuervain's syndrome or lateral epicondylitis. Dr. Layman pointed out that Dr. Nye failed to diagnose deQuervain's syndrome in light of his finding of a positive Finkelstein's test, and that Dr. Nye failed to conduct a wrist extension test which elicits signs of lateral epicondylitis. Accordingly, we find Dr. Nye's opinion unpersuasive.

Based on the persuasive medical evidence, we find that claimant has established that her lateral epicondylectomy and release of the first dorsal compartment were reasonable and necessary treatment for her compensable left wrist condition. Consequently, SAIF's "de facto" denial shall be set aside.

Claimant has finally prevailed after remand regarding the reasonableness and necessity of the proposed surgery. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991).

After considering the factors set forth in OAR 438-15-010(4), we agree that the Referee's award of an assessed attorney fee of $2,750 for services at hearing is a reasonable fee. Furthermore, after considering those same factors, we find that a reasonable assessed attorney fee for claimant's counsel's services before the Board, Court of Appeals, and Supreme Court is $6,000. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney fee petition to the Board and appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, the Referee's order dated June 7, 1991 is affirmed. For services rendered on Board review and the appellate court levels, claimant's attorney is awarded a $6,000 attorney fee, payable by the SAIF Corporation.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID A. MATTHEWS, Claimant
WCB Case No. 94-04509
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Kekauoha's order that: (1) awarded claimant temporary disability benefits from March 12, 1994 until termination of those benefits was authorized by law; and (2) awarded a $300 attorney fee pursuant to ORS 656.382(1) for an alleged discovery violation. On review, the issues are temporary disability and attorney fees.

We adopt and affirm the Referee's order with the following supplementation concerning the temporary disability issue.

The Referee found that the insurer improperly terminated temporary disability payments in reliance on Dr. Button's opinion that claimant was capable of returning to regular work. The Referee reasoned that Dr. Button was not claimant's attending physician, and that claimant's attending physician, Dr. Vu, had never released claimant to regular work. On this basis, the Referee directed the insurer to resume payment of temporary disability benefits until termination was authorized by law.

On review, the insurer first argues that Dr. Button was claimant's attending physician and that, consequently, he was authorized to release claimant to regular work. We disagree.

An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b). Dr. Button examined claimant at the insurer's request. In his report to the insurer, Dr. Button raised the possibility of further surgery on claimant's amputated right ring finger. Dr. Button described the proposed surgery as elective and indicated, among other things, that he "personally would defer treating claimant." (Ex. 22). Dr. Button also indicated in March 1994 that claimant's regular job was within claimant's current physical capacities. It was on the basis of this report that the insurer stopped paying temporary disability.

After reviewing this record, we are not persuaded that Dr. Button was the physician "primarily responsible for treatment of the worker's compensable condition." ORS 656.005(12)(b). In this regard, although Dr. Button brought up the possibility that claimant might consider surgery, and claimant apparently believed that Dr. Button was considering performing the surgery, there is no evidence that Dr. Button ever treated claimant and little evidence that Dr. Button actually considered performing surgery on claimant. Finally, Dr. Button indicated that he would personally "defer" treating claimant. Under such circumstances, we conclude that Dr. Button was not a physician who was "primarily responsible" for treatment of claimant's compensable condition.

In the event that we find that Dr. Button was not claimant's attending physician, the insurer seeks remand for the taking of additional evidence concerning the status of Dr. DiPaola and Dr. Button as claimant's attending physicians. We deny the motion.

In support of remand, the insurer cites to a July 13, 1994 letter from Dr. DiPaola to the insurer in which Dr. DiPaola purportedly states that it was not his intention or desire to become claimant's attending physician. (App. Br. at 13). The insurer cites that letter as "Appendix to Brief A." We note that no such document is appended to the Board's copy of the insurer's appellant's brief.

Notwithstanding its argument that the case should be remanded for additional evidence, the insurer asserts that claimant's relationships with Drs. DiPaola and Button are clear from the existing evidence in the record and that "Appendix to Brief A" is not necessary to make a decision concerning claimant's relationship with either physician.

Under the circumstances, we deny the insurer's motion for remand. We find that the record is completely developed on the issue of which physicians were claimant's "attending physicians." In

addition, we note that the insurer has not established that the July 13, 1994 letter from Dr. DiPaola was not obtainable with due diligence at the time of the July 29, 1994 hearing. See Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Finally, we note that even if Dr. DiPaola is not claimant's attending physician as the insurer argues, the outcome of this case would be unchanged since the record would still be devoid of evidence that claimant was released to regular work by an attending physician.

Finally, the insurer argues that claimant is not entitled to temporary disability benefits because he was discharged from employment for reasons unrelated to his injury. We disagree. Here, claimant was never released to regular work before his discharge from employment. Because claimant remained disabled from performing his regular work at the time of his termination, he was entitled to temporary disability benefits, regardless of the reason for his termination. See Wayne M. Paxton, 44 Van Natta 1788 (1992); Roberta L. Jones-Lapeyre, 43 Van Natta 942 (1991).

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 issue, and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 29, 1994 is affirmed. For services on review, claimant's attorney is awarded $800, payable by the insurer.

February 16, 1995 Cite as 47 Van Natta 258 (1995)

In the Matter of the Compensation of
PENNIE J. McADAMS, Claimant
WCB Case No. 93-07469
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Hall and Turner-Christian.

Claimant requests review of Referee Crumme's order which: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to award a penalty and/or attorney fee for an allegedly untimely denial. On review, the issues are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of finding number 14.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Radecki, the Referee found that claimant did not have carpal tunnel syndrome (CTS). The Referee further found that even if claimant had CTS, she failed to prove that her work activities were the major contributing cause of that condition or its worsening. We disagree.

The causation issue is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). In evaluating causation, we rely on those opinions which are well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986).

Dr. Carpenter first saw claimant on February 3, 1993. He diagnosed left carpal tunnel syndrome and right carpal tunnel symptoms. (Ex. 6). After conservative treatment failed, Dr. Carpenter recommended a carpal tunnel release. (Ex. 10).

Dr. Carpenter opined that claimant's work was the major cause of her symptoms. He explained that claimant's CTS developed from her tendonitis, which reached a point where she could no longer work and resulted in the need for treatment. Dr. Carpenter's opinion is consistent with claimant's history that she developed tingling, numbness and pain in her hands and wrists in early December 1992, and, even after changes in her job duties, her symptoms worsened. Claimant eventually sought treatment on January 5, 1993.

We find Dr. Carpenter's opinion to be persuasive because it is well-reasoned and based on an accurate history. See Somers v. SAIF, supra. Dr. Carpenter also had the benefit of observing the actual work that claimant performed. His opinion is further supported by Drs. Pettee and Eisler who also diagnosed claimant's condition as bilateral CTS and opined that the major cause of claimant's condition was her work activities.

In addition, Dr. Carpenter persuasively rebutted Dr. Radecki's opinion. Dr. Radecki opined that claimant did not have CTS[1] and that her ongoing symptoms were non-organically based. (Ex. 13). Dr. Carpenter testified that Dr. Radecki placed too much emphasis on the nerve conduction studies as being correlative to CTS. Dr. Carpenter felt that claimant had CTS based upon her examination findings, her symptoms and upon the continuation of symptoms despite conservative treatment. (Ex. 18-8).

Accordingly, we find that the persuasive medical evidence establishes that claimant's work activities were the major contributing cause of her CTS. Consequently, we set aside the employer's denial.

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

Penalty and Attorney Fee

The Referee did not assess a penalty because he found the CTS condition not compensable. Claimant seeks a penalty and attorney fee for the employer's failure to timely deny her CTS claim. Claimant contends that the employer had notice of her CTS claim on January 5, 1993 and that it failed to timely deny her claim.

On January 5, 1993, claimant filed a claim for bilateral hand "strain/numbness." Shortly thereafter, the employer received a Form 827 dated January 5, 1993 from Dr. Boss, which diagnosed claimant's condition as early CTS. On February 9, 1993, the employer accepted the claim for tendonitis. On April 23, 1993, Dr. Carpenter requested authorization to perform a carpal tunnel release. The employer, on September 21, 1993, issued a partial denial of claimant's claim for bilateral CTS. Thus, the employer issued its denial more than 90 days after it had notice of the CTS claim.

Because the employer delayed its denial of the CTS claim and offered no explanation for the delay, we find that its delay was unreasonable. For its unreasonable delay, the employer may be assessed a penalty under ORS 656.262(10)(a) based on any amounts of compensation due at the time of the late denial. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). However, inasmuch as there is no evidence of any amounts of compensation then due, there is no basis for assessing a penalty. See Charles W. Wilson, 43 Van Natta 2792 (1991).

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[1] We note that Dr. Radecki stands alone regarding the diagnosis and the cause of claimant's condition. Given the contrary medical evidence, we do not find Dr. Radecki's lonely position persuasive.

We may, however, assess an attorney fee under ORS 656.382(1) for the employer's unreasonable resistance to the payment of compensation. See Oliver v. Norstar, Inc., 116 Or App 333, 336 (1992). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we assess an attorney fee of $500. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 18, 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. Claimant's attorney is awarded a $500 assessed attorney fee for the employer's unreasonably late denial, to be paid by the employer. Claimant's attorney is also awarded a $4,000 assessed attorney fee for services at hearing and on Board review in prevailing over the employer's denial, to be paid by the employer.

In the Matter of the Compensation of
EWELL McCRAE, Claimant
WCB Case No. C403204
ORDER DENYING RECONSIDERATION
Gatti, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant's former attorney requests reconsideration of our February 2, 1995 order that: (1) approved a Claim Disposition Agreement (CDA) between claimant and the insurer; and (2) declined to grant claimant's former attorney's request that we direct the insurer to distribute a portion of the CDA proceeds to the former attorney. Reasoning that he was discharged shortly before claimant finalized his settlement with the insurer, claimant's former attorney contends that his attorney fee lien should be recognized.

To begin, since claimant's former attorney is not a "party" to the CDA, he lacks standing to challenge our order. See Raymond L. Rasmussen, 44 Van Natta 1704 (1992). Consequently, we are not inclined to reconsider our order approving the disposition. In any event, even if we considered claimant's former attorney's objection, we would adhere to our prior conclusion.

Although claimant's former attorney refers to a copy of an executed retainer agreement and an affidavit, no such documents have been included with his submission. As we alternatively noted in our prior order, lacking such an agreement, we are without authority to grant claimant's former counsel's attorney fee request. See OAR 438-15-010(1).

Moreover, even if we were inclined to reconsider our decision and assuming that such materials had been filed, it is highly unlikely that we would have granted claimant's former attorney's request. As discussed in our previous decision, claimant's eventual settlement (a $9,000 Disputed Claim Settlement and a $3,000 CDA) represents a different transaction than the purported $10,500 CDA negotiated by claimant's former attorney. In addition, since issuance of our approval order, we have received claimant's response to his former attorney's initial fee request. (Copies of claimant's submission have been included with the attorneys' copies of this order.) Challenging his former attorney's representations regarding the value of his services, claimant objects to distributing any portion of the CDA proceeds to his former counsel. Considering such circumstances, it would be highly speculative for us to determine what, if any, of claimant's former attorney's services which were devoted to negotiations regarding an unexecuted and unapproved CDA contributed to the parties' eventual "combined" settlement.

Based on the reasoning expressed above, we deny claimant's former attorney's request for reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES J. WARREN, Claimant
WCB Case No. 94-04610
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Herman's order that affirmed an Order on Reconsideration which reduced claimant's award of 11 percent (35.2 degrees) unscheduled permanent disability for a low back injury, as awarded by Notice of Closure, to zero. On review, the issue is extent of unscheduled permanent disability.

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

Claimant suffered a compensable lumbar strain in June 1993. Claimant's attending physician, Dr. Poulson (orthopedic surgeon), performed a closing examination on November 22, 1993, and concluded that there was 6 percent impairment due to lost range of motion in the lumbosacral spine. A Notice of Closure issued on December 10, 1993, awarding claimant 11 percent unscheduled disability. Claimant requested reconsideration.

Dr. Scheinberg was appointed as the medical arbiter and he examined claimant in January 1994. The medical arbiter found no permanent limitations resulting from the accepted lumbar strain. (Ex. 9-4). Dr. Scheinberg also noted that he was unable to obtain valid lumbar range of motion measurements of flexion and extension due to irreconcilable sacral range of motion measurements of flexion and extension. (Ex. 9-3). Based on the medical arbiter's report, a March 1, 1994 Order on Reconsideration reduced claimant's award of unscheduled permanent disability to zero.

Claimant requested a hearing. Relying upon the medical arbiter's report, the Referee found that claimant had failed to demonstrate any measurable impairment as a result of his accepted lumbar strain. Consequently, the Referee affirmed the Order on Reconsideration. See OAR 436-35-320(2).

Claimant contends that the preponderance of medical evidence indicates a different level of impairment than found by the medical arbiter. See OAR 436-35-007(9). Specifically, claimant argues that his treating doctor, Dr. Poulson, did obtain valid range of motion measurements demonstrating a measurable impairment of 6 percent. We disagree.

We adopt the Referee's finding that Dr. Poulson's closing exam was insufficiently explained to establish a level of impairment different than found by the medical arbiter. In particular, Dr. Poulson measured claimant's dorsolumbar range of motion several times between the date of injury and the closing exam. Beginning July 29, 1993, his chartnotes reveal that claimant had regained "almost full ROM [range of motion] on this visit." (Ex. 3-1). Dr. Poulson recorded the same "full ROM" on each successive examination up to the closing examination of November 22, 1993. (Ex. 3). However, the closing examination itself reflected range of motion findings that were inconsistent with the previous measurements. (Ex. 5). Dr. Poulson did not explain why the range of motion in claimant's low back had suddenly decreased after an extended period of "almost full ROM."

Considering the contradiction between Dr. Poulson's earlier medical reports and his closing examination, we find his closing examination findings and opinion to be conclusory and unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Instead, we find that Dr. Poulson's "pre-closure" range of motion measurements corroborate the medical arbiter's finding that claimant has no permanent impairment as a result of his compensable lumbar strain condition. See Somers v. SAIF, 77 Or App 259 (1986).

Accordingly, we agree with the Referee that the opinion of the medical arbiter is the most persuasive medical evidence in this case. However, we note that 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 have determined that the arbiter's report provides the most thorough, complete and well-reasoned evaluation of claimant's permanent impairment. Consequently, we rely on it. See Somers v. SAIF, supra.

ORDER

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

February 17, 1995 Cite as 47 Van Natta 262 (1995)

In the Matter of the Compensation of
RICHARD L. ELSEA, Claimant
WCB Case Nos. 94-00503, 93-12428 & 93-13294
ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney
Garrett, Hemann, et al., Defense Attorneys

Safeco Insurance Company requests reconsideration of our January 23, 1995 order which affirmed a Referee's order that found Safeco responsible for claimant's occupational disease claim for a left knee condition. Asserting that our decision provides "little direction as to how to process the occupational disease", Safeco asks that we provide clarification regarding when claimant's claim arose.

Pursuant to our decision, we affirmed the Referee's conclusion that Safeco's denials of claimant's occupational disease claim should be set aside and the claim remanded for processing in accordance with law. Based on certain references contained in one of its denials, as well as alternative findings included in our order, Safeco represents that it is unsure precisely when claimant's occupational disease claim arose. Reasoning that our decision "provides adequate basis for a finding that the claim arose in [May 1991]," Safeco seeks confirmation from us for future claim processing purposes. We decline Safeco's invitation.

As with many cases in which we are required to resolve responsibility disputes, we recognize that our determination may have a significant effect on the responsible carrier's claim processing obligations. See Larry W. Gange, 46 Van Natta 2203, on recon 46 Van Natta 2237, on recon 46 Van Natta 2346 (1994). Nevertheless, the potential ramifications of our responsibility determination do not provide a proper ground for addressing issues which exceed the scope of our review. Id.

Here, the specific issues presented for our resolution concerned whether claimant's current left knee condition was compensable and, if so, which carrier was responsible. We have resolved those questions, concluding that claimant's occupational disease claim for a left knee condition is compensable and that Safeco is responsible for that claim. Questions concerning precisely when that claim arose and future disability calculations are claim processing obligations which naturally flow from our compensability/responsibility determination. See William R. Arnett, 44 Van Natta 2560 (1992). Since it would be premature to address such matters, we decline Safeco's invitation to "clarify" our decision or to "confirm" its interpretation of our alternative findings. See Brian A. Bundy, 46 Van Natta 382, on recon 46 Van Natta 531 (1994).

Accordingly, we withdraw our January 23, 1995 order. On reconsideration, as supplemented herein, we republish our January 23, 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
PAMELA J. VINYARD, Claimant
WCB Case No. 93-13787
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

The insurer requests review of that portion of Referee Spangler's order which awarded an assessed attorney under ORS 656.386(1). On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded an assessed attorney fee of $1,800 pursuant to 656.386(1) for claimant's attorney's services in obtaining compensation for claimant when a hearing was not held. The insurer contends, first, that an attorney fee is not appropriate in this case or, in the alternative, that a fee of $1,800 is excessive.

We summarize the relevant facts. Claimant sustained a compensable hernia injury in 1984, Her claim was closed by a July 1985 Determination Order. On August 6, 1993, claimant's treating physician examined claimant and noted a recurrent hernia. He opined that surgery would be necessary. (Ex. 24). On August 10, 1993, claimant's attorney submitted a letter to the insurer, stating that claimant was making a claim under ORS 656.273. (Ex. 24A).

Claimant underwent surgery in September 1993, and bills were submitted to the insurer on September 7, 1993, September 10, 1993 and October 1, 1993. The insurer neither accepted nor denied the claim nor paid the bills. On November 22, 1993, claimant requested a hearing, asserting a "de facto" denial of an aggravation claim.

On January 13, 1994, noting that claimant's 1984 injury claim was within the Board's Own Motion jurisdiction when the aggravation claim was submitted, the insurer recommended denying the claim. (Ex. 30). On January 17, 1994, the insurer sent claimant a denial of the aggravation and medical services claim, stating that the current condition was not related to claimant's compensable injury. (Ex. 30A). On February 4, 1994, the insurer withdrew its January 17, 1994 denial.

The insurer first argues that, because claimant's claim was in Own Motion, the Referee had no jurisdiction to award compensation, and thus, no jurisdiction to assess an attorney fee. We disagree, and adopt the Referee's conclusion regarding this issue, with the following supplementation.

Because claimant's aggravation rights have expired, the Board has exclusive jurisdiction over reopening this claim for the benefits allowed pursuant to ORS 656.278. However, the Board's own motion jurisdiction does not extend to issues of compensability. Instead, the Hearings Division has initial jurisdiction over compensability issues. ORS 656.283(1).

Accordingly, because the insurer's denial denied that claimant's current condition was causally related to her compensable injury, the Referee had jurisdiction over this matter concerning a claim, ORS 656.283(1), and jurisdiction to award an attorney fee pursuant to ORS 656.386(1).

The insurer also argues that, if claimant's attorney is entitled to an attorney fee, the fee should be reduced to reflect the amount of time devoted to the issue by claimant's attorney. The Referee awarded an $1,800 attorney fee. The insurer contends that a fee of $350 is more appropriate.

In determining a reasonable fee attorney fee under ORS 656.368(1), we consider the factors recited in OAR 438-15-010(4). Those factors are as follows: (1) the time devoted to the case; (2) the

complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Here, where no hearing is held, claimant's attorney fee is determined by the extent of claimant's attorney's services prior to hearing. In this case, the record shows that claimant's attorney: (1) sent a letter to the insurer requesting that claimant's claim be opened under ORS 656.273; (2) requested a hearing on a "de facto" denial after the claim was not accepted or denied within 90 days; (3) filed a supplemental request for hearing after the insurer's written denial; and (4) solicited an opinion from claimant's treating physician concerning causation of claimant's current need for surgery.

Under such circumstances, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing because the request for hearing preserved claimant's right to challenge the denial. However, we consider the Referee's $1,800 attorney fee award to be excessive. After considering the factors set forth in OAR 438-15-010(4), we conclude that a $750 assessed attorney fee, payable by the insurer, is reasonable. In particular, we have considered the time devoted to the compensability issue (as represented by the hearing record), the value of the interest involved, the complexity of the issue, and the risk that claimant's counsel might go uncompensated. Finally, claimant is not entitled to a fee for "post-rescission" services regarding the attorney fee issue. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated February 10, 1994, as reconsidered March 22, 1994, is modified in part and affirmed in part. That portion of the order which awarded an $1,800 attorney fee is modified. In lieu of the Referee's attorney fee award, claimant is awarded an assessed attorney fee of $750, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
BELINDA V. KINYON-BECK, Claimant
WCB Case Nos. 94-04048, 94-01359 & 94-02008
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Raymond Myers (Saif), Defense Attorney
Mitchell, Lang & Smith, Defense Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Michael V. Johnson's order that: (1) upheld Kemper Insurance's (Kemper's) compensability and responsibility denial on behalf of J.M. Smuckers Co. (Smuckers) of claimant's current bilateral wrist condition; (2) upheld the SAIF Corporation's compensability and responsibility denials on behalf of Ushio Oregon Industries (Ushio) of the same condition; and (3) upheld Tokio Fire & Marine Insurance Company's (Tokio's) responsibility denial on behalf of Ushio of the same condition. On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant began working for Ushio in September 1990, not May 1991.

CONCLUSIONS OF LAW AND OPINION

Compensability

We summarize the relevant facts. In May 1990, after three years employment with Smuckers, Kemper's insured, claimant experienced bilateral hand pain and swelling. She was diagnosed with bilateral carpal tunnel syndrome (CTS), and underwent surgical correction of that condition. (Exs. 6-2, 7, 11, 14, 16). A presurgical nerve conduction study revealed mild bilateral CTS. (Ex. 3). Both treating and examining physicians agreed with that diagnosis. (Exs. 6-2, 7, 11, 14, 16; 20-1; 22-7). The claim was closed and, after a course of litigation, claimant was awarded 5 percent permanent disability for each wrist. (Exs. 30, 33).

In September 1990, claimant began working for Ushio assembling lamps. The work was very hand- and wrist-intensive. Ushio was insured by Tokio Fire & Marine Insurance Company (Tokio) through September 30, 1991; SAIF was the insurer thereafter. (Ex. 61).

On April 22, 1991, following closure of her CTS claim, claimant received medical services for "[p]ost carpal tunnel syndrome, residual." (Ex. 16). Her physical examination at the time was essentially negative, without evidence of recurrent CTS. (Id). It is not clear why claimant was examined that day.

In July 1992, she sought medical treatment for specific complaints of recurring pain and numbness. (Ex. 24). An August 1992 nerve conduction study, however, was normal. (Exs. 27, 28).

In June 1993, claimant sought treatment for continued hand pain and swelling. (Ex. 34). Dr. Krier, who became claimant's treating physician, diagnosed "[f]orearm tenderness secondary to overuse and mild tendonitis." (Id. at 2). In November 1993, Dr. Krier speculated that claimant had possible bilateral CTS. (Ex. 38-1). However, he later confirmed that he had not diagnosed CTS; rather, he adhered to his initial diagnosis of forearm tenderness secondary to overuse and mild tendonitis. (Ex. 39). Furthermore, he concluded that the major contributing cause of claimant's current wrist condition was her work activities at Ushio. (Id).

Dr. Isaacson, orthopedic surgeon, consulted with claimant. Isaacson diagnosed wrist overuse syndrome that resulted in "some tendinitis and even carpal tunnel syndrome bilaterally. This has required surgery." (Ex. 40-2). Isaacson concluded that the only way to ameliorate claimant's symptoms was for her to avoid repetitive hand work. (Id).

Dr. Nolan examined claimant in December 1993 on behalf of Kemper's insured. He concluded that claimant had a normal examination, except for less than normal wrist strength, which he determined was "nothing to do with her job but more to do with [her] constitution." (Ex. 41-2). He also opined that the cause of claimant's current condition was difficult work that she did not like. (Id. at 3). He found that she did not have worsened CTS or any other pathological process. (Id). In a supplemental opinion, Dr. Nolan adhered to his conclusion that claimant had a normal examination. (Ex. 54-2).

Dr. Radecki examined claimant in February 1994 on SAIF's behalf. He concluded that, based on claimant's borderline presurgical nerve conduction studies and her ongoing symptoms, her preclosure diagnosis of CTS may have been incorrect. (Ex. 51-3). He found that claimant had a positive Phalen's sign bilaterally, as well as slight bilateral medial epicondylar and left lateral epicondylar tenderness on palpation. (Id. at 2). He also noted discomfort on wrist flexion and some right middle finger tendon pain with resistance testing. (Id. at 3). Notwithstanding these abnormalities, Dr. Radecki diagnosed chronic pain complaints without objective findings. (Id).

Thereafter, Dr. Krier signed a concurrence letter drafted by Kemper's counsel, in which he agreed that claimant's current wrist condition was different from her accepted CTS condition. (Ex. 59-1). As evidence of this, Dr. Krier noted that claimant's 1992 nerve conduction studies were normal. (Id). Krier adhered to his diagnosis of forearm tenderness secondary to overuse and mild tendonitis. (Id). Finally, Dr. Krier agreed that, based on claimant's history, her work at Ushio was the major contributing cause of her current condition, disability and need for treatment. (Id).

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). 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 the reports of Dr. Krier most persuasive. He had the opportunity to observe claimant over the period of several months. Furthermore, we find compelling his conclusion that, in view of claimant's history of hand-intensive work at Ushio, and her present lack of electrodiagnostic findings, her work at Ushio was the major contributing cause of her current wrist condition.

We find persuasive reasons not to rely on the opinions of Drs. Isaacson, Nolan and Radecki. Dr. Isaacson's opinion did not directly address the causation issue; accordingly, we do not consider it in analyzing the cause of claimant's current wrist condition.

We find that Dr. Nolan's conclusions regarding claimant's wrist strength and causation lack adequate factual support and represent an unsupported value judgment. We find that Dr. Radecki's report lacks persuasive reasoning regarding the cause of claimant's current wrist condition. Particularly, we find his conclusions regarding the purported psychological foundation for claimant's current complaints without basis. Moreover, we find his report suspect because, although he found several abnormalities when examining claimant, he concluded that claimant's complaints were without an objective foundation. Last, we are not persuaded by his post hoc conclusions regarding the accuracy of claimant's preclosure CTS diagnosis. Accordingly, we discount both Dr. Nolan's and Dr. Radecki's opinions.

In reaching this conclusion, we acknowledge the carriers' arguments that Drs. Nolan and Radecki are specialists. Because we have found significant reasons to discount both of their opinions, we give no weight to their additional credentials in evaluating their opinions.

For these reasons, we conclude that Dr. Krier's opinions are sufficient to establish the compensability of claimant's current wrist condition. Consequently, we reverse the Referee's decision finding claimant's current bilateral wrist condition not compensable.

Responsibility

Having concluded that claimant's current wrist condition is compensable, our next task it to determine which carrier is responsible. In accomplishing that task, we must first ascertain whether this case is governed by ORS 656.308 or the last injurious exposure rule. We conclude that it is the latter.

SAIF and Tokio argue that ORS 656.308 applies, because claimant's current wrist condition is the same as her accepted CTS condition. Therefore, they argue, because Kemper has failed to establish that claimant's employment at Ushio was the major contributing cause of a worsening of that condition, Kemper remains responsible. We reject that argument.

Where claimant's current condition does not involve the same condition, but merely the same body part, as that previously accepted by a carrier, ORS 656.308 does not apply. Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993). The evidence persuades us, as it did the Referee, that, although it involves the same body part, claimant's current wrist condition is different than her accepted CTS condition.

The pre-closure medical experts uniformly agreed that claimant had CTS, which Kemper accepted. After closure, although she had continuing wrist pain, claimant's nerve conduction studies were normal. We find persuasive Dr. Krier's conclusion that, in view of those studies, claimant's current condition is not CTS, but rather overuse/tendinitis. That conclusion finds support in Dr. Nolan's conclusion that claimant did not have worsened CTS. In light of the uniformity in claimant's preclosure diagnoses and the supportive preclosure nerve conduction study, we find unpersuasive Dr. Radecki's post hoc conclusion that claimant's accepted condition may have been misdiagnosed.

Because we conclude that claimant's current and accepted conditions are not the same, it follows that ORS 656.308 does not apply. See SAIF v. Yokum, 132 Or App 18, 23 (1994) (ORS 656.308 does not apply unless there is an accepted claim for which some employer is responsible). Rather, we analyze this matter under the last injurious exposure rule.

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). 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).

The evidence establishes that claimant's employment at Ushio, while both Tokio and SAIF were on the risk, contributed to claimant's current wrist condition. We conclude, based on our review of the medical records, that claimant first sought medical treatment for her current wrist condition in July 1992, when she sought treatment for complaints of recurring pain and numbness. Claimant's nerve conduction studies one month later were normal, i.e., without evidence of CTS. This supports our conclusion that, whatever claimant's problem was in July 1992, it was not CTS. Dr. Krier's ensuing diagnosis of overuse syndrome/tendinitis confirms this proposition. In view of this evidence, we conclude that claimant first sought treatment for overuse/tendinitis in July 1992. See SAIF v. Kelly, supra. Accordingly, we find the "onset of disability" of claimant's current wrist condition was July 1992, at which time SAIF was on the risk.

In reaching this conclusion, we have taken into consideration claimant's receipt of medical services on April 22, 1991 for post-CTS residuals. Because the record does not establish the specific purpose of that appointment -- it could have been a routine post-surgical visit -- we do not consider it in ascertaining the onset of claimant's current wrist condition.[1]

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[1] We have also considered claimant's November 25, 1991 examination by Dr. McKillop, in which claimant reported ongoing symptoms (Ex. 19-2), and Dr. Isaacson's November 1993 report, which reports that claimant's hands have "never stopped hurting since she worked at Smucker's [sic]." (Ex. 40-1). We do not find them sufficient to dissuade us from relying on Dr. Krier's analysis.

Because we have concluded that claimant first sought treatment for her current wrist condition while SAIF was on the risk, responsibility for that condition is initially assigned to SAIF. See Boise Cascade Corp. v. Starbuck, supra. SAIF can shift responsibility to Tokio, the prior carrier, by showing that claimant's work exposure while Tokio was on the risk was the sole cause of claimant's current wrist condition, or that it was impossible for conditions while SAIF 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). SAIF has failed to carry that burden. Dr. Krier's reports, which issued while SAIF was on the risk, indicate that claimant's ongoing work activities at Ushio contributed to her wrist condition. That evidence precludes SAIF from prevailing on the "sole cause" or "impossibility" theories. Accordingly, we conclude that SAIF remains responsible for claimant's current wrist condition.

Alternatively, even if the disability date arose while Tokio was on the risk, the evidence reveals claimant's work activities while SAIF was on the risk actually contributed to her current condition. Under those circumstances, although Tokio would be initially responsible, it would be entitled to shift responsibility for claimant's current wrist condition to SAIF. Oregon Boiler Workers v. Lott, 115 Or App 70, 74 (1992).

Claimant is entitled to an attorney fee for prevailing over SAIF's denials. 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 SAIF. 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 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 the SAIF Corporation's denials is reversed. SAIF's denials are set aside and the claim is remanded to SAIF 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 SAIF.

In the Matter of the Compensation of
MELVIN L. MARTIN, Claimant
WCB Case No. 90-20361
SECOND ORDER ON REMAND
Welch, Bruun, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our January 26, 1995 Order on Remand that awarded an assessed fee of $3,500 for his attorney's services at the Board, Court of Appeals, and Supreme Court. On reconsideration, claimant requests that the assessed fee for these levels of review be increased to $10,500 based on his Petition for Attorney Fees with the Supreme Court.[1]

Claimant informs us that, after prevailing at the Supreme Court, he filed a Petition for Attorney Fees seeking a total fee of $12,000 for services performed by his current and former counsel before the Referee, the Board, the Court of Appeals and the Supreme Court. Claimant notes that the SAIF Corporation objected to this petition, in part, on the ground that any award would be premature because claimant had yet to finally prevail on the merits. Claimant also informs us that the Supreme Court sustained SAIF's objection and denied claimant's petition for attorney fees. With his request for reconsideration, claimant submits copies of his Petition for Attorney Fees, SAIF's objection, claimant's reply, and the Supreme Court's order.

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[1] Claimant does not request reconsideration of the Referee's assessed fee of $1,500 for services at hearing, which the Board affirmed in its Order on Remand.

SAIF objects to claimant's request for additional assessed attorney fees. SAIF bases its objection on an assumption that we have already had an opportunity to review claimant's petition before the Supreme Court. However, SAIF is mistaken in its assumption. The Court did not forward claimant's attorney fee petition with the appellate record. Therefore, we have not had an opportunity to previously consider this petition. Having received claimant's petition and the parties' respective positions, we proceed with our reconsideration of claimant's attorney fee award.

In determining a reasonable attorney fee award, 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.

Neither party challenges the Referee's attorney fee award of $1,500 for services at hearing. After considering the factors set forth in OAR 438-15-010(4), we continue to find that award to be reasonable. We turn to an evaluation of the record for purposes of determining a reasonable attorney fee award for claimant's counsel's services before the Board, before the Court of Appeals, and before the Supreme Court.

As demonstrated by the number of appellate decisions (culminating in a Supreme Court opinion), the jurisdiction issue represented a complex legal question. On the other hand, the reasonableness and necessity of the proposed medical treatment presented a medical question which is similar to medical issues which the Board normally confronts. As a general rule, the value of the interest, as well as the benefit secured, in the form of medical services are considered to be rather modest. Dwight E. Fillmore, 40 Van Natta 794 (1988), aff'd Weyerhaeuser Co. v. Fillmore, 98 Or App 567, 571, rev den 308 Or 608 (1989); Derry D. Blouin, 35 Van Natta 570 (1983). The appellate briefs from each of the parties establishes that their respective arguments were presented in an articulate and skillful manner. Finally, there was a substantial risk that claimant's counsel might go uncompensated.

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 before the Board and before the appellate courts is $7,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the nature of the proceedings, the complexity of the issues, the benefit secured by claimant, the time devoted to the case (as represented by the record, claimant's appellate briefs, and claimant's counsel's petition to the Supreme Court), and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our January 26, 1995 order. For services at hearing, claimant's attorney is awarded a fee of $1,500, to be paid by SAIF. For services before the Board and before the appellate courts (in lieu of our prior attorney fee award), claimant's attorney is awarded $7,000, also payable by SAIF.[2]

IT IS SO ORDERED.

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[2] We note that claimant was represented by an attorney at hearing, who subsequently associated with a second attorney to represent claimant before the Board and the Court of Appeals and a third attorney to represent claimant before the Supreme Court. Thus, it would appear that each of the three attorneys is entitled to a share of the attorney fee award. Nevertheless, SAIF is required to pay the entire award to claimant's current attorney of record, the attorney who represented claimant at the Supreme Court and before the Board on remand. Thereafter, the manner in which the fee is shared by claimant's current and former counsel is a matter to be decided among them, not this forum. Gabriel Zapata, 46 Van Natta 403 (1994); Fred L. Snider, 43 Van Natta 577 (1991).

In the Matter of the Compensation of
AUBRY L. TUCKER, Claimant
Own Motion No. 93-0581M
CORRECTED OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The insurer initially submitted claimant's request for temporary disability compensation for his compensable laminectomy at L5 and diskectomy left at L4-5 injury. Claimant's aggravation rights expired on May 13, 1992. The insurer denied the compensability of claimant's need for treatment and the request for surgery. In addition, the insurer opposed reopening on the grounds that: (1) surgery or hospitalization is not reasonable and necessary for the compensable injury; (2) claimant has not sustained a worsening of the compensable injury; and (3) claimant was not in the work force at the time of disability. Claimant requested a hearing with the Hearings Division. (WCB Case No. 93-12744).

On December 1, 1993, the Board consolidated the own motion matter with the hearing pending the outcome of that litigation. On January 10, 1995, Referee Poland issued an Opinion and Order in which she set aside the insurer's denial of medical services, and found the surgery compensable. That order was not appealed and has become final by operation of law. In addition, the Referee took testimony regarding whether claimant was in the work force at the time of disability.

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

On February 7, 1994, Dr. Miller, claimant's treating neurosurgeon, performed surgery to relieve claimant's recurrent L4-5 disc herniation, and lateral recess stenosis at L5-S1. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, 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 contends that claimant is not in the work force. Claimant contends that he was willing to work and seeking work when his compensable injury worsened requiring surgery. Claimant has the burden of proof on this issue.

Claimant testified at the hearing that, following his last employment in 1992, he engaged in work search activities. These efforts included contacting the employment office, at which time claimant received information regarding a possible forklift job at a mill near Glide, Oregon. Claimant testified that, in 1993 sometime prior to May, he visited the mill and applied for the job but was not hired. Claimant also testified that he attempted to obtain work as a fire watcher in the summer of 1993. Claimant's contention and testimony are unrebutted.

On this record, we conclude that claimant has established that he was willing to work and seeking work when his compensable injury worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning February 8, 1994, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA A. COOPER, Claimant
WCB Case No. 93-04711
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Claimant requests reconsideration of our January 23, 1995 order which: (1) awarded a $50 insurer-paid attorney fee for claimant's counsel's services in securing the rescission of the insurer's "de facto" denial of a medical bill without a hearing; and (2) found that the insurer's conduct was not unreasonable. Specifically, claimant asserts that our attorney fee award was inadequate and that the insurer's conduct was unreasonable.

After considering claimant's contentions, we adhere to our prior conclusions. However, we provide the following supplementation in response to claimant's assertions.

To begin, claimant challenges our $50 attorney fee award. Arguing that such an award does not even satisfy her counsel's overhead expenses, claimant takes issue with the factors we particularly considered in reaching our determination of a reasonable attorney fee award under OAR 438-15-010(4).

As stated in our prior order, we considered all of the factors set forth in OAR 438-15-010(4) in reaching our decision, particularly the time devoted to the $45 medical bill issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated for his efforts. Such an explanation regarding our determination of a reasonable attorney fee award is consistent with our statutory and administrative authority. See Higgins v. Schramm Plastics, 112 Or App 563 (1992). Nonetheless, in the interests of providing claimant with further illumination regarding the basis for our attorney fee award, we offer these additional comments.

Claimant does not dispute our conclusion that the value of the disputed issue totalled $45. Instead, arguing that there was no evidence presented or statement made regarding claimant's counsel's time devoted to the issue, she reasons that we could not have particularly considered such a factor. Claimant is mistaken. She has apparently misinterpreted our reference to the "hearing record" when we considered the "time devoted to the issue" factor. Based on her argument, claimant apparently believes that our "hearing record" reference indicates that we confined our consideration of claimant's counsel's services to those represented by the hearing transcript. We did not. Rather, our review included the entire record, which would also necessarily include claimant's counsel's hearing request, pre-hearing correspondence, exhibits, and any other written material generated by claimant's counsel prior to hearing.

Claimant also challenges our reference to the risk that claimant's counsel might go uncompensated for his efforts, arguing that, in light of the then-applicable Court of Appeals' decision in SAIF v. Allen, 124 Or App 183 (1993), her counsel's risk of going uncompensated was very high. Once again, claimant has apparently misperceived our reasoning. We did consider it a risky proposition regarding whether claimant's counsel would be compensated for his efforts. However, we based such reasoning on the viability of claimant's securing payment of the medical bill, not on the viability of claimant's counsel's entitlement to an attorney fee for services rendered in obtaining satisfaction of that medical bill. In any event, even if we considered the "risk" factor in the manner claimant asserts, such consideration would not alter our ultimate conclusion regarding the amount of a reasonable attorney fee award to be granted.

Finally, claimant contends that the record does not support our prior finding that payment of the medical bill was not attributable to any services rendered by claimant's counsel. This finding was based on the fact that the insurer paid the medical bill shortly after claimant's physician resubmission of the bill with a notation relating the services to claimant's compensable low back condition. In light of such circumstances, we are inclined to adhere to our prior conclusion that satisfaction of the bill was based on the insurer's initiative, rather than claimant's counsel's efforts. Nevertheless, even if we withdrew such a finding, the record (when viewed in a light most favorable to claimant) would only establish that claimant's counsel's efforts in securing payment of the medical bill were essentially confined to filing a hearing request. Such a finding would not prompt us to alter our prior conclusion that, after consideration of the factors recited in OAR 438-15-010(4), an attorney fee award of $50 is reasonable in this particular case.

Claimant also contests our conclusion that the insurer's conduct was not unreasonable. Characterizing our conclusion as "absolutely inexplicable," she argues that the insurer's failure to accept, deny, or pay the medical bill within 90 days constitutes a blatant violation of its statutory obligations which cannot be ignored. Once again, claimant misinterprets our reasoning.

Our decision was not designed to "ignore" the insurer's failure to timely accept or deny the claim. Instead, our order addressed the specific question of whether the insurer's conduct under these particular circumstances was unreasonable. For the reasons expressed in our prior order, we did not consider the insurer's conduct to have been unreasonable, particularly considering the confusion caused by the prior Disputed Claim Settlement and the lack of an express reference to claimant's low back condition in her physician's medical bills. After further considering the question, we continue to adhere to that conclusion.

Accordingly, we withdraw our January 23, 1995 order. On reconsideration, as supplemented herein, we republish our January 23, 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
JEWEL D. CULP, Claimant
WCB Case No. 94-03036
ORDER ON REVIEW
Dennis H. Henninger, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Mills' order that dismissed claimant's request for hearing on the issue of the choice of an attending physician. On review, the issue is jurisdiction.

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

Claimant contends that, since he has not exhausted his three-doctor limit under ORS 656.245(3)(a), the Hearings Division has jurisdiction to address the merits of his choice of doctor issue. We disagree.

We have previously concluded that jurisdiction lies with the Director where an insurer's denial was premised on its assertion that claimant exceeded the number of attending physicians allowable without its prior approval. Steve A. McCalister, 45 Van Natta 187 (1993). Here, the insurer has taken the position that claimant has already chosen the three physicians he is entitled to under ORS 656.245(3)(a). Consequently, the Hearings Division does not have subject matter jurisdiction over this matter. See also Ronald D. Robinson, 44 Van Natta 1657 (1992) (The Hearings Division did not have jurisdiction to address the matter of whether the claimant had changed physicians more than two times); Tracy Johnson, 43 Van Natta 2546 (1991), (The Hearings Division does not have subject matter jurisdiction to address a dispute regarding whether the claimant has exhausted his three-doctor limit).

ORDER

The Referee's order dated May 31, 1994 is affirmed.

In the Matter of the Compensation of
ALAN J. DAVIS, Claimant
WCB Case No. 91-02485
ORDER ON REVIEW (REMANDING)
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Hall and Turner-Christian.

Claimant, pro se, requests review of Referee T. Lavere Johnson's order which dismissed his request for hearing. On review, the issue is the propriety of the order of dismissal. We remand.

FINDINGS OF FACT

Claimant has a compensable 1977 back injury claim. In January 1991, the self-insured employer denied responsibility for claimant's medical treatment. Claimant, pro se, requested a hearing and then retained counsel. In April 1991, a postponement of the hearing was granted in order to allow claimant's attorney to prepare for hearing. In August 1991, after claimant's counsel withdrew, a second postponement was allowed.

In November 1991, claimant requested a third postponement asserting that he had filed a claim with the Veterans' Administration (VA) regarding his compensable back injury and a Post Traumatic Stress Disorder (PTSD). Claimant also asserted that the VA would resolve the issue of whether his current need for treatment was due to his back injury. The postponement request was allowed.

In June 1992, the case was set for an August 1992 hearing. A fourth postponement was allowed in order to allow claimant to receive the VA's decision. On September 18, 1992, an interim order issued directing claimant to provide the employer's counsel with requested tax documents and the VA decision or indicate that the information did not exist. In September 1992, a fifth postponement was allowed in order to provide the employer's attorney an opportunity to review the requested tax documents, which were disclosed by claimant the day before hearing.

An October 8, 1992 hearing was scheduled. Claimant requested a sixth postponement arguing that the VA decision had not yet issued, but that it had informed him that it expected to render its decision within 90 days of September 21, 1992. The Referee denied the motion on the basis that claimant had not shown "extraordinary circumstances" required by OAR 438-06-081. After that ruling, claimant indicated that he had not subpoenaed his witnesses and could not go forward with his case. Consequently, he requested a dismissal, which was granted by the Referee.

Claimant appealed the Referee's decision. On August 27, 1993, we issued an order concluding that there were "extraordinary circumstances" beyond the control of claimant concerning the VA decision that warranted a postponement of the hearing. Alan J. Davis, 45 Van Natta 1662 (1993). Therefore, we remanded the case to the Referee for further proceedings.

Hearing was rescheduled for February 11, 1994. On December 20, 1993, the Referee notified claimant that a hearing was pending, and advised claimant that, because the case appeared to be complex, he should retain the services of counsel. At the hearing, claimant requested a seventh postponement due to "extraordinary circumstances" beyond his control. Specifically, claimant asserts that he is awaiting further information from the VA concerning his PTSD claim, that he is in pain and under a doctor's care due to a recent accident, and that he retained an attorney who he subsequently had to fire just prior to hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee reasoned that, because claimant had known since the Board's August 1993 remand order that he was granted a hearing, and because he took no action to obtain legal counsel until late January 1994, claimant had not exercised due diligence in obtaining legal counsel. Consequently, the Referee determined that claimant had not established extraordinary circumstances beyond his control to warrant the further postponement of his hearing. We disagree.

OAR 438-06-081 provides that a "scheduled hearing shall not be postponed except by order of a referee upon finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." Furthermore, "extraordinary circumstances" does not include "incomplete case preparation, unless the referee finds that completion of the record could not be accomplished with due diligence." OAR 438-06-081(4).

Here, claimant asserts, in part, that he had retained an attorney near the end of January 1994, but had to fire the attorney the week before the February 11, 1994 hearing because he was not being represented appropriately. The employer agrees that it received a letter from an attorney on January 31, 1994 stating that he represented claimant. The employer's attorney prepared to mail requested records to claimant's attorney. However, on February 8, 1994, the employer's attorney received a letter from the attorney's office stating that claimant had never been represented by them.

We acknowledge that claimant did not attempt to retain an attorney until less than a month before the scheduled hearing when he had four months to retain one. Nevertheless, because claimant eventually made such an attempt and apparently believed that he had successfully retained legal representation prior to hearing, we conclude that the subsequent termination of that representation prior to the hearing constitutes "extraordinary circumstances" beyond the control of claimant. See OAR 438-06-081. Although we recognize that the question is a very close one, we note that claimant's prior postponements were not granted based on a failure to obtain legal representation. In light of such circumstances, we find that the record could not be completed with due diligence. But see, Rebecca Marks, 45 Van Natta 802 (1993) (no postponement warranted where claimant had six months prior to hearing to secure legal counsel, but had not attempted to do so, when prior postponement had been granted for the same reason).

Although claimant has previously obtained a postponement because his attorney withdrew, he has not had a hearing postponed for the reason that he discharged his attorney and failed to obtain another attorney prior to the scheduled hearing. When this situation is considered in conjunction with claimant's apparent confusion with the workers' compensation system, his complaints arising from his recent motor vehicle accident and the potential impact (if any) of the VA decision on his claim, we conclude that these circumstances are "extraordinary" and do not constitute "incomplete case preparation." Moreover, even if we did consider this situation to be "incomplete case preparation," we would find that given the pre-hearing termination of claimant's attorney, the record could not have been established with due diligence. Therefore, having found that claimant established "extraordinary circumstances" to justify a postponement of his hearing, we reinstate his request for hearing.

We may remand a case to the Referee if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Under the circumstances, we find that remand is appropriate. See Compton v. Weyerhaeuser Co., 301 Or 641,646 (1986). Therefore, we remand to the Referee with instructions to schedule a hearing in the ordinary course of business. At that hearing, the parties shall have the opportunity to present evidence regarding the issues raised by claimant's hearing request.

In taking this action, we are very cognizant of the fact that claimant has been given numerous opportunities to present his case. We likewise acknowledge that, following our August 1993 remand order, claimant apparently neglected to attempt to retain counsel until less than one month before the February 11, 1994 hearing. In light of such circumstances, any future postponement requests based on similar grounds would likely be rejected. Nonetheless, in the interests of substantial justice regarding this particular motion for postponement, we conclude that claimant should be afforded an opportunity to retain an attorney and proceed with his hearing request.

Accordingly, the Referee's order dated March 30, 1994 is vacated. This matter is remanded to Referee T. Lavere Johnson for further proceedings consistent with this order. Following these further proceedings, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT FELDE, Claimant
WCB Case No. 93-06478
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of Referee Michael V. Johnson's order that upheld the self-insured employer's denial of claimant's bilateral hearing loss claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's finding of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that the Referee improperly weighed the medical evidence in concluding that claimant failed to establish the compensability of his hearing loss. We agree.

Claimant has worked in the employer's paper mill for over 31 years. During that time, he was exposed to significant noise at work. Since 1966, he has had progressive hearing loss. He began wearing hearing protection in the 1970's. His present claim arose when he began to have severe high frequency hearing loss. Claimant has had no significant off-work noise exposure.

Four physicians have rendered opinions regarding claimant's hearing loss.[1] We find that none of those physicians is entitled to deference as a treating physician, because the most any of them did was examine and test claimant on an occasional basis. Therefore, we give the most weight to those opinions that are both well-reasoned and based on complete information, Somers v. SAIF, 77 Or App 259 (1986), without regard to the authors' nominal status as treating, consulting or examining physicians.

There is no dispute that claimant has significant hearing loss. The dispute concerns the cause of that condition. Drs. S. Hodgson and R. Hodgson stated that claimant's hearing loss curve is compatible with noise-induced hearing loss. (Exs. 12-2, 16-3). Drs. Olsen and Swan could not definitively rule out noise-induced hearing loss, but suggested that other factors may have contributed to claimant's condition. (Exs. 9-1, 10). On this record, we conclude that the preponderance of the medical evidence establishes that claimant's hearing loss is noise-induced.

The remaining question is whether claimant has established that his hearing loss is work-related. We answer that question "yes."

Dr. S. Hodgson stated that, "on a more probable than not basis, that without the occupational history that this hearing loss would not be anywhere near as severe as it is today and perhaps would be no hearing loss at all if [claimant] had never worked around noise." (Ex. 16-3). S. Hodgson then stated:

> "The issue then of effective hearing protection arises. [Claimant] states that he used cotton initially when exposed to loud noise which provides virtually no hearing protection. Rubber ear plugs and later foam ear plugs were used. Whether or not this was effective hearing protection is unclear. There are two possibilities here. One is that the ear plugs were not used properly and did not completely seal the ear canal providing minimal ear protection and exposing [claimant] to damaging noise. Second is the possibility that noise levels were high enough to even with hearing protection damaging noise was still occurring. This would depend on the ambient noise levels as well as the attenuation of the plugs used. None of these facts are clear and probably never will be at this point, many years after the fact." (Id).

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[1] A nose engineer also rendered an opinion regarding claimant's hearing loss. Because the engineer is not a medical expert,and because the other experts are physicians, we have disregarded his opinion in ascertaining the cause of claimant's hearing loss.

Based on claimant's audiogram, and the progression of his high frequency hearing loss in the face of high work-related noise exposure, Dr. S. Hodgson concluded that the occupational noise was the major contributing cause of claimant's hearing loss. (Id). After reviewing the contrary medical evidence, Dr. S. Hodgson adhered to that conclusion. (Ex. 19).

We find Dr. S. Hodgson's opinion, coupled with the evidence of claimant's long history of working in a noisy paper mill, and the lack of significant off-work noise exposure, sufficient to establish the compensability of claimant's hearing loss. In reaching this conclusion, we reject the employer's argument that, because there is no evidence that claimant did not correctly use his hearing protection, Dr. S. Hodgson's opinions are entitled to little weight. Hodgson's conclusion is based on claimant's audiogram and long history of exposure to high levels of noise, not claimant's use of ineffective hearing protection. Accordingly, we disregard Hodgson's speculation regarding the efficacy of claimant's hearing protection in analyzing his opinion.

We find persuasive reasons not to rely on the other medical evidence in the record. Dr. R. Hodgson concluded that, in light of claimant's 35 decibel hearing loss between 1975 and 1990, at a time when he was using "effective" hearing protection, one could not state whether claimant's hearing loss was work-related. (Exs. 12-2, 15). Because that reasoning assumes that the hearing protection was, indeed, "effective," and because the record does not support that assumption, we discount R. Hodgson's report.

We likewise discount Dr. Olsen's reports. Olsen believed that claimant's audiometric pattern was "more compatible with premature presbycusis." (Ex. 9-1). That pattern, as well as claimant's hearing loss progression, and history of consistent use of hearing protection devices, led Dr. Olsen to suspect that claimant's hearing loss was not work related. (Id.; see also Exs. 18, 20) Because Olsen's opinion conflicts with the persuasive evidence that claimant's hearing loss was noise-induced, and because it is, like R. Hodgson's reports, based on the assumption that claimant's hearing protection was effective, we afford Dr. Olsen's reports little weight.

In sum, we find the reports of Dr. S. Hodgson both persuasive and based on complete information, and sufficient to establish the compensability of claimant's hearing loss. Somers v. SAIF, supra. Accordingly, we reverse the Referee's decision upholding the employer's denial of that condition.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 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 is $3,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and 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 March 4, 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 $3,500, to be paid by the employer.

In the Matter of the Compensation of
KEVIN S. LARSEN, Claimant
WCB Case No. 94-01591
ORDER ON RECONSIDERATION
Coughlin, et al., Claimant Attorneys
Charles L. Lisle, Defense Attorney

The self-insured employer requests reconsideration of our January 26, 1995 Order on Review in which we applied Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), to find that claimant had established a compensable aggravation claim. On reconsideration, the employer argues that Jocelyn does not apply, as claimant's accepted condition has not worsened.

In the Matter of the Compensation of
KYLE J. SHURTZ, Claimant
WCB Case No. 93-14719
ORDER ON REVIEW
Dennis W. Skarstad, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Schultz's order which found that the Hearings Division lacked jurisdiction to address the issue of temporary disability benefits. The insurer cross-requests review of that portion of the Referee's order which awarded an assessed attorney fee pursuant to ORS 656.386(1). On review, the issues are jurisdiction, and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was injured on July 28, 1992. Dr. Azhar, treating physician, released claimant to work on September 8, 1992. (Exs. 5-1, 6). The employer accommodated claimant by giving him light work but, shortly thereafter, claimant resumed his regular work duties. (Tr. 16, 17).

The insurer paid temporary disability benefits through September 7, 1992. On June 29, 1993, claimant first saw Dr. Scribner. (Exs. 9, 9A-1). Although claimant was not working, Dr. Scribner apparently "released" claimant from work. On August 3, 1993, Dr. Scribner signed a change of physician form, and stated that claimant was released to return to regular work on August 9, 1993.

On October 12, 1993, the insurer sent claimant a "denial" letter stating that the insurer had not received an authorization releasing claimant from work in June 1993. (Ex. 11). Further, the insurer stated that it had not paid any benefits since September 7, 1992. Id.

On January 7, 1994, a Determination Order (DO) issued, awarding claimant temporary disability benefits from July 31, 1992 to September 7, 1992. On January 26, 1994 an amended DO issued, awarding claimant additional temporary disability benefits from June 29, 1993 to August 8, 1993. The parties stipulated at hearing that all the benefits awarded by the DO's had been paid.

Jurisdiction

We adopt the Referee's conclusion with regard to this issue.

Attorney Fee

The Referee awarded a $750 assessed attorney fee pursuant to ORS 656.386(1) for claimant's counsel's services in overturning the insurer's "denial" of temporary disability benefits. We modify.

Claimant is entitled to an assessed fee under ORS 656.386(1) if he prevailed at hearing over a denial of a claim for compensation. Within this context, a "denial of a claim for compensation" is a denial of the compensability of a condition or a medical service, as opposed to a denial concerning the amount of benefits paid. See James R. Jones, Jr., 42 Van Natta 238 (1990). Therefore, because the issue involved the amount of temporary disability benefits, rather than a denial of compensability, an assessed fee is not appropriate. Accordingly, rather than an assessed attorney fee, claimant is awarded an approved attorney fee equal to 25 percent of the increased compensation created by the "rescission" of the insurer's "denial" of temporary disability, not to exceed $1,050.

ORDER

The Referee's order dated March 23, 1994, as reconsidered May 6, 1994, is modified in part and affirmed in part. The Referee's attorney fee award is modified. In lieu of the Referee's assessed attorney fee award of $750, claimant is awarded an approved attorney fee equal to 25 percent of the increased temporary disability compensation created by the "rescission" of the insurer's "denial," not to exceed $1,050. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
FRANK A. TAYLOR, Claimant
WCB Case No. 93-13382
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of those portions of Referee Neal's order that: (1) found that claimant's psychiatric claim was not prematurely closed; and (2) affirmed an Order on Reconsideration that awarded no permanent disability for the psychiatric condition. In addition, claimant: (1) moves that we strike part of the insurer's respondent's brief; (2) argues that the Referee abused her discretion in admitting Exhibit 30, which is a medical arbiter's report; and (3) submits an affidavit from his attorney and a copy of a letter from his attorney to a Review Specialist at the Department's Appellate Review Unit. We treat claimant's submissions as a motion for remand. On review, the issues are remand, motion to strike, evidence, premature closure, and extent of permanent disability.

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

Evidence

At hearing and on review, claimant argues that Exhibit 30 is not admissible. Exhibit 30 is a report from Dr. Klecan, a psychiatrist who was appointed as a medical arbiter by the Director. Claimant argues that the insurer requested appointment of a medical arbiter for the sole purpose of countering claimant's contention that he was not medically stationary at claim closure. Claimant contends that, because ORS 656.268(7) provides for the appointment of a medical arbiter when there is a disagreement concerning the impairment findings, the Director's appointment of a medical arbiter to address claimant's medically stationary status exceeds the statutory limitations of the statute. Therefore, claimant argues, the Referee abused her discretion in admitting Exhibit 30. We disagree.

Here, claimant requested reconsideration of the February 18, 1993 Determination Order, indicating, in part, that he: (1) objected to the medically stationary date; (2) contended that his claim was prematurely closed; and (3) objected to the rating of impairment. (Ex. 33-1). Although claimant did not object to the impairment findings used in rating his disability, the insurer requested appointment of a medical arbiter panel on that basis. (Ex. 33-2). We note that, pursuant to ORS 656.268(7), either party may request appointment of a panel of medical arbiters. However, the insurer indicated that its position was that claimant was not entitled to any benefits beyond those awarded by the Determination Order. (Ex. 29B). On the other hand, the insurer also stated that, should additional benefits be awarded, it reserved the right to offset any overpayment against that award. Id.

Thus, contrary to claimant's argument, the insurer requested appointment of a medical arbiter panel based on its objection to the impairment findings. (Ex. 33-2). Furthermore, although contending that claimant was not entitled to additional benefits beyond those awarded by the Determination Order, the insurer also acknowledged that additional benefits might be awarded, presumably based on the medical arbiter's findings.

The Court of Appeals recently examined ORS 656.268(7) and held that the appointment of a medical arbiter was required "when there is a 'disagreement with the impairment' used to rate claimant's disability." Sedgwick James of Oregon v. Hendrix, 130 Or App 564, 568 (1994). We recently examined ORS 656.268(7) and applied the court's holding in the Hendrix decision in Flor Irajpanah, 47 Van Natta 189 (1995). In Irajpanah, the claimant requested reconsideration of a Determination Order; however, she did not disagree with the rating or the findings of impairment, nor did she request appointment of a medical arbiter. In addition, the carrier did not challenge the impairment used to rate the permanent disability or request appointment of a medical arbiter. We held that, where the impairment used to rate permanent disability is not challenged by a party on reconsideration, the Department's obligation under ORS 656.268(7) to appoint a medical arbiter is not triggered. Under those circumstances, we declined to consider the report furnished by a Director-appointed medical arbiter. Furthermore, because the medical arbiter's report was not concurred in by the attending physician, we found no statutory basis for admission of the report and did not consider it on review.

Here, as in Hendrix, and unlike Irajpanah, a party disputed the impairment used to rate the permanent disability and requested appointment of a medical arbiter. Therefore, the Department's obligation under ORS 656.268(7) to appoint a medical arbiter was triggered. Consequently, the medical arbiter's report is admissible and we consider it on review in regard to both the impairment issue and the premature closure issue.

Motion to Strike/Remand

In its respondent's brief, in arguing that the Referee did not abuse her discretion in admitting the medical arbiter's report, the insurer stated that "claimant did not object to the arbiter exam or the report until he saw the arbiter's opinion." (Respondent's Brief, page 3). Claimant moves that we strike that sentence of the insurer's brief, contending that there is no evidence to support the insurer's statement. In support of his motion, claimant submits an affidavit from his attorney and a copy of a letter from his attorney to a Review Specialist with the Department's Appellate Review Unit, in which claimant's attorney objected to the insurer's request for the appointment of a medical arbiter.

We treat new evidence submitted on review as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

We note that the Referee also found that claimant did not object to the appointment of the arbiter until the time of hearing. (Opinion and Order, page 3). At hearing, claimant's attorney made no mention of any previous objection to the appointment of a medical arbiter. Because both the affidavit and the letter presented on review are authored by claimant's attorney, we find that they were obtainable with due diligence at the time of the hearing. Therefore, remand is not appropriate.

As to the motion to strike, considering our evidentiary decision as discussed above, which is not based on the timing of any objection to the appointment of a medical arbiter, we find that the insurer's statement does not effect our evidentiary decision. Therefore, we deny the motion to strike.

ORDER

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

In the Matter of the Compensation of
EDWIN P. VINING, Claimant
WCB Case No. 94-01051
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Lipton's order which: (1) declined to direct the self-insured employer to pay for medical treatment pursuant to a prior referee's order; and (2) declined to assess a penalty and related attorney fee for the employer's allegedly unreasonable claim processing. On review, the issues are enforcement of a prior referee's order, penalties and attorney fees. We reverse.

FINDINGS OF FACT

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 eventually came under the care of Dr. Jura.

From March 1993 through December 1993, claimant received physical therapy at Rockwood Orthopedic & Fracture Clinic (Rockwood), as prescribed by Dr. Jura. By letter dated May 5, 1993, the employer's claims processing agent, Scott Wetzel Services, advised claimant:

> "On behalf of the...employer we must respectfully deny compensability on this claim for your current condition and related treatment for your low back and hips. This is on the basis of preponderance of medical opinion that your original compensable low back strain is not related to your current condition which is due to degenerative joint disease.
>
> "Therefore, this current condition denial is issued." (Ex. 101, emphasis supplied).

Claimant requested a hearing on the denial, and a hearing was convened on September 7, 1993, before Referee Davis. Referee Davis concluded that the low back condition was compensably related to the original industrial injury. By Opinion and Order dated November 29, 1993, he set aside "[t]he denial of the current condition of the low back and related treatment" and remanded the matter to the employer "for any appropriate processing." (Ex. 104-6, emphasis supplied). Referee Davis' order was not appealed.

On or about January 24, 1994, the employer requested the Director's assistance in determining whether medical services provided to claimant were appropriate. By letter dated January 24, 1994, the Department's Medical Review Unit notified the parties that the Director was initiating review of the appropriateness of treatment provided by Dr. Jura and Rockwood. By Proposed and Final Order Concerning a Bona Fide Medical Services Dispute dated April 13, 1994, the Director concluded that physical therapy rendered between March 1993 and December 1993 and a June 29, 1993 office visit with Dr. Jura were not appropriate treatment for the compensable injury. (Exs. 104A, 105).

Claimant requested a hearing to seek payment for the disputed medical services and a penalty for the employer's allegedly unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that the prior litigation before Referee Davis precluded the employer from seeking Director review of the disputed medical treatment. Citing the Board's decisions in Stanley Meyers, 43 Van Natta 2643 (1991) and Michael A. Jaquay, 44 Van Natta 173 (1992), the Referee noted that, under the prevailing case law at the time of the prior hearing before Referee Davis, the Hearings Division did not have jurisdiction to decide medical treatment disputes except to determine whether the treatment was causally related to the compensable injury (compensability). Finding no indication that any issue other than compensability of treatment was raised in the prior hearing, the Referee held that the employer was not precluded from seeking Director review of the appropriateness of treatment. On review, claimant maintains that the employer was precluded from seeking Director review of the disputed medical treatment.

We treat claimant's request as a request for enforcement of Referee Davis' November 29, 1993 order. The issue before Referee Davis was the propriety of the employer's May 5, 1993 partial denial. The denial explicitly denied the low back condition and "related treatment." The denial was based on the contention that the low back condition was not compensably related to the original industrial injury. There was no indication that the employer was contesting, or reserving the right to contest, the appropriateness of the claimed treatment for the low back condition. (Ex. 101).

At hearing, the employer did not amend its denial to exclude "related treatment." We therefore find that the compensability of claimant's low back treatment (i.e., physical therapy and related office visit) was expressly at issue before Referee Davis. See Tattoo v. Barrett Business Services, 118 Or App 348, 351-52 (1993) (held that an employer was bound by express language of its denials). Furthermore, the employer did not amend its denial to challenge the appropriateness of the treatment for claimant's low back condition. Rather, based on the express language of its denial, we find that the employer's entire defense to the claim for low back treatment was that the low back condition was not compensably related to the original industrial injury. See id. In fact, at hearing the parties proceeded to litigate only the causal relationship between the industrial injury and the low back treatment rendered in 1993. There was no indication that the employer intended to challenge the appropriateness of the treatment itself.

At the time of hearing, the Board's decisions in Meyers and Jaquay were the prevailing case law on the respective jurisdictions of the Board and the Department to decide medical treatment disputes. In those decisions, the Board held that the Board and its Hearings Division lacked jurisdiction to decide medical treatment disputes, except those concerning the causal relationship between the compensable injury and the condition requiring treatment, i.e., compensability. However, the evidentiary record in the hearing before Referee Davis remained open until September 30, 1993. Prior to that date, on September 15, 1993, the Court of Appeals reversed the Board's decision in Meyers. Meyers v. Darigold, Inc., 123 Or App 217 (1993). The court held that, if no party "wishes" Director review of a medical treatment dispute and gives the appropriate notice under ORS 656.327(1)(a), the conditions for exclusive Director jurisdiction have not been satisfied, and the medical treatment dispute remains within the Board's (and Hearings Division's) jurisdiction. Id. at 222. Consequently, under the court's opinion in Meyers, the Hearings Division properly had jurisdiction to review the appropriateness of medical treatment, provided the conditions for exclusive Director jurisdiction under ORS 656.327 were not satisfied.

Thus, the prevailing case law concerning the Hearings Division's jurisdiction of medical treatment disputes had changed prior to closure of the hearing record before Referee Davis. Further, the conditions for exclusive Director jurisdiction under ORS 656.327 were not satisfied prior to closure of the record before Referee Davis. Therefore, Referee Davis had jurisdiction to review the appropriateness of claimant's medical treatment.

Indeed, it could be argued that, notwithstanding the Board's interpretation of the statutes, Referee Davis always had jurisdiction under the statutes to review the appropriateness of treatment (in accordance with the court's Meyers opinion, which is current prevailing case law). We need not address that question here, however, because we find that the employer had ample opportunity, following the issuance of the court's Meyers opinion, to expressly raise the appropriateness of treatment as an issue before Referee Davis. Yet, the employer did not raise that issue, either prior to the closure of the hearing record, or by requesting reconsideration of his order. Instead, Referee Davis' order became final by operation of law.

In his order, Referee Davis "set aside" the employer's May 5, 1993 "denial of the current condition of the low back and related treatment." (Emphasis supplied.) Thus, Referee Davis set aside not only the denial of the low back condition but also the denial of "related treatment," i.e., physical therapy and the related office visit. Inasmuch as that order became final, the employer was required to accept responsibility for the disputed treatment. In this context (of "setting aside" the denial), we conclude that Referee Davis' remand to the employer for "any appropriate processing" imposed the obligation to pay the disputed medical billings, i.e., for physical therapy from March through December 1993 and for the June 29, 1993 office visit with Dr. Jura. Accordingly, we direct the employer to pay those billings.

Referee Davis' order setting aside the employer's denial of low back treatment was unambiguous and, therefore, left the employer no legitimate doubt of its liability for the treatment. Therefore, the employer's refusal to pay the billings and its subsequent request for Director review of the disputed medical treatment constituted an unreasonable refusal to pay compensation. See Brown v. Argonaut Ins. Co., 93 Or App 588 (1988). Accordingly, the employer is assessed a penalty under ORS 656.262(10)(a) in an amount equal to 25 percent of all medical benefits made payable by Referee Davis' order. The penalty shall be paid in equal shares to claimant and his attorney.

Finally, we conclude that the employer's refusal to pay the medical billings amounted to a "de facto" denial of those billings. See SAIF v. Allen, 320 Or 192, 222 (1994). Therefore, claimant's counsel is entitled to an assessed attorney fee under ORS 656.386(1) for prevailing against that denial. 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 at hearing and on review is $2,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate brief), the complexity of the issues, 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 award for his counsel's services regarding the penalty issue.

ORDER

The Referee's order dated April 25, 1994 is reversed. The self-insured employer's "de facto" denial of claimant's claim for physical therapy (from March through December 1993) and related office visit (on June 29, 1993) with Dr. Jura regarding his low back condition is set aside. The employer is directed to pay those medical billings. The employer is assessed a penalty in an amount equal to 25 percent of the medical billings made payable by this order, to be paid in equal shares to claimant and his attorney. Claimant's attorney is awarded an assessed fee of $2,500 for services at hearing and on review, to be paid by the employer.

February 23, 1995 Cite as 47 Van Natta 286 (1995)

In the Matter of the Compensation of
ROBERT J. LYON, Claimant
WCB Case No. 93-14048
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Turner-Christian.

The SAIF Corporation requests review of Referee Black's order that set aside its denial of claimant's right knee degenerative condition and related treatment. On review, the issue is compensability.

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

The Referee concluded that claimant's compensable right knee injury caused his asymptomatic preexisting degenerative condition to become symptomatic. The Referee further concluded that claimant's compensable right knee injury remains the major contributing cause of his resultant knee condition and need for medical treatment. See ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

On review, SAIF argues that claimant has only established that the work injury "precipitated" the onset of claimant's symptoms. Thus, SAIF contends that, pursuant to Dietz v. Ramuda, 130 Or App 397 (1994), claimant's current right knee condition is not compensable. We disagree.

In general, the determination of the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. Id. at 401. Although the immediate or precipitating cause may be the major contributing cause, that is not always true. Id. Under ORS 656.005(7)(a)(B), the relative contribution of each cause, including the precipitating cause and the preexisting condition itself, must be evaluated under the particular circumstances of each case. Id.

There are two medical opinions concerning causation. Dr. Jany, claimant's treating orthopedic surgeon, explained that removal of a portion of the medial or lateral meniscus adversely effects weight distribution over the knee joint and leads to further degenerative change. Although he recognized that claimant has degenerative joint disease that preexisted the May 1990 injury and which contributes to claimant's current condition, Dr. Jany opined that the work injury continues to be the major cause of claimant's ongoing need for medical treatment.

SAIF argues that, at his deposition, Dr. Jany agreed with SAIF's counsel that the degenerative condition is the major cause of claimant's current disability. However, as noted by the Referee, the question as posed by SAIF was based on the incorrect premise that claimant was pain free for several years after the 1990 surgery. That was not the case. Ultimately, based on a correct history, Dr. Jany concluded that the work injury continues to be the major cause of claimant's current right knee condition.

Dr. Woolpert, an orthopedic surgeon, examined claimant for SAIF. He agreed that removal of the meniscus accelerates degenerative changes. Dr. Woolpert opined, however, that considering the severity of claimant's preexisting degenerative joint changes, the degenerative condition is the major contributing cause of claimant's current condition and need for treatment.

The medical evidence thus is divided whether the preexisting condition or the work injury continues to be the major cause of claimant's ongoing need for medical treatment and surgery. We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find no such reasons. Therefore, we defer to the opinion of Dr. Jany.

Based on Dr. Jany's opinion, we find that the medical evidence establishes that the work injury, rather that the preexisting degenerative condition, is the major contributing cause of the need for treatment. Therefore, claimant's resultant condition under ORS 656.005(7)(a)(B) is compensable. Accordingly, we affirm the Referee's decision setting aside SAIF's denial of claimant's current right knee degenerative condition and resulting treatment.[1]

Claimant's counsel is entitled to an attorney for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,200, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 1, 1994 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, to be paid by the SAIF Corporation.

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[1] We further note that claimant has not challenged the Referee's conclusion that, by virtue of a prior claim disposition agreement, claimant's rights to benefits for his current right knee condition are limited to medical services. See Jeffrey B. Trevitts, 46 Van Natta 1583 (1994).

February 23, 1995 Cite as 47 Van Natta 287 (1995)

In the Matter of the Compensation of
LAWRENCE RUNNINGHAWK, Claimant
WCB Case Nos. 93-09177 & 93-06876
ORDER ON RECONSIDERATION
Welch, Bruun, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney
Werst, Shields, et al., Defense Attorneys

The SAIF Corporation requests reconsideration of our January 26, 1995 order that: (1) concluded that the Referee had jurisdiction to litigate the compensability of claimant's March 15, 1993 herniated disc condition; and (2) found that SAIF was responsible for that claim. SAIF contends that the issue of whether claimant sustained a new compensable injury in March 1993 was not litigated during the hearing and was not properly before the Referee. Having received claimant's and Kemper Insurance Company's responses, we proceed with our reconsideration.

We briefly summarize the procedural history. Claimant sustained a low back injury on July 12, 1985, which was accepted by Kemper Insurance Company (Kemper). The claim was closed in May 1986 by a Determination Order that granted 15 percent unscheduled permanent disability. On August 19, 1992, claimant suffered a low back strain while moving arborvitae when he was working for SAIF's insured. SAIF accepted the claim for a nondisabling lumbosacral strain, which was completely resolved by November 1992. On March 15, 1993, claimant suffered acute low back and left leg pain when he was installing a water meter while employed by SAIF's insured. Claimant's CT scan showed an extruded disc fragment and surgery was proposed.

SAIF contends that we erred by finding that the Referee had jurisdiction to decide the case on the basis of a March 15, 1993 "new injury" claim. According to SAIF, the only issues at hearing were whether SAIF was responsible based on its accepted 1992 back strain, or whether Kemper was responsible based on the accepted 1985 injury. Relying on Edward R. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989), SAIF contends that Kemper improperly raised the "new injury" theory of responsibility in closing argument.

In Rankin, the parties agreed at the beginning of the hearing that the issue was the causal relationship between a compensable injury and the denied medical services. After the closing of the hearing, during unrecorded closing arguments, the insurer raised a reasonable and necessary question concerning claimant's medical services claim. We concluded that, under those circumstances, the Referee should not have addressed the new "reasonable and necessary" issue.

Here, in contrast, the issue of a March 1993 "new injury" claim was not raised for the first time in closing argument. At the beginning of the hearing, the parties discussed the issues to be decided. When SAIF noted that its accepted injury claim was August 29, 1992, claimant pointed out that there was a "subsequent incident." (Tr.4). SAIF acknowledged that and said that its denial was for responsibility for claimant's current condition. (Id). The Referee summarized the parties' understanding that SAIF's denial was of claimant's current condition and a denial of responsibility. (Tr. 5). In light of this discussion, we find that SAIF was aware of the "subsequent" March 1993 incident at the beginning of the hearing.

Furthermore, we do not agree that the only issues to be litigated were SAIF's accepted 1992 back strain and Kemper's accepted 1985 injury. At the end of the initial hearing, the Referee held the record open for admission of depositions of Drs. Ferguson and Lax. The record indicates that the issues changed in the course of the proceeding as a result of a post-hearing deposition of Dr. Ferguson. Prior to that deposition, the medical opinions concerning causation were that claimant's current condition was either related to the 1985 injury claim with Kemper or the August 1992 injury claim with SAIF. Dr. Lax opined that the major contributing cause of claimant's current condition was the July 12, 1985 injury and he said that the August 1992 and March 1993 incidents represented exacerbations. (Ex. 45B). On the other hand, Dr. Ferguson stated that claimant's current injury was related to the August 1992 injury claimant sustained while moving arborvitae and was not related to the injury in July 1985. (Ex. 47).

At deposition, Dr. Ferguson reviewed claimant's medical record and changed his opinion about the arborvitae incident. (Ex. 48-17). Dr. Ferguson said that the arborvitae incident had completely resolved and he believed that the water meter incident on March 15, 1993 caused the problem with claimant's disc. (Id). Dr. Ferguson testified that the arborvitae incident was not even a material contributing cause of claimant's current condition. (Ex. 48-19 & 48-20). He testified the March 1993 incident with the water meter was the major contributing cause of claimant's condition. (Ex. 48-20).

More than a month after Dr. Ferguson's deposition, the parties deposed Dr. Lax. After the "post-hearing" depositions, closing arguments were recorded. Relying on Dr. Ferguson's deposition testimony, claimant asserted that there had been a new injury in March 1993. (Exs. 49-33, 49-38 & 39). Kemper asserted that claimant had a new condition caused by the 1992 and 1993 incidents. (Ex. 49-35). SAIF raised no objection to claimant's "new injury" theory. Instead, SAIF argued that Dr. Ferguson's post-hearing deposition indicated that SAIF's August 1992 injury was a separate and distinct injury that had resolved, which left the 1985 and 1993 injuries to be litigated. (Ex. 49-37).

In light of claimant's reference to the March 1993 "subsequent incident" at the beginning of the hearing and Dr. Ferguson's post-hearing deposition testimony that claimant had a new injury in March 1993, we reject SAIF's argument that the only issues at hearing were whether SAIF was responsible based on its accepted 1992 back strain, or whether Kemper was responsible based on the accepted 1985 injury. Furthermore, we disagree that the "new injury" claim was improperly raised in closing arguments.

SAIF also contends that it did not have notice of the March 1993 "new injury" theory and that, if it had, it would have requested an opportunity to generate evidence to disprove that claimant sustained a "new injury." In this regard, we note that Dr. Lax's deposition was on November 22, 1993, more than a month after Dr. Ferguson's October 4, 1993 deposition which contained Ferguson's opinion that the March 1993 incident was the major contributing cause of claimant's condition. SAIF asked Dr. Lax about Dr. Ferguson's theory that claimant's August 1992 "arborvitae" incident had resolved. Dr. Lax responded that he could not agree or disagree. (Ex. 49-17). Kemper asked Dr. Lax about claimant's March 1993 incident in the form of a hypothetical question and asked whether a new injury would have occurred. Dr. Lax responded that there was no way to answer that question. (Ex. 49-27). SAIF had an opportunity to ask Dr. Lax follow-up questions. We note that the Referee did not close the record until February 11, 1994.

Under these circumstances, we find that SAIF had notice of the "new injury" theory well before the closure of the record and that it had an opportunity to disprove that theory. Moreover, we find no evidence in the record that SAIF sought to continue the proceeding or objected to the closure of the record.

In our previous order, we concluded that SAIF's failure to object to litigation of the March 1993 injury claim constituted a "denial of the claim and a valid waiver of all procedural errors relating to litigation of the claim." Thomas v. SAIF, 64 Or App 193 (1983). We concluded that the Referee had jurisdiction to litigate the compensability of claimant's March 15, 1993 injury. On reconsideration, we adhere to that conclusion.

Finally, SAIF argues that Kemper did not issue a timely disclaimer to the March 15, 1993 injury, and therefore, Kemper should be estopped from raising a new theory for shifting responsibility. Inasmuch as this issue was not raised before the Referee, we are not inclined to consider it on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

In any event, we disagree with SAIF's argument. Although a carrier's failure to comply with the disclaimer notice of ORS 656.308(2) may preclude the carrier from attempting to shift responsibility to another carrier, the carrier's violation does not preclude the claimant from pursuing the claim with another carrier. See Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994); Jon F. Wilson, 45 Van Natta 2362 (1993).

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's request for reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $150, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response to the request for reconsideration), the complexity of the issues, and the value of the interest involved.

In conclusion, we withdraw our January 26, 1995 order. On reconsideration, we continue to adhere to the reasoning and conclusions reached in our original order. Accordingly, on reconsideration, as supplemented herein, we republish our January 26, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

February 23, 1995 Cite as 47 Van Natta 289 (1995)

In the Matter of the Compensation of
SHANTI M. URI, Claimant
WCB Case No. 91-17242
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Referee Spangler's order that: (1) found that claimant's claim for a left elbow injury was untimely; (2) upheld the SAIF Corporation's denial of claimant's injury claim for a left elbow condition; and (3) upheld SAIF's denial of claimant's psychological condition. On review, the issues are the timeliness of the claim and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF was prejudiced by claimant's late filing of her injury claim. Accordingly, the Referee found that claimant's claim was time-barred under ORS 656.265(1). Alternatively, addressing the merits, the Referee found that claimant's left elbow and psychological conditions were not compensable. Because we conclude that claimant has not established compensability of her left elbow or psychological conditions on the merits, we find it unnecessary to address the timeliness issue.

Compensability of Left Elbow/Upper Extremity Condition

In July 1991, claimant was leaving work to go to a training seminar when she fell and struck her left elbow in the employer's parking lot. Claimant did not report the injury to her employer or seek medical attention. Claimant continued to perform her job without apparent difficulty. However, she continued to experience some pain in the left elbow even after the bruise caused by the fall resolved. In August 1991, while on a camping trip, claimant experienced excruciating pain in the left elbow while lifting a coffee pot. Thereafter, claimant sought medical treatment. She reported the July work injury in September 1991.

Because the injury was not immediately reported and because there is expert testimony that the July 1991 incident did not cause a left elbow injury, we conclude that expert medical evidence is necessary to establish compensability. See Barnett v. SAIF, 122 Or App 279 (1993); Uris v. Compensation Department, 247 Or 420 (1967).

Several physicians address the nature and cause of claimant's left elbow condition. Claimant saw Dr. Winthrop after the August 1991 camping incident. Dr. Winthrop diagnosed epicondylitis and referred claimant to Dr. Lawton, orthopedist. Dr. Lawton determined that claimant had acute lateral epicondylitis and a probable traumatic extensor tendon tear. Dr. Lawton, in turn, referred claimant to Dr. Hiebert, who diagnosed reflex sympathetic dystrophy (RSD) of the left upper extremity and treated claimant with left stellate ganglion blocks and intravenous sympathetic Bretyllium blocks.

Claimant was examined on behalf of SAIF by Drs. Tesar, orthopedist, and Wilson, neurologist. These physicians believed that claimant had a contusion of her left elbow at the time of the July 1991 fall. However, because claimant's severe pain came on after her injury lifting the coffee pot, Tesar and Wilson believed that this incident was the major contributing factor in claimant's need for treatment. Drs. Tesar and Wilson felt that claimant's subjective complaints far outweighed her objective physical findings. They could not account for claimant's marked pain with any motion of the entire left upper extremity. The physicians noted that claimant did not have findings of a sympathetic dystrophy. (Exs. 12; 34-22; 35-11). Both Drs. Tesar and Wilson opined that the July 1991 injury was not a material contributing cause of claimant's disability or need for treatment. (Exs. 34-19; 35-9).

Dr. Fraback, rheumatologist, examined claimant for SAIF and diagnosed possible RSD. He noted that claimant's degree of guarding made examination difficult. He stated that claimant's history was unusual in that there were two months after the July 1991 fall before claimant sought medical attention. He noted that claimant did not have typical findings of RSD. By history, Dr. Fraback related claimant's need for treatment to the July 1991 incident.

Claimant was seen by Dr. Steinhauer, a physiatrist, who diagnosed RSD of the left upper extremity. Dr. Steinhauer believed that the onset probably occurred with the July 1991 fall. Dr. Steinhauer noted that claimant had not had a bone scan to document RSD and did not have much in the way of vasomotor instability. However, Dr. Steinhauer believed that claimant's symptoms and her inability to tolerate movement of the left arm was consistent with RSD. (Ex. 28-3).

Dr. Winthrop referred claimant to Dr. Grewe, a neurosurgeon. Dr. Grewe diagnosed RSD affecting the left upper extremity. He believed that the etiology was related to her work injury of July 1991. (Ex. 33-8). Dr. Grewe performed sympathectomy surgery and implanted an epidural stimulator.

Claimant was examined by Drs. Ochoa and Verdugo on behalf of SAIF. Drs. Ochoa and Verdugo believed that claimant had "pseudo-RSD" which most likely had a psychogenic origin. They performed a neurological evaluation of claimant which indicated that claimant had no neuropathic or central nervous system lesion which would explain claimant's complaints. In addition, Drs. Ochoa and Verdugo indicated that they found positive evidence in their examination that many of claimant's manifestations are not organic in origin and could be qualified as "psychogenic." (Ex. 38-12).

After reviewing the medical evidence, we are not persuaded that claimant has established that she has a compensable left upper extremity condition related to the July 1991 fall at work. After the July 1991 fall, claimant sought no medical treatment and experienced no disability for approximately two months. Only after the off-work coffee pot lifting incident did she experience severe symptoms and disability. Although claimant's treating physicians believe that claimant has RSD related to the July 1991 injury, their opinions are for the most part, conclusory and lacking in explanation and analysis.

In this regard, the reports of Drs. Grewe, Winthrop and Hiebert contain little or no explanation of why they believe that claimant has RSD due to the July 1991 injury. Although Dr. Steinhauer indicates that claimant's symptoms and her inability to tolerate movement of the left arm is consistent with RSD, neither he nor any of the other treating physicians address the effect, if any, of claimant's diagnosed psychological condition on her left upper extremity symptoms. We likewise do not find persuasive Dr. Fraback's report relating claimant's disability and need for treatment "by history" to the July 1991 injury. We note that the Referee found claimant not credible based upon her demeanor. We defer to the Referee's demeanor-based credibility finding. See Bush v. SAIF, 68 Or App 230 (1984). Thus, we are reluctant to rely on a medical opinion based solely on her history. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

Moreover, in light of the opinions of Drs. Ochoa and Verdugo and Drs. Tesar and Wilson, we are not persuaded that claimant has met her burden of proof. We find the reports of Drs. Ochoa, Verdugo, Tesar and Wilson to be well reasoned and based on complete information. Accordingly, we find their opinions more persuasive than those of the treating physicians. See Somers v. SAIF, 77 Or App 259 (1986).

Drs. Verdugo and Ochoa performed extensive neurological testing and found no organic basis for claimant's complaints. These findings are consistent with the inability of Drs. Tesar and Wilson to find objective evidence of RSD in their examination. Both Drs. Tesar and Wilson opined that if claimant indeed had RSD, this condition was more likely to be related to the off-work camping incident which brought forth severe symptoms.

Claimant argues that the reports of Drs. Ochoa and Verdugo are unpersuasive because they examined claimant after her sympathectomy surgery. We disagree. Although claimant reported that her hand had become warm since the sympathectomy, she still reported pain symptoms to Dr. Steinhauer. In fact, Dr. Steinhauer indicated that there was essentially no change in claimant's pain from his first evaluation. (Ex. 40-1). This is consistent with Dr. Ochoa's report that claimant was fully symptomatic during the evaluation. (Ex. 56A). Accordingly, we do not find the opinions of Drs. Ochoa and Verdugo unpersuasive on the basis that their examination occurred after the sympathectomy surgery.

Based on this record, claimant has not established that she has any disability or need for treatment which is materially related to the July 1991 injury. Under such circumstances, she has failed to establish that she sustained a compensable injury to her left elbow. ORS 656.005(7)(a).

Compensability of Psychological Condition

Claimant contends that SAIF's handling of her July 2, 1991 injury claim caused her preexisting psychological condition to become symptomatic. She asserts that her condition is compensable under ORS 656.005(7)(a)(B). However, because we have found the July 2, 1991 injury claim not compensable, we likewise conclude that claimant's psychological condition is not compensable. Alternatively, even if the July 2, 1991 injury claim was compensable, for the reasons which follow, we would still find that claimant has failed to establish a compensable psychological condition.

Claimant relies primarily on the opinion of her treating psychiatrist, Dr. Elder. Dr. Elder diagnosed claimant's condition as post-traumatic stress disorder (PTSD), major depression, multiple personality disorder and panic disorder. Neither Dr. Elder, nor any other physician, has opined that the July 2, 1991 fall at work was the major contributing cause of any of her psychological diagnoses. In fact, Dr. Elder has opined that claimant's childhood abuse was the major contributing cause of her PTSD. (Ex. 56-15 to 16, 61 to 64). Dr. Elder also agreed that the primary cause of claimant's psychological diagnoses was her childhood experiences. (Ex. 56-70 to 71). Drs. Voiss and Newton, psychiatrists, examined claimant on behalf of SAIF. They diagnosed claimant's condition as undifferentiated schizophrenia with a somatoform pain disorder. They opined that the July 2, 1991 fall was not the major contributing cause of claimant's psychiatric condition or disability or need for treatment.

Claimant argues that Dr. Elder's opinion supports a conclusion that the "triggering" event that brought out her psychological symptoms was SAIF's handling of the claim and especially her contact with SAIF's investigator Bob Rose.

However, even assuming claimant's left elbow claim "triggered" claimant's psychological symptoms, it does not necessarily follow that this triggering event is the major contributing cause of claimant's disability and need for treatment. Determining the "major contributing cause" of a disease or injury involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. See Dietz v. Ramuda, 130 Or App 397 (1994) (the 'precipitating' or immediate cause of an injury may or may not be the 'major contributing cause'). Based on this record, we are unable to conclude that the July 2, 1991 fall at work was the major contributing cause of claimant's disability and need for treatment.

ORDER

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

February 24, 1995 Cite as 47 Van Natta 292 (1995)

In the Matter of the Compensation of
JANICE CONNELL, Claimant
Own Motion No. 94-0719M
OWN MOTION ORDER ON RECONSIDERATION
Hollander & Lebenbaum, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our December 29, 1994 Own Motion Order, in which we declined to reopen her 1979 claim for the payment of temporary disability compensation because she failed to establish she was in the work force at the time of her current disability. With her request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to allow sufficient time to consider the motion for reconsideration, we abated our order and requested that the SAIF Corporation respond to the motion. No response has been received from SAIF. Therefore, we withdraw our prior order and issue the following order in place of our December 29, 1994 order.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant is not in the work force. Claimant contends that she qualifies for temporary disability compensation because she was willing to work and making reasonable efforts to obtain work until her compensable injury worsened requiring surgery. Claimant has the burden of proof on this issue and must provide evidence, such as a medical opinion supporting her contention that she is unable to work because of the compensable injury, and an affidavit supporting her position that she was willing to work and would be employed or seeking employment but for the compensable injury.

In our December 29, 1994 order, we found that claimant's physician, Dr. Nash, had opined that claimant remains "totally unemployable," and has been unable to be productively employed since the date of injury on October 7, 1979. However, claimant did not establish that, even though her physician opined that she is unable to work, she is willing to work and to seek work. With her request for reconsideration, claimant submitted an affidavit in which she stated that "[b]ut for my industrial injury disabilities I would either be working or looking for work if I was not employed." Thus, claimant has satisfied the third criterion set forth above.

On this record, we conclude that claimant has established that she is willing to work, but is unable to work because of the compensable injury. In addition, SAIF has not responded to the evidence claimant submitted which supports her contention. Therefore, claimant's contention is unrebutted.

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

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

IT IS SO ORDERED.

February 24, 1995 Cite as 47 Van Natta 293 (1995)

In the Matter of the Compensation of
MAX W. MADDEN, Claimant
WCB Case No. 93-13513
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Referee Spangler's order that: (1) denied its motion to dismiss claimant's request for hearing for lack of jurisdiction; (2) set aside SAIF's "de facto" denial of claimant's proposed low back surgery request arising from a managed care organization (MCO) dispute; and (3) awarded an attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable claim processing. On review, the issues are jurisdiction, medical services and attorney fees.

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

In January 1992, claimant compensably injured his low back while working for SAIF's insured. After a course of conservative treatment, claimant came under the care of Dr. Hacker, a member of CareMark Comp, an MCO with whom SAIF had contracted.[1] Hacker requested authorization from CareMark Comp to perform a spinal fusion surgery. (Ex. 47; see Ex. 36). CareMark Comp disapproved the proposed surgery request. (Exs. 37, 48).

Thereafter, claimant requested a hearing regarding SAIF's alleged "de facto" denial of his claim for low back surgery. Arguing that exclusive jurisdiction over the dispute rested with the Director, SAIF moved for dismissal of the hearing request. The Referee denied the motion, and set aside SAIF's "de facto" denial. SAIF requested Board review.

Subsequent to the Referee's order, the Board issued its decision in Job G. Lopez, 47 Van Natta 193 (1995).[2] There, after the Director upheld an MCO's disapproval of the claimant's physician's

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[1] Earlier, claimant had been under the care of another CareMark Comp physician, whose requests for authorization to perform surgery also had been disapproved. Those disapprovals are not directly at issue here.

[2] Before claimant filed his request for hearing, Dr. Hacker requested Director review of the dispute. (Ex. 49). After the Referee issued his Opinion and Order in this matter, the Director issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute, finding that the requested surgery was appropriate. SAIF enclosed a copy of the Director's Order with its Appellant's Brief. Ordinarily, we would treat such a submission as a request for remand to the Referee for the taking of additional evidence. ORS 656.295(5); Lester E. Saunders, 46 Van Natta 1153 (1994). In view of our conclusion that the Director was without jurisdiction to address this issue, see discussion infra, we perform our review without regard to the Director's order. See Job G. Lopez, supra, 47 Van Natta at 201 n 15 (slip op at 30). Accordingly, we need not address the remand issue.

surgery request, the claimant requested a hearing. The carrier moved for dismissal of the hearing request, arguing that the Director had exclusive jurisdiction over the dispute. The referee denied the motion, and the carrier requested Board review.

On review, the Board rejected the carrier's contentions that, under ORS 656.260(4)(d) and (6), and 656.704(3), the Director had exclusive jurisdiction over the dispute. 47 Van Natta at 194-200. Rather, the Board concluded that, in the MCO context, determining where jurisdiction lies depends on the nature of the medical services issue in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994) and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Board decided that, because the particular disputed medical treatment involved a proposed surgery, jurisdiction to review the dispute vested solely in the Hearings Division. Id. at 201. On the merits, the Board relied on the opinion of one of the claimant's treating physicians to find that the proposed surgery was appropriate. Id. at 201-202.[3]

SAIF presses essentially the same jurisdictional arguments that we rejected in Lopez. We adhere to our rejection of those arguments. Rather, in light of Lopez, we determine the nature of the disputed medical services issue in this case to ascertain who had jurisdiction to resolve the medical services issue presented by this case.

Here, as in Lopez, the dispute involves claimant's attending physician's request to perform spinal surgery. Because the request involves proposed curative medical services, under Martin v. City of Albany, and Jefferson v. Sam's Cafe, we conclude that jurisdiction to review the request is vested solely in the Hearings Division pursuant to ORS 656.283. Accordingly, we affirm the Referee's decision denying SAIF's motion to dismiss.[4]

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 436-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on Board review regarding the jurisdictional and medical services issues is $1,075, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated February 17, 1994 is affirmed. For services on Board review, claimant's counsel is awarded $1,075, to be paid by the SAIF Corporation.

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[3] Board Chair Neidig acknowledges that she is bound by the Lopez holding. However, she continues to disagree with that holding, and the underlying analysis, for the reasons stated in the dissent in that case. Id. at 202-206.

[4] At hearing, SAIF argued that ORS 656.260 exempts it from claims processing laws. (See Opinion and Order at 6-7). SAIF does not press that argument on review; accordingly, we do not consider it, except to note that we have adopted and affirmed the Referee's order in its entirety. Further, we note that ORS 656.262(1), which states, in part, that "[p]rocessing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer[,]" makes no distinction between carriers that contract with MCOs and those that do not. See also ORS 656.245(1)(a) (sets forth a carrier's obligation to provide medical services without distinguishing between carriers using MCOs and those that do not).

In the Matter of the Compensation of
JAMES C. SCHULTZ, Claimant
WCB Case No. 94-02146
ORDER ON REVIEW (REMANDING)
Richard F. McGinty, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Emerson's order that dismissed claimant's hearing request concerning his procedural entitlement to temporary total disability benefits. In his brief, claimant requests remand for the taking of additional evidence. On review, the issues are jurisdiction and remand. We vacate the Referee's order and remand.

FINDINGS OF FACT

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

On February 16, 1994, claimant requested a hearing on the rate of temporary disability, entitlement to temporary disability, and penalties and attorney fees. The hearing was scheduled for May 10, 1994.

The May 3, 1994 Determination Order declared claimant medically stationary on January 26, 1994 and awarded temporary disability, including temporary partial disability from November 15, 1993 through January 26, 1994.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted low back injury claim that was closed by Notice of Closure in July 1993. A February 1, 1994 Order on Reconsideration found that claimant was not medically stationary at the time of claim closure. Thus, the July 1993 closure notice was set aside and the claim was reopened.

Claimant filed a request for hearing on February 19 , 1994, raising the issues of entitlement to temporary disability, rate of temporary disability and penalties and attorney fees. The hearing was set for May 10, 1994. However, prior to the hearing, the claim was again closed by Determination Order on May 3, 1994. Claimant was awarded temporary disability through January 26, 1994, the date he was declared medically stationary.

At hearing, the Referee concluded that the Hearings Division lacked jurisdiction to address the question of claimant's entitlement to temporary disability after January 26, 1994. Reasoning that claimant was seeking a greater temporary disability award than that granted by the Determination Order, the Referee concluded that the appropriate method for resolution of the issue was by means of the reconsideration process.

Under ORS 656.268(5), the Hearings Division lacks initial jurisdiction to address challenges regarding an injured worker's substantive entitlement to temporary disability. However, a Referee has original jurisdiction over disputes concerning an injured worker's procedural entitlement to temporary disability because that issue is ripe for adjudication prior to claim closure. See Galvin C. Yoakum, 44 Van Natta 2403, 2404, on recon 44 Van Natta 2492 (1992).

In Yoakum, we established the criteria for distinguishing whether a dispute concerns procedural entitlement to temporary disability benefits. First, the hearing request must be filed before the claim was closed. Second, the request must raise issues regarding the carrier's "pre-closure" conduct. Third, the claimant is not seeking a greater temporary disability award than that granted by the Notice of Closure or Determination Order.

Subsequent to Yoakum, we further refined our analysis in Michael J. Drake, 45 Van Natta 1117 (1993). In Drake, we concluded that, when a claim has been closed subsequent to a request for hearing regarding a procedural temporary disability issue, the appropriate method to resolve an issue regarding

the resumption of temporary disability is by means of review of the closure notice or order. We reasoned that the analysis for the resumption of temporary disability is essentially the same as when evaluating substantive entitlement to such benefits following claim closure, i.e., what period was the claimant disabled from work due to his compensable injury before becoming and remaining medically stationary. We also recognized that the matter would have had some preclusive effect on the review of the closure document. Therefore, we determined that such a procedural temporary disability matter is, in effect, an objection to a notice of closure or determination order and should be directed through the reconsideration process in accordance with ORS 656.268(5)-(7).

Conversely, we concluded in Kenneth W. Metzker, 45 Van Natta 1631 (1993), that, where a claimant is objecting to the carrier's unilateral termination of temporary disability while the claim was in open status, the claimant was raising an issue regarding the carrier's "pre-closure" conduct. Under such circumstances, we held that the Hearings Division had jurisdiction over the matter.

Thus, 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. However, we are unable to determine this issue from the record developed at the hearing.

Claimant filed the hearing request on February 19, 1994, prior to the May 3, 1994 Determination Order. At the May 10, 1994 hearing, claimant framed the issue as procedural entitlement to temporary total disability from January 26, 1994 through February 24, 1994, and asserted that his request was not based on a challenge to the medically stationary date. (Trs. 3, 6). However, claimant did not clarify whether he was alleging that the insurer failed to resume payment of temporary disability or whether the insurer improperly terminated temporary disability. Such clarification is imperative in determining this jurisdictional question.

We may remand a case for further evidence if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Although exhibits were admitted at hearing, no testimony was taken. Moreover, the hearing was curtailed because the Referee believed he lacked jurisdiction to hear the matter.

Our review is limited to the record developed at the hearing level. In this case, because no testimony was taken and the hearing ended before the parties made specific contentions regarding the merits of the case, we are unable to resolve the issues raised by claimant's request for review. Under such circumstances, we find that the record is insufficiently developed. Therefore, a compelling basis for remand exists. Kienow's Food Stores v. Lyster, supra.

Accordingly, we vacate the Referee's order and remand this matter to Presiding Referee Tenenbaum for assignment to another referee. This assigned referee shall schedule further proceedings, at which time the parties shall have the opportunity to clarify the issues for resolution, as well as to present evidence regarding those issues. The assigned referee shall have the discretion to proceed in any manner that will achieve substantial justice, and will insure a complete and accurate record of all exhibits, examination and/or testimony. Thereafter, the referee shall issue a final, appealable order.

Finally, we note that the May 23, 1994 Determination Order has been affirmed by a July 20, 1994 Order on Reconsideration. We further note that neither party has filed a request for hearing contesting the reconsideration order. Thus, in presenting their respective positions to the referee, the parties should address the effect, if any, such events have on the matters disputed in this claim.

ORDER

The Referee's order dated May 10, 1994 is vacated. Claimant's request for hearing is reinstated. This matter is remanded to Presiding Referee Tenenbaum for further action consistent with this order.

In the Matter of the Compensation of
BARBARA NELSON, Claimant
WCB Case No. CV-94010
CRIME VICTIM ORDER
Kramer & Toth-Fejel, Applicant Attorneys
Mary H. Williams, Assistant Attorney General

Barbara Nelson (hereinafter "applicant"), sought Board review of the Department of Justice's Findings of Fact, Conclusions of Law and Order on Reconsideration dated August 29, 1994. By its Order, the Department denied compensation to applicant under the Compensation of Crime Victim Act, ORS Chapter 147.

Following our receipt of the request for Board review, applicant was advised, through her attorney, of her entitlement to request a hearing. Applicant also was instructed that, if no hearing was requested, she could submit written argument.

Applicant then timely submitted written argument. The Department timely responded with its own written argument. We now proceed to conduct our review based on the record, applicant's written argument and the Department's written response.

ISSUE

Whether applicant is entitled to benefits under ORS Chapter 147.

FINDINGS OF FACT

On February 12, 1993, police responded to a domestic disturbance call. A deputy interviewed applicant, who provided a report containing the following information. Applicant and her boyfriend, Gordon Barron, argued earlier in the evening and Barron ordered her to return a diamond engagement ring. When applicant refused to give Barron the ring, Barron pulled her left arm behind her back and put his other arm over her face. Applicant then bit Barron "to get him away." Barron thereupon put his thumb behind applicant's lower front teeth and yanked down, causing two teeth to come out of applicant's mouth.

A deputy also interviewed Barron and produced a report with the following information. Barron and applicant were sitting down to dinner when applicant accused Barron of lying to her. Barron then demanded return of the ring; applicant refused. Barron grabbed applicant's left hand to remove the ring from her finger. Applicant grabbed Barron's other hand and bit him. Barron, in the process of yanking his hand out of applicant's mouth, pulled out two of her teeth. They continued struggling, during which time applicant bit Barron three more times and struck him in the groin. Throughout the altercation, Barron pinned applicant's left arm behind her back to remove the ring.

The deputy observed bite marks on Barron's left upper arm, left middle finger, right thumb and right middle finger. Applicant and Barron were both cited for domestic assault in the fourth degree. Both sought emergency care. Applicant also underwent extensive dental treatment and is in need of additional treatment.

On December 21, 1993, applicant applied for crime victims' compensation, alleging that Barron committed domestic assault in the fourth degree by knocking "2 teeth out," injuring her arm and finger and forcefully taking off her ring.

On January 14, 1994, applicant wrote to a deputy district attorney urging prosecution of Barron and describing the events of February 12, 1993 as follows. While applicant was serving dinner to Barron, he began shouting and became agitated, twisting applicant's arm behind her back to remove the ring. Barron also put a hand over applicant's mouth; applicant then bit Barron's hand and shoulder to escape from Barron's grip. Barron next "used his hand to wrench downward against" applicant's lower teeth, causing two teeth to come out. Barron did not stop twisting applicant's arm behind her back until he had removed the ring from her finger.

On June 28, 1994, the Department denied the application for compensation, finding that there was "mutual provocation."

Applicant requested reconsideration and submitted a written statement as follows. Barron grabbed applicant's hand to remove the ring and forced her left arm behind her back, pushing her into the bathroom. When Barron put his hand over applicant's mouth, applicant bit him in "self-defense." Barron then pulled his hand down, causing the teeth to come out.

Applicant also participated in a teleconference with the Department's claims examiner. As described in the Department's Order on Reconsideration, applicant stated that she and Barron began arguing when she confronted Barron about his illegal activities; Barron then grabbed applicant's hand to remove the ring.

The claims examiner also interviewed Barron; his statement also is described in the Order on Reconsideration. According to Barron, he had fixed dinner when applicant accused him of lying; Barron told her that he wanted to call off the wedding and ordered the return of the engagement ring. Applicant refused and ran into the bathroom, threatening to flush the ring down the toilet. Applicant kneed him in the groin and bit his elbow. She then leaned over the bathtub and bit Barron's finger. When Barron pulled his finger out of applicant's mouth, her teeth were dislodged. According to Barron, applicant's teeth had been damaged and in need of repair before the incident.

On reconsideration, the Department found that, in view of the conflicting statements by applicant and Barron, the case had become "so confused" that applicant had failed to prove that her actions "did not provoke the alleged assailant or contribute to her injuries."

CONCLUSIONS OF LAW AND OPINION

The standard of review for cases appealed to the Board under ORS Chapter 147 is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

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). Eligibility for benefits also in part is based on finding that injury to the victim "was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim." ORS 147.015(5). "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 137-76-010(8).

In seeking crime victims' compensation, applicant has asserted before the Department and on review that Barron initiated the physical confrontation when he grabbed applicant's hand to remove the engagement ring. We are persuaded that, following a verbal argument by applicant and Barron, Barron demanded the return of the engagement ring and, when applicant refused, he pinned applicant's left arm behind her back until he removed the ring. This version of the event is supported by applicant's and Barron's statements to deputies. Inasmuch as the statements were made shortly after the altercation, we find it more reliable evidence than Barron's later allegation that applicant threatened to dispose of the ring and then, when he attempted to intervene, kicked and bit him. E.g., Steve F. Hilden, 45 Van Natta 1673 (1993).

We further find that Barron's actions in pinning applicant's arm behind her back constituted a compensable crime in that his conduct was intentional and caused injury to applicant's arm and shoulder, as well as eventually the loss of teeth. See ORS 163.160(1)(a).

Moreover, we find that applicant's injuries were not due to any "wrongful act" by applicant nor was there was "substantial provocation" by applicant to the assault. Before Barron pinned applicant's arm behind her back, the couple was verbally arguing over the return of the ring. We find that applicant's refusal to return the ring, by itself, does not constitute a "wrongful act" and is not sufficiently provocative to result in Barron's assaultive conduct, which escalated the disagreement into a physical confrontation. Thus, we conclude that applicant is eligible for victims' compensation benefits.

However, the Department must reduce or deny the amount of compensation according to the degree or extent to which the victim's conduct "provoked or contributed" to the injuries. ORS 147.125(1)(c). We do find "contribution" by applicant to her injuries. There was corroboration that applicant bit Barron four times during the course of the altercation and that at least one bite caused the skin to break. According to applicant, she bit Barron in "self-defense" to repel Barron's assault. We find some support for this assertion in view of our previous finding that Barron initiated the conflict and pinned applicant's arm behind her back until he removed the ring.

However, based on the extent of applicant's bites, we find that her conduct in biting Barron was more than "self-defense" and showed that she was an active participant in the conflict and further elevated the physically violent nature of the altercation. See Kenneth C. Fanning, 45 Van Natta 2417, 2419 (1993) (applicant eligible for benefits because the assailants initiated and escalated altercation but benefits reduced by own contribution to the event); Robert D. Rasmussen, 41 Van Natta 5, 10-11 (1989) (same).

Weighing applicant's conduct in biting against our finding that Barron was the initial physical aggressor and continued to pin applicant's arm behind her back until he removed the ring, we conclude that applicant's contribution to her injuries was 25 percent. Consequently, we conclude that applicant's benefits should be reduced by 25 percent. However, only those dental expenses that are materially related to the compensable crime are reimbursable; if, as alleged by Barron, the Department determines that applicant's dental expenses were attributable to a preexisting condition, such costs are not part of the victims' compensation claim. See Sue C. Chesselot, 42 Van Natta 357 (1990).

The June 28, 1994 Findings of Fact, Conclusions of and Order of the Department of Justice, as reconsidered August 29, 1994, is reversed. Applicant's claim for benefits is remanded to the Department with instructions to accept and process the claim in accordance with law. Applicant's benefits shall be limited to 75 percent of her medical expenses, up to the statutory maximum.

IT IS SO ORDERED.

February 27, 1995 Cite as 47 Van Natta 299 (1995)

In the Matter of the Compensation of
DENNIS L. MARTINDALE, Claimant
WCB Case No. 94-04363
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Referee Holtan's order that: (1) vacated an Order on Reconsideration which had awarded 20 percent (30 degrees) scheduled permanent disability for loss of use or function of the right hand; and (2) remanded the claim to the Director for consideration of promulgation of a temporary rule addressing claimant's loss of right hand grip strength due to bony injury. On review, the issues are the Referee's remand ruling and extent.

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

Without expressly finding that the existing standards addressed claimant's disability, the Director issued an Order on Reconsideration which increased claimant's scheduled permanent disability award from 17 percent to 20 percent. However, the reconsideration order did not award permanent disability for claimant's lost pinch or grip strength. The Director has not made an express finding indicating whether claimant's strength-loss disability is addressed by existing standards. Moreover, even assuming that the standards do not address claimant's strength loss due to bony injury, the Director has not indicated whether promulgation of a temporary rule addressing that disability has been considered.

Under these circumstances, we agree with the Referee that the claim must be remanded to the Director for consideration and/or promulgation of a temporary rule under ORS 656.726(3)(f)(C). See Gary D. Gallino, on remand, 46 Van Natta 246 (1994) (Board is compelled to remand to the Director upon a finding that, at the time of the issuance of an Order on Reconsideration, a disability was not addressed by the existing standards and the Director neglected to stay further proceedings and adopt a temporary rule). In reaching this conclusion, we note that the Director has promulgated numerous temporary rules addressing grip strength loss in other cases. See id. at 246 (The lack of an express finding regarding whether claimant's disability was addressed by the standards, in conjunction with the

Director's "post-order" promulgation of permanent rules addressing that disability, convinced us that claimant's disability was not addressed by the standards at the time of the Order on Reconsideration); compare Valerie L. Leslie, 46 Van Natta 1919 (1994) (Where the Order on Reconsideration stated that claimant's disability was addressed by the standards and expressly declined to promulgate a temporary rule, remand was not appropriate).

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 $1,275, 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 attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 30, 1994 is affirmed. For services on review, claimant's counsel is awarded $1,275, payable by the insurer.

February 27, 1995 Cite as 47 Van Natta 300 (1995)

In the Matter of the Compensation of
MARY M. MITCHELL, Claimant
WCB Case No. 93-14829
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Livesley's order that: (1) did not require the insurer to repay claimant's medical services provider $924.29 under the terms of a Disputed Claim Settlement (DCS); and (2) declined to award penalties and related attorney fees for the insurer's allegedly unreasonable resistance to the payment of compensation. Claimant contends that the Board should consider extrinsic evidence of the parties' intent in entering into the DCS. In its brief, the insurer contends that the Board and its Hearings Division lack jurisdiction to consider this matter. On review, the issues are jurisdiction, enforcement of a DCS, and penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the parties' stipulated facts and the Referee's findings of fact. In addition, we briefly summarize the pertinent findings.

Claimant sustained a compensable left upper back injury in July 1991. Claimant was released to return to work in August 1991 and the claim was closed. Between April 3 and June 16, 1992, claimant sought treatment from the Eugene Clinic for right upper back pain. The clinic billed the insurer $924.29 under the July 1991 claim number, and the insurer paid those medical billings. In October 1992, the insurer denied claimant's right upper back condition as not related to her compensable July 1991 injury. Between November 1992 and March 1993, the insurer requested reimbursement from the clinic. The insurer did not copy those requests to claimant or to her counsel. Thereafter, the insurer made no further reimbursement request.

In June 1993, with the knowledge that the insurer had previously paid the clinic for medical services provided to her in 1992, and with the understanding that those bills would remain paid, claimant and the insurer entered into the DCS for $500 wherein claimant agreed, inter alia, that her right upper back condition would remain denied. The DCS further provided:

> "Claimant agrees to assume responsibility for medical billings related to the denied conditions and to hold [the insurer] and its insured harmless from any claims for reimbursement from medical providers for treatment or other services provided in connection with the denied conditions."

The insurer did not seek reimbursement from the clinic after June 1993. Nevertheless, after the DCS was approved by a referee on June 28, 1993, the clinic reimbursed the insurer $924.29. Thereafter, the clinic billed claimant for that amount.

Claimant sought an order enforcing the DCS, which the Referee denied. This appeal followed.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the Board should enforce the DCS by directing the insurer to repay the clinic $924.29. The insurer first argues that the Board and its Hearings Division lack jurisdiction over this dispute. The insurer further argues that, under the terms of the DCS, the disputed medical bills are claimant's responsibility. To resolve this dispute, we must decide: (1) whether claimant is required to pay the clinic $924.29 for medical services provided in 1992; and (2) if not, whether the insurer is required to reimburse monies repaid to it by the clinic.

The threshold question is whether we have jurisdiction to consider either issue. Enforcement of a DCS constitutes a "matter concerning a claim," thereby entitling a claimant to request a hearing under ORS 656.283. Thus, the Board generally has jurisdiction over a dispute regarding enforcement of a DCS. Howard v. Liberty Northwest Ins., 94 Or App 283 (1988). Because this enforcement dispute arises solely from claimant's contractual rights under the DCS, we find that we have jurisdiction to consider it. Imperial Fabrics v. Simmons, 125 Or App 588 (1993); Howard v. Liberty Northwest Ins., supra; EBI Companies v. Moore, 90 Or App 99 (1988); Tom D. Browning, 45 Van Natta 1724 (1993); Sharon L. Dominy, 44 Van Natta 872, 873 n.1, on recon 44 Van Natta 974 (1992). However, we do not have jurisdiction to decide whether the insurer is required to reimburse monies repaid to it by the clinic because resolution of that dispute is within the Director's exclusive jurisdiction.

We first address whether the DCS requires claimant to pay the clinic $924.29 for medical services provided in 1992. The Referee found that the DCS is silent as to whether there were any bills paid or payable at the time the parties signed the agreement. Nonetheless, reciting that the parol evidence rule precludes looking beyond the terms of a document to determine the intent of the parties, the Referee concluded that he had no authority to order the insurer to reimburse monies repaid to it by the clinic.

Citing Sisters of St. Joseph v. Russell, 318 Or 370 (1994), claimant argues that where a settlement agreement is ambiguous on a material matter, the parties' intentions and the circumstances under which the agreement was reached are relevant to ascertain the meaning of the agreement. Therefore, claimant urges the Board to consider extrinsic evidence of the parties' intent in interpreting the DCS.

Inasmuch as the parties' agreement was expressly intended to fully settle all issues arising from the denied claim, it follows that the DCS was intended to be a complete and unambiguous statement of the parties' rights and obligations regarding the denied claim. We read the DCS as providing that claimant would hold the insurer harmless from any outstanding claims for reimbursement from medical providers for treatment related to the denied conditions. The DCS is silent, however, regarding claimant's obligation to reimburse the insurer for past medical payments made to the clinic. We believe that is essentially the obligation the insurer sought to impose on claimant by accepting reimbursement from the clinic for past medical payments.

At the time the parties signed the DCS, there were no unpaid medical bills, the insurer had ceased its reimbursement efforts, and there is no indication the insurer had a reasonable expectation that the clinic would return the monies paid to it. Indeed, given the fact the insurer ceased its collection efforts in March 1993, we find the insurer had no expectation of receiving reimbursement. The DCS did not contemplate that the insurer would be reimbursed for past medical payments made to the clinic. At the time of settlement, both parties expected that the clinic bills paid by the insurer would remain paid.

Therefore, we find that the terms of the DCS regarding medical reimbursement were incomplete and, thus, should be augmented with extrinsic evidence of the parties' intent. Inasmuch as the obligation to pay the clinic's past billings of $924.29, if inconsistent with the parties' intent, would effectively eliminate the consideration ($500) supporting the parties' bargained-for exchange, we find this to be an extreme situation where, in the interests of substantial justice, the DCS should be interpreted consistent with the intent of the parties. See Kenneth L. Orr, 44 Van Natta 1821 (1992); Mary Lou Claypool, 34 Van Natta 943, 946 (1982); James Leppe, 31 Van Natta 130 (1981).

Turning to the extrinsic evidence, claimant's uncontroverted stipulated testimony establishes that she accepted the insurer's settlement offer with the knowledge and understanding that: the clinic bill had been paid by the insurer; the clinic bill would remain paid; she would not be liable for medical services provided to her in 1992; and she would be liable for future medical expenses. Under the circumstances, we find that the parties intended that claimant only be responsible for payment of medical treatment related to the denied conditions rendered after June 1993. Therefore, claimant is not required to pay the Eugene Clinic's $924.29 medical billing that was not outstanding at the time the parties signed the DCS.

The second issue is whether the insurer is required to reimburse the monies repaid to it by the clinic. Because claimant has already received the medical treatment for which Eugene Clinic has billed her, and we have determined that claimant is not liable for that billing, we find that this dispute is over the insurer's liability for the medical services provider's medical fee; this dispute is not a "matter concerning a claim" under ORS 656.001 to ORS 656.794 that affects claimant. See Lloyd v. Employee Benefits Ins., 96 Or App 591, 594-95 (1989). Accordingly, because resolution of this medical fee dispute involves the Director's jurisdiction, we lack jurisdiction to decide whether the insurer is required to reimburse the Eugene Clinic. ORS 656.704(3); ORS 656.248(13).

Penalties and Attorney Fees

In light of our conclusion that the DCS terms were incomplete, we find that the insurer had a legitimate doubt as to its responsibility to repay the contested billings. Therefore, on this basis alone, we would decline to assess a penalty. See Brown v. Argonaut Co., 93 Or App 588 (1988). More importantly, however, the relief to which claimant is entitled under the terms of the DCS is not "compensation" under ORS 656.005(8). Howard v. Liberty Northwest Ins., supra at 286. Under the circumstances, the insurer's conduct could not constitute an unreasonable delay or refusal to pay compensation that would support a penalty award under ORS 656.262(10). Otto W. Wirth, 41 Van Natta 1689, 1694 (1989).

Similarly, the Workers' Compensation Law does not authorize an assessed attorney fee for claimant's counsel's efforts at hearing or on Board review concerning this matter. Absent an order or decision denying a claim for compensation, a claimant is not entitled to a carrier-paid attorney fee award under ORS 656.386(1). Shoulders v. SAIF, 300 Or 606, 611 (1986).

Here, there has been no order or decision denying a claim for "compensation," inasmuch as DCS proceeds are not "compensation." Howard, supra. Therefore, the insurer's conduct could not constitute a denial of a claim for compensation that would support a carrier-paid attorney fee award under ORS 656.386(1). Shoulders v. SAIF, supra; Otto W. Wirth, supra; 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).

Furthermore, inasmuch as claimant requested the hearing and Board review in this matter, an assessed fee may not be awarded under ORS 656.382(2). Finally, because no additional compensation has been awarded by this order, claimant's counsel is not entitled to an out-of-compensation fee pursuant to ORS 656.386(2).

ORDER

The Referee's order dated April 28, 1994 is affirmed in part and modified in part. Under the terms of the Disputed Claim Settlement, claimant is not required to pay the Eugene Clinic $924.29 for medical services provided in 1992. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CLIFTON N. MUDDER, Claimant
WCB Case Nos. 94-04653 & 94-03706
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Bethlahmy's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right elbow condition. On review, the issue is compensability.

We adopt and affirm the Referee's order.

ORDER

The Referee's order dated July 20, 1994 is affirmed.

Board Member Hall specially concurring.

I write to address one issue pertaining to Exhibit 25, a so-called "check-the-box" report with which Dr. Hanley, claimant's treating physician supposedly agreed.[1] The self-insured employer argues that the report is entitled to little, if any weight, because it is unsigned and unexplained. I agree wholly with the first reason, but only agree qualifiedly so with the second.

Exhibit 25 is a summary of a conversation between Dr. Hanley and claimant's counsel that explains, in detail, why Dr. Hanley believes that claimant's work activities are the major contributing cause of his right elbow condition. In that regard, Exhibit 25 is not an unexplained "check-the-box" report. The persuasiveness of a "check-the-box" (or "concurrence") report depends on the persuasiveness of the foundation on which the report rests. Marta I. Gomez, 46 Van Natta 1654 (1994). I would conclude that Exhibit 25 is based on an adequate foundation and that it is sufficient to meet claimant's burden of proof if it were Dr. Hanley's only report. It is not. In several earlier reports, Dr. Hanley concluded that claimant's condition was related to an off-work accident. (Exs. 15, 22, 24-2). Because Exhibit 25 fails to explain why Dr. Hanley changed his mind, I am compelled to conclude that, notwithstanding that the report is otherwise persuasive and well-reasoned, Gomez, supra, it is nevertheless inadequate to carry claimant's burden of proof. Moe v. Ceiling Systems, 44 Or App 429 (1980).

[1] I use the word "supposedly," because the filled-in report is unsigned.

In the Matter of the Compensation of
RUSSELL C. TERRY, Claimant
WCB Case No. 93-10570
ORDER ON REVIEW
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of Referee Brazeau's order dismissing his request for hearing. The insurer moves to dismiss claimant's request for review for lack of jurisdiction. On review, the issue is dismissal.

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

Motion to Dismiss

The insurer moved to dismiss claimant's request for review for lack of jurisdiction. We deny the motion.

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). Here, claimant filed a letter requesting Board review on October 12, 1994, the 29th day after the Referee's September 13, 1994 order issued. Copies of the request for review were mailed to all appropriate parties. ORS 656.295(2). Thus, claimant properly invoked the Board's jurisdiction over his request for review. Therefore, because we have jurisdiction over claimant's request for review, we deny the insurer's motion to dismiss.

Claimant's Request for Review

Turning to the merits of claimant's request for review, we find no basis for reversing the Referee's order.

On July 26, 1994, the Board approved a Claim Disposition Agreement (CDA) in which claimant released his right to "[t]emporary disability, permanent disability, vocational rehabilitation, survivor's benefits, and aggravation rights." In return, claimant, who was represented by an attorney, received $42,000 (less a $6,075 attorney fee). Claimant's September 14, 1993 request for hearing had raised issues concerning entitlement to temporary disability benefits and penalties and attorney fees. Finding that all matters raised by the hearing had been resolved pursuant to the CDA, the Referee dismissed claimant's hearing request. We find no error in the Referee's order. Because the CDA resolved all issues raised by claimant's hearing request, the Referee properly dismissed the hearing request.

On review, claimant appears to argue that the amount of the disposition is inadequate. However, by signing the CDA, claimant agreed to its terms, including the statement that "[t]he proceeds of this agreement are meant to compensate Claimant for his actual pecuniary loss and are recognition of his lost earning capacity and wages." (CDA at 3). Thus, by signing the agreement, claimant agreed that the amount of the disposition was adequate compensation in exchange for release of all his workers' compensation claim benefits, except medical benefits. Specifically, claimant agreed to release his entitlement to benefits for temporary and permanent disability, vocational assistance, survivor's benefits, and aggravation rights in exchange for the agreed-upon amount of the disposition.

The Board approved the CDA in a final order pursuant to ORS 656.236. Such an order would not issue if the Board found the agreement unreasonable as a matter of law, or based on an intentional misrepresentation of material fact, or if claimant had requested the Board to disapprove the agreement within 30 days from the date it was submitted to the Board. ORS 656.236(1). Because we approved the CDA, we conclude there was no evidence of impropriety regarding the terms of the CDA. Once we issued our order approving the CDA, the agreement became final. Our order approving the CDA is not subject to review. ORS 656.236(2). Accordingly, we find no basis for setting aside the CDA.

ORDER

The Referee's order dated September 13, 1994 is affirmed.

Board Member Gunn specially concurring.

I write solely for the pro se claimant who alleges he is a functional illiterate. I must hope that, as he found someone to prepare his appeal, he has the resources to find someone to read him this document.

Claimant argues that the CDA that he signed and for which he received money is inadequate for his injuries. Furthermore, he is unemployed due to his injuries and seeks schooling or retraining for future employment. Claimant asks the Board to understand that he would not have signed a final agreement that did not adequately compensate him for his injuries or provide vocational retraining. The problem is that he did.

The CDA by its written terms resolved any and all claims against the employer, except for medical services. The CDA process has a number of safeguards to protect claimants. Here, they may have little value, because all those safeguards are in writing and assume literacy of the claimant. In this case, however, claimant was represented by an attorney who is legally compelled by ethical canons and administrative rules to advise claimant of the terms and effects of the CDA.

Claimant does not advise us that, due to his illiteracy, he was unable to understand the agreement that he was signing. There is no evidence that at the time he signed the CDA, he did not understand its terms and conditions. Claimant is bound by the legal agreement, the CDA, that he signed and for which he took money. By signing that agreement, he gave up his right to any further benefits on this claim except for medical services.

I understand that claimant may now feel the agreement is inadequate or insufficient. He is, however, legally bound by that agreement. Even if we were to interpret his appeal as a request to set aside the CDA, we are without legal authority to set aside the agreement, once we have approved it. In fact, since claimant was represented by an attorney at the time of the CDA, his dispute over that agreement would not be in this forum, but instead would be a matter for the Oregon State Bar's Professional Liability Fund. As the Workers' Compensation Board, we have no authority to hear or decide legal malpractice claims.

Claimant may now regret signing the CDA. As with much in this life, we often regret and do not realize the full extent of our actions until it is too late to do anything about them. Claimant signed the CDA. There is no evidence that he did not understand the nature and extent of the agreement. There is no evidence of fraud, material misrepresentation, or any other reason to set aside the CDA. There is no evidence that claimant's lawyer failed to inform claimant of the nature and extent of that agreement. Claimant waived the relief he now seeks from us when he signed the agreement and took money from the employer for that agreement. He is now bound by its terms.

In the Matter of the Compensation of
CHARLES A. TUREAUD, Claimant
WCB Case No. 93-13097
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
Bottini, et al., Defense Attorneys

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

The insurer requests review of Referee Neal's order that set aside its "back-up" denial of claimant's low back injury claim. On review, the issues are "back-up" denial and, potentially, compensability. We affirm.

FINDINGS OF FACT

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

Beginning in 1979, claimant's symptoms resulting from his 1978 compensable lumbar strain injury with a prior employer involved his low back and right thigh. No radiculopathy or nerve involvement was found. Claimant last sought medical treatment for his 1978 injury in 1982, not 1992, and his 1978 claim was last closed in 1982, not 1980. (See Exs. 1 through 23).

On May 17, 1993, Dr. Eubanks, D.O., certified claimant as qualified in accordance with the Federal Motor Carrier Safety Regulations. He noted no head or spinal injuries. (Ex. 23A).

On August 18, 1993, when claimant sought medical treatment for pain and numbness in his left leg, he reported his 1978 back injury to his physician. (Tr. 69, Exs. 24-1, 24-4, 25 and 26). Claimant's physician reported the 1978 injury to the employer. (Ex. 26).

Claimant filled out a Form 801 on August 20, 1993. He answered question 15, "Had body part been injured before?," as follows: "Back injured but no leg pain as now." (Ex. 27).

Claimant was scheduled for back surgery pending the insurer's approval of the surgery request and an IME examination, which was recommended based on claimant's previous back injury and findings of some facet hypertrophy and degenerative disc disease. (Exs. 40 and 41).

Dr. Barnhouse released claimant to modified work from October 13, 1993 to October 30, 1993. (Ex. 53).

On October 18, 1993, claimant's supervisor wrote him up for failure to provide the employer with a work release for October 6 through 8 and 11 through 13, 1993. On the same date, claimant brought in a modified work release that said no stooping, bending, twisting or squatting and limited lifting to less than 25 pounds. The employer was unable to provide a light duty job within these parameters. (Ex. 59).

CONCLUSIONS OF LAW AND OPINION

"Back-up" Denial

Claimant's low back claim was officially accepted on September 7, 1993. On November 1, 1993, the insurer issued a "back-up" denial of compensability. The Referee concluded that the denial was permissible, but that claimant sustained his burden of proving the claim compensable.

The insurer contends that the compensability of the claim should be reevaluated in light of claimant's material misrepresentations and the impossibility of independent corroboration of his unwitnessed injury. Claimant, on the other hand, asserts that the denial was impermissible, or, if the denial is found to be permissible, that the claim is compensable.

A "back-up" denial is permissible if the insurer establishes by a preponderance of the evidence that its acceptance was induced by fraud, misrepresentation or other illegal activity. Tony N. Bard, 45 Van Natta 1225 (1993) (citing Bauman v. SAIF, 295 Or 788 (1983)). A "back-up" denial of a previously accepted claim will be upheld if the insurer can prove that the fraud, misrepresentation or other illegal activity alleged could have "reasonably affected" the insurer's original decision regarding the

compensability of the claim. Ebbtide Enterprises v. Tucker, 303 Or 459, 738 P2d 194 (1987) (The measure of materiality for the purpose of justifying a "back-up" denial is a showing by the insurer that it would have denied the claim had it known about the undisclosed information.); cf. Liberty Northwest Insurance Corp. v. Salyers, 91 Or App 538 (1988) (Where the claimant subsequently admitted an off-the-job incident, but maintained that his injury initially occurred at work, the court found that the carrier had failed to sustain its burden of proof that the claimant's misrepresentations could have reasonably affected its decision to accept the claim.); but see Newport Elks Club v. Hays, 92 Or App 604, 607 (1988) (Where the claimant provided inconsistent histories to her treating physicians, one of which did not indicate that an industrial injury had occurred, the court upheld a "back-up" denial, reasoning: "it requires no elaboration to conclude that employer's acceptance could have been influenced by having the information that no industrial injury had occurred.").

A review of case law further reveals that where a "back-up" denial under Bauman has been invoked, the employer or insurer has attempted to show that it was induced to accept the claimant's claim by his or her fraudulent statement, affirmative act of misrepresentation or omission. See, e.g., Rogers v. Weyerhaeuser Co., 82 Or App 46 (1986); Liberty Northwest Ins. Corp. v. Powers, 76 Or App 377 (1985). Thus, a direct causal link must be shown between the claimant's act of omission and the insurer's subsequent acceptance of the claim.

In the present case, the alleged misrepresentations and fraud involved are claimant's alleged omission of his left leg involvement in his 1978 injury; his alleged omission of his low back strain when providing medical information to Dr. Eubanks, who performed a preemployment examination for federal certification; and his admitted prevarication about working on his fence and roof subsequent to the acceptance of the claim, but during the period he was released to modified work.

Upon issuing a "back-up" denial, the insurer must demonstrate that claimant's omission of left leg symptoms resulting from his 1978 injury, his omission of past back problems on a preemployment physical, and his lies about the fence and roofing activities he performed at his house constituted fraud, misrepresentation, or other illegal activity; and it must prove that claimant's non-disclosure was sufficiently material to reasonably affect the insurer's original decision regarding the compensability of his low back claim.

Here, upon seeking treatment for his low back and left leg condition, claimant reported his 1978 low back injury to his physician. The fact that claimant sustained a 1978 low back injury was also provided to the employer on Form 827 and Form 801. (Exs. 25 and 27). On the 801, claimant indicated that his back and left leg were the body parts currently affected. He also indicated that his back had been injured previously, but "no leg pain as now." (Ex. 27). Moreover, claimant provided information to the claims adjuster that he had previously injured his low back about 10 years earlier. (Ex. 54-16, 17). Given claimant's consistent reports to his physician, employer and the claims adjuster that he injured his low back in 1978, we are not persuaded that claimant's failure to report relatively minor left leg complaints that occurred early during the course of that claim was sufficiently material to reasonably affect the insurer's decision to accept the claim.[1]

Moreover, the insurer knew about the 1978 incident and that it involved the same body part as the 1993 incident. An insurer has a duty to fully investigate the claim in order to determine claimant's right to compensation. See, e.g., Tom C. Reeves, 38 Van Natta 31, 32 (1986). For this reason, in light of its knowledge about claimant's prior injury, we conclude that the insurer's failure to further investigate the claim prior to acceptance is not sufficient to support a "back-up" denial based on fraud, misrepresentation or other illegal activity. Consequently, we conclude that the insurer has failed to prove that claimant's failure to report that he experienced left leg symptoms in 1978 or Dr. Eubanks' failure to note "spinal injuries" on the pre-employment certification document constituted material fraud or misrepresentation. Moreover, there is no evidence that, even if it had known of claimant's preexisting left leg involvement, it would have denied his claim. See Ebbtide, supra; Salyers, supra; Newport Elks Club, supra.

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[1] We note that Dr. Rosenbaum's opinion that claimant's previous industrial injury did not contribute to his current condition and need for surgery was based on knowledge of the 1978 injury, including a 1981 CT scan of the lumbar spine, and the fact that claimant had not had any active treatment for his lumbar spine for the past 10 years. Dr. Rosenbaum's opinion was provided to the insurer prior to its issuance of the "back-up" denial.

In addition, the employer has shown no direct causal link between claimant's lies about working on his roof and fence in October, when he had been released from work, and a showing that the employer was thereby induced to accept the claim by his allegedly fraudulent statement. Thus, we conclude that the insurer's "back-up" denial is not permissible. Rogers v. Weyerhaeuser Co., supra; Liberty Northwest Ins. Corp. v. Powers, supra.

We find that the insurer has not met the burden of establishing that its "back-up" denial was permissible. Accordingly, the claimant is not required to establish that the claim is, in fact, compensable. Parker v. North Pacific Ins. Co., supra; Liberty Northwest Ins. Corp. v. Powers, supra.

In any event, were we to have found the "back-up" denial permissible, we would adopt and affirm the Referee's opinion on the compensability issue.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the "back-up" denial is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 14, 1994 is affirmed. For services on Board review, claimant's attorney is awarded $1,500, to be paid by the insurer.

Board Member Haynes specially concurring.

The majority concludes that the insurer failed to meet its burden of establishing that its "back-up" denial was permissible. Unlike the majority, I would find that the insurer established by a preponderance of the evidence that the later-discovered misrepresentations by claimant regarding his past back problems and left leg symptoms, in addition to claimant's lies about activities he performed around his house, were sufficiently material to have affected claim acceptance if they had been known at the time of acceptance. Consequently, I respectfully dissent from the majority's analysis.

Where an insurer issues a "back-up" denial on the basis of fraud, misrepresentation or other illegal activity, it need prove only that the fraudulent activity materially affected its claim acceptance by a preponderance of the evidence. Once this is done, the burden shifts to the claimant to prove the compensability of the claim, also by a preponderance of the evidence. In contrast, if an insurer issues a back-up denial within two years from the date of acceptance, without proof that its acceptance was induced by fraud, misrepresentation or other illegal activity, and that denial is appealed, it is the insurer's burden under ORS 656.262(6) to prove by clear and convincing evidence that the claim is not compensable. Tony N. Bard, supra.

I agree with the Referee's findings that claimant admitted that he had lied about the activities he had performed around his house, lied on a pre-employment physical about past back problems and failed to indicate on the 801 that he had experienced left leg symptoms prior to the current injury. These lies were told in order to obtain benefits. I find that these misrepresentations caused the insurer to doubt the compensability of the claim and would have affected claim acceptance had they been known at the time of acceptance.

Accordingly, the insurer established by a preponderance of the evidence that those misrepresentations were material to its acceptance of the claim. Thus, I conclude that the "back-up" denial was appropriate. Bauman v. SAIF, 295 OR 788 (1983); Ebbtide Enterprises v. Tucker, 303 Or 459 (1987); Tony N. Bard, 45 Van Natta 1225 (1993) (An insurer that can prove by a preponderance of the evidence that it was induced to accept a claim through fraud, misrepresentation or other illegal conduct can revoke its acceptance at any time, thereby requiring the claimant to prove the compensability of the claim).

However, because I agree with the Referee's conclusion on the compensability issue, I would affirm the Referee's decision to set aside the insurer's "back-up" denial.

In the Matter of the Compensation of
RAYMOND A. BAKER, Claimant
WCB Case No. 94-06707
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of Referee Michael V. Johnson's order which dismissed its request for hearing from an Order on Reconsideration/ Notice of Closure as untimely. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

SAIF closed claimant's compensable hearing loss claim by a September 8, 1993 Notice of Closure, which awarded 16.53 percent scheduled permanent disability. On March 7, 1994, 180 days after the closure notice issued, claimant requested reconsideration pursuant to ORS 656.268(4)(e). On May 25, 1994, the Department issued its Order on Reconsideration, awarding a total of 31.94 percent scheduled permanent disability. SAIF requested a hearing on June 2, 1994, more than 180 days after the September 8, 1993 Notice of Closure, excluding the period during which the matter was on reconsideration. See ORS 656.268(6)(b).

CONCLUSIONS OF LAW AND OPINION

The parties stipulated that the issue of whether SAIF's hearing request was untimely could be resolved based upon the record. Thus, no testimony was given at the scheduled hearing. Although finding that SAIF was diligent in its efforts to timely request a hearing, the Referee determined that there was no "good cause" exception to the requirement that a hearing be requested within 180 days of a Determination Order or Notice of Closure. ORS 656.268(6)(b). The Referee, thus, concluded that SAIF's hearing request was untimely and that the Hearings Division lacked jurisdiction to consider issues related to the Notice of Closure and reconsideration order. See Nowak v. SAIF, 121 Or app 563 (1993); Steve Werner 44 Van Natta 2467 (1992).

On review, SAIF initially contends that its untimely hearing request should be excused because the May 25, 1994 Order on Reconsideration was mailed to another insurer rather than SAIF. SAIF cites Anton V. Mortensen, 40 Van Natta 1177, 1179, on recon 40 Van Natta 1702 (1988), in which the Board held that the statutory period in which to request a hearing on a Determination Order would not begin to run until the date of a successful mailing or actual notice of the order. See also Bruce C. Darr, 45 Van Natta 305 (1993) (where facts rebutted presumption that there was a successful mailing of a Determination Order to the claimant's residence, statutory period appeal period did not begin to run until the claimant actually received the Determination Order). Therefore, SAIF asserts that, because it was not properly mailed, the reconsideration order in this case was not issued until the date SAIF was actually notified that an order had issued on May 25, 1994. Relying on an unsworn interoffice memo of June 28, 1994 from a claims assistant (Ms. Coburn), SAIF alleges that it was not notified until June 1, 1994 that an Order on Reconsideration had issued.

In her memorandum, Ms. Coburn wrote that she had telephoned the Department on May 18, 1994 to advise them that she needed to be informed the day the reconsideration order issued so that it could be timely appealed. When she did not receive any information on the status of the reconsideration order, Ms. Coburn called the Department on June 1, 1994 and was informed that the reconsideration order had issued on May 25, 1994. Ms. Coburn stated that the "original order" arrived the next day. Ms. Coburn concluded her memorandum by stating that the reconsideration order "apparently" had gone to Liberty Northwest, another insurer.

Under these circumstances, SAIF asserts that its June 2, 1994 hearing request was timely because it was filed within one day of actual notice of the Order on Reconsideration. We disagree with SAIF's contention.

Ms. Coburn's unsworn memorandum is insufficient evidence that the Department improperly mailed the reconsideration order. There is no indication of the basis on which Ms. Coburn concluded that the order was mailed to another carrier. The copy of the reconsideration order in the record does not contain any reference to Liberty Northwest and correctly lists SAIF as the insurer. We also reject SAIF's invitation to infer that the reconsideration order was improperly mailed from the time Ms. Coburn stated it took SAIF to receive the order. The reconsideration order in the record is not date stamped. In the absence of more conclusive evidence of improper mailing, we are unwilling to infer that an erroneous mailing occurred from hearsay statements in Ms. Coburn's memorandum. Inasmuch as we find insufficient evidence of an unsuccessful mailing, we find this case distinguishable from Mortensen and Darr.

SAIF also asserts that we should infer a 30-day appeal period when a party requests reconsideration at the end of the 180 period in which to request a hearing on a Determination Order or Notice of Closure. SAIF contends that under such circumstances there is effectively no time in which to request a hearing, thus depriving a claimant of his or her due process rights. We do not find these arguments persuasive.

We acknowledge that claimant's request for reconsideration on the 180th day left SAIF with little time in which to request a hearing. However, it did have one day in which to request a hearing, inasmuch as the date of mailing of the reconsideration order is not included in the 180-day period. Melissa B. Munn, 46 Van Natta 527 (1994); Beverly A. Hulse 44 Van Natta 2431, 2433 (1992). While it may be burdensome for SAIF to maintain daily contact with the Department in order to determine when an Order on Reconsideration will issue, this is a problem more appropriately addressed by the legislature. We are unwilling to fashion a remedy such as SAIF urges that is not provided by statute. See Wright v. Benkins Moving and Storage, 97 Or App 45, 49 (1989); Robert G. Hopkins, 44 Van Natta 1751, 1752 (1992).

Finally, we note that SAIF is not alleging that its due process rights were violated in this case. It cites an example in which a hypothetical claimant would arguably be deprived of due process if an insurer requested reconsideration on the 180th day. Whatever the merits of SAIF's arguments might be, we need not, and will not, address these hypothetical concerns in this case.

Inasmuch as claimant has prevailed over SAIF's request for review, 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 a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 17, 1994 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,000, payable by SAIF.

In the Matter of the Compensation of
KERRI A. HOUGHTON, Claimant
WCB Case No. 94-01016
ORDER ON RECONSIDERATION
Coons, Cole, & Cary, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Claimant has requested reconsideration of the Board's January 5, 1995 Order on Review, as corrected January 6, 1995, which affirmed a January 13, 1994 Order on Reconsideration award of 7 percent (22.4 degrees) unscheduled permanent disability for a neck condition. Claimant asserts that our decision is contrary to our holding in Sara J. Smith, 46 Van Natta 895 (1994).

On February 3, 1995, we abated our order to consider the motion for reconsideration and granted SAIF an opportunity to respond. Having received SAIF's response, we proceed with our reconsideration.

In Smith, the claimant compensably injured her low back on May 21, 1985, while SAIF was on the risk. The 1985 low back claim was closed by an October 8, 1987 Determination Order (DO). On June 4, 1986, the claimant compensably injured her neck and upper back, while Sedgwick was on the risk. A Referee subsequently found Sedgwick responsible for the claimant's low back condition as a "new injury." Sedgwick, as the then-responsible party, closed the low back and cervical claim by an August 18, 1989 DO. We subsequently found SAIF responsible for the claimant's low back condition, but Sedgwick remained responsible for the claimant's cervical condition. We held that since two separate conditions and claims were involved (the aggravation claim for SAIF's 1985 low back claim and the 1986 cervical "new injury" claim), each claim would normally be separately closed and rated, including having the age, education and adaptability factors separately rated. Id. at 898.

Smith is factually distinguishable. In essence, the Smith case involved the initial claim closure of two separate claims (an aggravation claim and a new injury claim). This case involves the claim closure of only one claim (the May 1992 cervical claim). Thus, the inquiry is the extent to which a prior disability award (for claimant's November 1989 low back injury) is considered in arriving at the appropriate permanent disability for claimant's May 1992 cervical injury. Therefore, the present case involves the applicability of ORS 656.214(5) and OAR 436-35-007.

After reviewing claimant's motion, we conclude that we have previously considered the remainder of the arguments raised by claimant. Therefore, we continue to adhere to our prior conclusion.

Accordingly, as supplemented herein, we adhere to and republish our January 5, 1995 Order on Review, as corrected on January 6, 1995, in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

February 28, 1995 Cite as 47 Van Natta 311 (1995)

In the Matter of the Compensation of
PAMELA J. PANEK, Claimant
WCB Case No. 91-01720
ORDER ON REMAND
Pozzi, Wilson, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. Panek v. Oregon Health Sciences University, 123 Or App 636 (1993). Reasoning that the Hearings Division lacked jurisdiction over this dispute, our prior order vacated those portions of the Referee's order which set aside the SAIF Corporation's denials of claimant's claims for proposed counseling and swimming therapy. Pamela J. Panek, 44 Van Natta 933, recon den 44 Van Natta 1445 (1992). Citing Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the court has remanded for reconsideration of those portions of our order.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable right foot injury in 1983. Her obesity and psychological conditions are also compensable.

In 1990, Dr. Friedman, psychiatrist, became claimant's principal attending physician. Claimant received psychological counseling from Virginia Terhaar, a professional counselor who is licensed to provide psychological counseling in Oregon. Claimant's treatment team (Dr. Friedman, Ms. Terhaar, and Dr. Dewey, psychologist) recommended that claimant begin swimming to help with weight loss.

In September 1990, the SAIF Corporation indicated that it would no longer pay for Ms. Terhaar's services because those services were not provided under the direct control of Dr. Friedman, attending physician. See OAR 436-10-050(7). In November 1990, SAIF informed Dr. Friedman that it would not pay for a swimming program recommended by Dr. Friedman, unless claimant swam at least 3 or 4 times per week (based on SAIF's claims examiner's belief that less swimming would not benefit claimant). In addition, SAIF reiterated that it would not pay Ms. Terhaar's bills. Claimant requested a hearing.

The Referee noted that Ms. Terhaar's counseling is approved by Dr. Friedman as part of claimant's treatment plan for her compensable psychological condition. In addition, the Referee found that Ms. Terhaar is licensed to provide counseling in Oregon. Under these circumstances, the Referee concluded that OAR 436-10-050(7) does not prohibit Ms. Terhaar from providing compensable medical services outside the direct control of claimant's attending physician. Thus, finding that Ms. Terhaar's counseling does not violate the Director's rule, the Referee set aside SAIF's denial of Ms. Terhaar's counseling services and assessed a penalty for an unreasonable denial.

In addition, the Referee found that SAIF's refusal of claimant's request for authorization for a swimming program constituted a "de facto" denial of additional medical services recommended for claimant's compensable conditions. Further finding the recommended swimming program to be medically appropriate, the Referee set aside SAIF's "de facto" denial of those medical services and assessed a "penalty-related" attorney fee for unreasonable claim processing. SAIF requested Board review.

Reasoning that the Hearings Division lacks jurisdiction over a dispute involving medical services allegedly in violation of a Director's rule, we vacated the Referee's order insofar as it purported to set aside SAIF's denial of Ms. Terhaar's services. Pamela J. Panek, supra. In addition, we vacated those portions of the Referee's order which had awarded a $2,500 attorney fee for prevailing against that denial and a penalty for an unreasonable denial. Further reasoning that we lacked jurisdiction over the dispute involving claimant's proposed swimming program, we vacated those portions of the Referee's order that set aside SAIF's "de facto" denial of the swimming program, as well as the associated $500 assessed attorney fee and $250 penalty-related attorney fee.

On appeal, the court reversed those portions of our order addressing the proposed medical treatment disputes and remanded for reconsideration in light of Jefferson v. Sam's Cafe, supra. In that case, the court held that ORS 656.327, which provides a procedure for Director review of medical services disputes, does not apply to disputes regarding proposed medical treatment. The Jefferson court concluded that since ORS 656.327 does not apply to future medical treatment, the Board and its Hearings Division have exclusive jurisdiction to resolve disputes concerning proposed medical treatment. See Martin v. City of Albany, 320 Or 175, 188 (1994).

On reconsideration, we agree with the Referee that Ms. Terhaar's counseling does not violate OAR 436-10-050(2). In addition, we find that Ms. Terhaar is a "physician" within the meaning of ORS 656.005(12). See Driver v. Rod & Reel Restaurant, 125 Or App 661, 665 (1994) (Finding that a physical therapist is a "physician" under ORS 656.005(12) because he or she practices a "healing art" within the Supreme Court's definition in Cook v. Workers' Compensation Department, 306 Or 134 (1988)).

Accordingly, we agree with the Referee that Ms. Terhaar may practice her "healing art" and provide compensable medical services without direct supervision by claimant's attending physician. Moreover, we adopt the Referee's conclusion that SAIF's denial of those medical services was unreasonable. Specifically, we are not persuaded that SAIF had a legitimate doubt regarding its liability for the counseling services, particularly considering that Ms. Terhaar was a licensed counselor and was a member of claimant's "treatment team." Finally, there was no medical evidence which would support a conclusion that Ms. Terhaar's counseling is not compensable.

In conclusion, we affirm the Referee's order that set aside SAIF's "de facto" denial and remanded the claim to SAIF for processing according to law. In addition, the Referee's $2,500 attorney fee (for prevailing against the denial) and his 25 percent penalty (for the unreasonable denial), to be shared equally by claimant and her counsel are affirmed.

We also conclude, as did the Referee, that the record establishes that claimant's proposed swimming program is reasonable and necessary medical treatment for her compensable conditions. In reaching this conclusion, we find the opinion and recommendation of claimant's physicians more persuasive than SAIF's claims examiner's personal beliefs about medically appropriate treatment for claimant. We further agree with and adopt the Referee's conclusion that SAIF's processing of the claim for proposed swimming therapy was unreasonable. In this regard, we are not persuaded that SAIF had a legitimate doubt regarding its liability for the swimming program, because there is no medical evidence suggesting that it would not be compensable.

Accordingly, we affirm the Referee's order that set aside SAIF's "de facto" denial of claimant's swimming program is set aside and remanded the claim to SAIF for processing according to law. In addition, we affirm the Referee's $500 assessed attorney fee (for prevailing against the "de facto" denial) and $250 penalty-related attorney fee under ORS 656.382(1) (for unreasonable resistance to the payment of compensation).

Finally, inasmuch as claimant has finally prevailed before the Board after remand from the court, he is entitled to a reasonable attorney fee for services before every forum. See ORS 656.388(1). Since claimant's counsel provided services before the Board and court, a reasonable fee for such efforts shall be awarded (in addition to the Referee's assessed fees, which we have previously reinstated and affirmed). Id. After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services before the Board and court concerning the medical treatment issues is $3,000. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by 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. We further note that claimant is not entitled to an attorney fee for services pertaining to the penalty and attorney fee issues. See Jay A. Nero, 47 Van Natta 163 (January 31,1995); Amador Mendez, 44 Van Natta 766, 737 (1992); Juan A. Garcia, 43 Van Natta 2813, 2815 (1991).

Accordingly, on reconsideration, the Referee's order dated June 27, 1991 is affirmed.

IT IS SO ORDERED.

February 28, 1995 Cite as 47 Van Natta 313 (1995)

In the Matter of the Compensation
PAMELA J. PANEK, Claimant
WCB Case No. 91-11126
ORDER ON REMAND
Pozzi, Wilson, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. Panek v. Oregon Health Sciences University, 123 Or App 623 (1993). Reasoning that the Hearings Division lacked jurisdiction over this dispute, our prior order vacated that portion of the Referee's order which set aside the SAIF Corporation's "de facto" denial of claimant's claim for home health care services. Pamela J. Panek, 44 Van Natta 1625 (1992). Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court has remanded for us to consider the merits of the claim for home health care.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable right foot injury in 1983. Her obesity and psychological conditions are compensable.

On September 26, 1990, Dr. Friedman, attending physician, requested authorization for home health care for claimant, five afternoons per week. This care was provided.

On November 13, 1990, SAIF advised Dr. Friedman that claimant's home health care would be gradually phased out and terminated. SAIF did not formally deny the home health care claim, but it informed Dr. Friedman that it would not provide such care unless specifically ordered to do so. Claimant requested a hearing.

The Referee concluded (inter alia) that home health care is compensable, reasonable, and necessary medical treatment for claimant. The Referee awarded a $5,000 assessed attorney for prevailing against SAIF's "de facto " denial (termination) of claimant's home health care and for the unreasonableness of SAIF's conduct. SAIF requested review.

On review, we vacated the Referee's order regarding the claim for home health care, reasoning that the Director has exclusive jurisdiction over the medical services issue. Pamela J. Panek, supra. In addition, we vacated the Referee's associated attorney fee. Id. Claimant appealed.

The court reversed and remanded for reconsideration, in light of its decision in Meyers v. Darigold, Inc., 123 Or App 217 (1993). Panek v. Oregon Health Sciences University, 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. Specifically, the court has instructed us to consider the merits of the compensability of the home health care claim.

SAIF first argues that claimant's home health care claim is precluded because the issue was previously litigated. However, no prior referee's order decided whether claimant was entitled to home health care, (see Ex. 49), and this claim arose after all previous litigation (see Ex. 10-47). Under these circumstances, the current home health care issue was not previously actually litigated and the claim could not have been litigated at a prior hearing. Consequently, prior litigation has no preclusive effect on the current dispute.

On the merits, SAIF argues that the home health care claim is for mere housekeeping, not medical services. Therefore, it contends that the claim is not compensable. Under the circumstances of this case, we disagree.

ORS 656.245(1) (c) provides in relevant part: "Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services. . . ." However, compensable medical services include only those "other related services" which are "of the same kind or class as those services specifically enumerated in [ORS 656.245(1)(c)]." Lorenzen v. SAIF, 79 Or App 751, 752 (1986). We have held that housekeeping services were not compensable where they were recommended solely because of claimant's inability to perform household chores. Douglas R. Barr, 46 Van Natta 763, 764 (1994). On the other hand, where home health care assistance was expressly prescribed to assist the claimant in recovering from his surgery, we have held that the prescribed services transcended mere housekeeping tasks. As such, they were compensable. Robert P. Holloway, 45 Van Natta 2036, 2038 (1993).

Here, we conclude that the services at issue are more than mere housekeeping. Based on the unrebutted opinions of claimant's physicians (including Dr. Friedman, attending psychiatrist), we find that claimant's compensable psychological and physical conditions render her unable to care for herself. Her compensable conditions worsen without the home health care (including housekeeping, shopping for food, meal preparation, and personal hygiene assistance) repeatedly requested by Dr. Friedman and the other members of claimant's treatment team. (See Exs. 7, 10-46-7, 15-14). Therefore, we conclude that claimant's home health care claim is compensable.

In addition, we agree with the Referee that SAIF's resistance to the provision of medical services, specifically home health care, has constituted unreasonable resistance to the payment of compensation in this case. Accordingly, we further agree that claimant is entitled to attorney fees under ORS 656.386(1) (for prevailing against SAIF's "de facto" denial of home health care) and ORS 656.382(1) (for SAIF's unreasonable resistance to the payment of compensation). See Snowden A. Geving, 46 Van Natta 2355, 2356 (Where SAIF's "de facto" denial of claimant's claim for home health care services was not confined to the amount of compensation or extent of disability and claimant finally prevailed at hearing in overturning that denial, claimant was entitled to an attorney fee under ORS 656.386(1)). After considering the factors set forth in OAR 438-15-010(4), we conclude that reasonable fees for services at the hearing level (under ORS 656.386(1) and 656.382(1)) total $5,000, as awarded by the Referee.

Finally, inasmuch as claimant has finally prevailed before the Board after remand from the court, he is entitled to a reasonable attorney fee for services before every forum. See ORS 656.388(1). Since claimant's counsel provided services before the Board and court, a reasonable fee for such efforts shall be awarded (in addition to the Referee's assessed fees, which we have reinstated). Id. After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services before the Board and court is $3,000. In reaching this conclusion, we have particularly considered the time devoted to the home health care issue (as represented by 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 services devoted to the penalty and attorney fee issues. See Jay A. Nero, 47 Van Natta 163 (1995); Amador Mendez, 44 Van Natta 766, 737 (1992); Juan A. Garcia, 43 Van Natta 2813, 2815 (1991).

Accordingly, on reconsideration, the Referee's order dated November 27, 1991, as reconsidered December 20, 1991, is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
THERESA R. CALLAHAN, Claimant
WCB Case No. 93-07453
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

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

The insurer requests review of Referee Thye's order that found that claimant's claim for a psychological condition was prematurely closed. On review, the issue is premature closure.

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

We find that the compensability of claimant's psychological condition after May 3, 1993 to be at issue. We further find that it was claimant's compensable condition that was not medically stationary as of May 3, 1993.

The insurer contends that Exhibits 3-10 should be in the record and that Exhibit 70 should be "readmitted." We disagree.

At hearing the Referee stated that the parties agreed that Exhibits 3-13 and 70 (inter alia) "may be withdrawn." (Tr. 5). Neither party objected to the Referee's statements regarding admission or exclusion of evidence. The Referee's order reflects that Exhibits 2-4 and 6-10 (inter alia) were admitted. Neither party objects to the admission of these exhibits. Thus, only Exhibits 5 and 70 (of those disputed by the insurer) were not admitted.

As we have noted, the insurer failed to object (at hearing, when it had the opportunity) to the Referee's characterization of Exhibits 5 and 70 as withdrawn. Under these circumstances, we conclude that the Referee did not abuse his discretion by failing to admit this evidence. See ORS 656.283(7).

In addition, the insurer asks us to take judicial notice of a different Referee's February 10, 1993 order regarding this claimant.

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 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 judicial notice of Referee Hazelett's February 10, 1993 Opinion and Order regarding this claimant. However, our recognition of the prior order does not affect the outcome of the present case, because we find nothing in the order relevant in resolving the premature closure issue before us.

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

ORDER

The Referee's order dated April 28, 1994 is affirmed. For services on review, claimant is awarded a $500 attorney fee, payable by the insurer.

Board Member Haynes dissenting.

Claimant bears the burden of proving that the May 3, 1993 Determination Order prematurely closed her claim. To prevail, she must come forward with a preponderance of persuasive medical evidence establishing that there was a reasonable expectation of improvement in the compensable condition at claim closure. Such evidence is sorely lacking.

Claimant's theory is that her continued use of Prozac (and the plan to wean her off it eventually) indicates that she was not psychologically stationary when her claim was closed. However, because claimant's compensable psychological treatment resolved before the claim was closed, her continued use of Prozac is irrelevant. See Clarke v. SAIF, 120 Or App 11, 14 n. 1, ("Medical treatment prescribed for a psychological condition must be reasonably expected to improve the compensable psychological condition itself.") (emphasis added).

Claimant relies on the opinions of Gail Getz, psychological counselor, and Dr. Maletzky, psychiatrist, despite their flawed reasoning and conclusions. Dr. Maletzky's opinion is unreliable because it is admittedly based on an incomplete history. There is no indication that Dr. Maletzky ever reviewed or thoughtfully considered the "extensive materials" about claimant which were available to him. (See Exs. 18-1, 99AA-12-17). Thus, Dr. Maletzky was in no position to distinguish claimant's undisputed preexisting condition from the accepted "work-related" condition.

Gail Getz provides the only other opinion suggesting that claimant was not medically stationary when her claim was closed. However, Ms. Getz confused claimant's work-related problems with her preexisting noncompensable condition. Moreover, although Ms. Getz opined that claimant was not medically stationary, she stated in the same report that the Prozac prescription could help claimant "maintain" stationary status. (Ex. 91). Where is the expectation of improvement in this reasoning?

Nonetheless, the majority relies on a Dr. Maletzky, whose history is materially incomplete, and Counselor Getz, whose reasoning is internally inconsistent. I fail to see why the majority thinks the result is supportable. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
JODY A. HENDRICKSON, Claimant
WCB Case No. 93-07169
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

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

Claimant requests review of Referee Holtan's order that upheld the SAIF Corporation's denial of her claim for a left elbow contusion. On review, the issue is compensability.

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

On review, claimant argues that the medical reports establish that she had "objective findings," as required by ORS 656.005(7). Claimant contends that Dr. McDonald, M.D., noted that she was "mild to moderately tender over the epicondyle laterally." Dr. McDonald also diagnosed "contusion left lateral epicondyle."

After reviewing the record, we conclude that, even if Dr. McDonald's report does constitute "objective findings" as required by the statute, claimant has nevertheless failed to establish either medical or legal causation. Accordingly, for the remaining reasons stated by the Referee, we conclude that claimant has failed to establish a compensable injury.

ORDER

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

Board Member Gunn dissenting.

For the following reasons, I respectfully dissent from the majority's decision. First, I believe that this case is an example of how lawyers and an overly "legalistic" approach can be detrimental to the Workers' Compensation system. If the majority's expectations of workers are actually implemented, the public should prepare for workplace productivity to come to a screeching halt. Specifically, I note that the facts in this case are not in dispute. While working, claimant banged or bumped her elbows several times. She reported to her supervisor that day that her elbow hurt. However, in this case, claimant is being penalized because she has honestly admitted that she cannot remember a specific event or incident at work which caused her injury.

On the other hand, if claimant had made a note every time she banged or bumped her elbow at work (or better yet said that the "third" bump at work caused her condition) she would undoubtedly have established a compensable claim. Consequently, I believe that the exactitude that the majority expects of claimant is unrealistic. While such legal theories and requirements may look impressive on paper, they have no application in an actual workplace. If the majority expects workers to start noting every bump, bang and other minor trauma that occurs at work, the workday will be used to fill out and process accident report forms, and employers will need to decrease productivity expectations.

Finally, I acknowledge that claimants must prove their injuries. However, the last time I reviewed the law, it only required that workers prove that it is more likely than not that the injury occurred. In the instant case, claimant (whom the Referee found to be a credible witness) told her doctor that she bumped her elbow several times at work and the doctor diagnosed "contusion left lateral epicondyle". Based on those undisputed facts, I would find that, due to the repeated trauma to her elbow, claimant sustained a contusion which is a compensable industrial injury.

In sum, there is a reason that the Workers' Compensation Act uses "substantial justice" as a standard, and the forum is exempt from the rules of evidence. The system has been designed to give workers the benefit of the doubt, and that should not include the type of scrutiny and excessive documentation expected by the majority. Rather, we should apply the aforementioned standards to promote a nonlitigious administrative process free from the evidentiary restrictions applied by the majority in this case. For these reasons, I must respectfully dissent.

In the Matter of the Compensation of
KEVIN G. ROBARE, Claimant
WCB Case No. 94-01054
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Myzak's order that upheld the insurer's denial of his claim for neck injuries. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

We summarize the Referee's findings of fact. Claimant, a sheet metal installer, travels daily to the employer's construction sites. Although the employer maintains a business office in Portland, the construction work is carried out by employees at job sites at different locations. On September 15, 1993, claimant was working for the employer at a construction site in Corvallis. Claimant had an unpaid one-half hour lunch period, during which time he was free to do as he wished. The employer provided a lunchroom at the construction site in a trailer that it owned or leased. At the end of his lunch period but before he had returned to work, claimant choked on water. Claimant injured his neck when he passed out and fell to the floor.

The Referee concluded that claimant's injury, which occurred during the lunch hour in the employer-controlled premises, met the requirement that the injury occurred in the course of employment. However, after applying the seven factors of the work relationship test identified in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985), the Referee found that claimant's injury did not have a sufficient relationship to work and, therefore, was not compensable.

Claimant argues that he was a "traveling employee" and his injury occurred in the course and scope of employment. As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, where travel is a necessary part of employment, risks incident to travel are covered by the workers' compensation law even though the employee may not be working at the time of injury. Proctor v. SAIF, 123 Or App 326, 329 (1993). In SAIF v. Reel, supra, the court said:

> "The risk inherent in travel may arise out of the employment where such travel is a necessary incident of the employment. That is, when the travel is essentially part of the employment, the risk remains an incident to the employment even though the employe may not actually be working at the time of the injury." 303 Or at 216.

Thus, the first question is whether travel was a "necessary incident" of claimant's employment as a sheet metal worker. In Elva McBride, 46 Van Natta 282 (1994), we concluded that the claimant qualified as a "traveling employee." The claimant, a field engineer, was dispatched by the employer every morning by telephone from her home in Bend, Oregon to various worksites in central Oregon. Claimant used her own car for work-related travel and received car and mileage allowances in addition to wages.

We recognize that the "traveling employee" rule is not limited to employees who travel overnight. See PP&L v. Jacobson, 121 Or App 260, rev den 317 Or 583 (1993). Nevertheless, in the instant case, we find that travel was not an essential part of claimant's employment. Unlike in Elva McBride, claimant's work activities did not involve traveling for the employer. There is no evidence that claimant was compensated for any travel time. Rather, claimant's "travel" in this case amounted to commuting to the work site. Claimant's commuting was not work-related business and was not an integral part of his employment. Under these circumstances, we conclude that travel was not a "necessary incident" of the employment and claimant was not a "traveling employee."

We proceed to analyze whether the claim is compensable under general principles of workers' compensation law. There are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arise out of employment" tests the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 368 (1994). Both elements must be evaluated, neither is dispositive.

Here, claimant was injured on the employer's premises at the end of his lunch period but before he had returned to work. Although claimant was not paid during his lunch period and he was free to leave the premises, claimant and his supervisor both testified that it was customary for employees to bring their lunches and eat lunch in the trailer. (Tr. 5, 7, 40). Under these circumstances, we agree with the Referee that claimant was injured "in the course of employment."

To prove compensability, claimant must also establish that his injury "arose out of employment." Norpac Foods, Inc. v. Gilmore, supra. The fact that an employee is injured on the employer's premises during working hours does not of itself establish a compensable injury. Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983). In Clark v. U.S. Plywood, 288 Or 255, 262 (1980), the Court said that "[l]unchtime 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." (Emphasis added). See also Fred H. Jacobson, 43 Van Natta 1420 (1991), aff'd PP&L v. Jacobson, supra (the claimant was injured when a stool collapsed beneath him while eating lunch at a restaurant).

Here, claimant was injured when he choked on water and passed out, injuring his neck. Under the facts in this case, neither choking on water nor passing out were related to any premises hazard or to claimant's work activities. Those risks were "personal to claimant." See Henderson v. S.D. Deacon Corp., 127 Or App 333, 338 (1994). Under these circumstances, we agree with the Referee that there is no causal connection between claimant's injury and his employment. Therefore, claimant did not meet his burden of proving that the injury occurred within the course and scope of employment.

Claimant also argues that he is entitled to a penalty for failure of the employer to produce a claim document that was in the employer's possession. The record indicates that the insurer learned of the document's existence at the same time claimant did. Although the insurer concedes that there was a discovery violation, the underlying claim is not compensable. Thus, there has been no unreasonable delay or refusal to pay compensation. Under such circumstances, claimant is not entitled to a penalty pursuant to ORS 656.262(10). See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Carla G. Pavlicek, 46 Van Natta 693 (1994).

ORDER

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

March 1, 1995 Cite as 47 Van Natta 319 (1995)

In the Matter of the Compensation of
BRIAN W. SCOTT, Claimant
WCB Case No. 93-11713
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

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

The SAIF Corporation requests review of Referee Menashe'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.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant, who did not attend the hearing,[1] had established the compensability of his low back strain claim. The Referee reasoned that Dr. Duncan's medical notes, in conjunction with a co-worker's verification of the kind of work performed by claimant on the alleged date of injury and SAIF's failure to produce contradictory evidence, were sufficiently persuasive to fulfill claimant's burden to prove compensability by a preponderance of the evidence.

SAIF, citing Zurita v. Canby Nursery, 115 Or App 330 (1992), rev den 315 Or 443 (1993), contends that claimant failed to prove that he injured his back in the course and scope of employment. We agree.

Claimant has the burden to prove that he experienced an injury in the course and scope of his employment on April 26, 1993. ORS 656.266; ORS 656.005(7)(a). The only evidence that claimant's injury occurred at work is in the form of claimant's hearsay statements in the medical reports. Although such evidence is admissible for the truth of claimant's statements to the extent that those statements were reasonably pertinent to medical diagnosis and treatment, such evidence is not probative evidence concerning what caused claimant's injuries or where they occurred. See ORS 656.310(2); Zurita v. Canby Nursery, supra; 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).

Here, claimant filed an 801 form on May 20, 1993, in which he reported that he had injured his low back on April 26, 1993, as a result of shoveling out a ditch. His employer indicated on the form that it was "unknown" whether the injury arose out of the course and scope of his employer. Claimant sought treatment on May 21, 1993, several weeks after the alleged date of injury, and reported the same date and circumstances of injury to Dr. Duncan.

Although the medical report constitutes prima facie evidence that claimant sustained a low back strain injury, Zurita, supra, the only evidence regarding the work-connectedness of the strain injury comes from claimant himself, who was not present to testify at hearing. Moreover, although claimant's co-worker acknowledged that claimant had been performing ditch cleaning and shoveling on the date claimant alleged he injured his low back, the co-worker testified that he had not noticed any signs that claimant had been injured and that claimant had not complained of any pain on April 26, 1993, or during the next two weeks prior to the filing of the injury claim.

The co-worker's testimony does not support claimant's contention that he injured his low back while performing work activities. Although the testimony does not necessarily establish that claimant did not injure his back, the burden is on claimant to affirmatively prove a causal connection between his need for treatment and his work activities. The co-worker's testimony fails to accomplish that requirement.

Inasmuch as the only evidence that relates claimant's treatment to his work activities is claimant's statement in his physician's report, which is not persuasive, we conclude that there is insufficient evidence to establish that claimant's low back strain occurred at work on April 26, 1993. See Zurita, supra.[2] Consequently, claimant has failed to carry his burden to prove that his low back strain occurred in the course and scope of his employment.

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[1] The Referee provided claimant several weeks to file a motion to reopen the record to present testimony. (Tr. 32). Claimant failed to avail himself of the opportunity and the record was closed on January 28, 1994.

[2] The dissent misconstrues our application of Zurita, supra. In Zurita, the court held that medical reports establish prima facie evidence of medical matters. The court also determined that the Board may receive hearsay evidence and evaluate its weight in light of the circumstances of the case, noting that, where a claimant relies on hearsay statements contained in medical reports, the reports may not be sufficient to carry the burden of proof on work-connectedness.

Here, as in Zurita, claimant relied on hearsay statements contained in medical reports. We give those reports little weight in light of the passage of time before claimant sought treatment and the co-worker's failure to corroborate claimant's alleged injury. For the same reason, we accord little weight to the same hearsay statements contained in the 801 and 827 claim forms.

ORDER

The Referee's order dated February 10, 1994 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's $2,250 attorney fee award is reversed.

Board Member Gunn dissenting.

I must dissent because my colleagues misapply case law and impose a higher evidentiary standard than that required by law. If claimant's evidence was solely the statements of the treating doctor, then the application of Zurita v. Canby Nursery, supra, would be relevant. But Zurita applies to whether hearsay statements regarding the cause of an injury contained in medical reports constitutes prima facie evidence of causation. The majority fails to recognize or assign any weight to the two signed statements by claimant, his 801 and 827 forms (Exs. 1 and 2). Both these documents were admitted into the evidentiary record without objection.

The majority misapplies Zurita in two ways. The Zurita court was interpreting the language in ORS 656.310(2). The question answered by the court was did the word "matter" in that statute make all material in a medical report prima facie evidence. The court only noted that medical reports in the context of that statute can only establish prima facie evidence of medical matters. The court did not state that such evidence would not or could not constitute probative evidence. The court did not say that such hearsay evidence would not or could not be sufficient to meet claimant's burden of proof.

The Zurita court was quick to note that the Board was not bound by the rules of evidence. Thus, the Board can consider and weigh hearsay evidence. In Zurita, the evidence was sufficient to get to the fact-finder, but insufficient to convince them. Nowhere in dicta or by inference can we conclude from Zurita that in all cases that medical reports are legally insufficient to establish anything beyond medical matters. The majority would impose such an interpretation, but none exists in the Zurita decision.

It is the Board's responsibility to consider all evidence and determine its weight and sufficiency. In the instant case, the majority must not only consider the evidence in the medical report, but also all the other evidence in the record. Claimant filled out and signed two official documents as to the cause and date of his injury. He signed and dated both documents. Both these documents attribute his injury to work activity on the 26th of April. The 801 form in the bottom portion filled out by the employer acknowledges that he was assigned to the duty claimant says caused his injury. His co-worker confirmed that physical activity took place.

In addition, at hearing the insurer acknowledged that they had a statement by claimant taken by an investigator. Claimant requested a copy of that statement. The insurer objected, indicating the evidence was being withheld as impeachment evidence. The Referee requested and the insurer provided a copy of the claimant's taped statement. However, that statement is not in the record. Under such circumstances, a remand to the Referee might be in order to have the report in the record. A more reasonable action would be to consider that if such report contains material detrimental to claimant's position or advantageous to the insurer's position. In light of the insurer's failure to offer the report as evidence, I would infer that, as with the 801 and 827 forms, the statement supported claimant's position.

For all of the above reasons, I must respectfully dissent.

The dissent also recommends remanding this case to the Referee in order to have a copy of claimant's taped statement in the record. We do not agree with the dissent's recommendation.

We have remanded to the Hearings Division for admission of such undisclosed and unoffered evidence where a claimant requested remand. See former OAR 438-07-017; Ashwani K. Grover, 42 Van Natta 2340 (1990); Iris J. Wirth, 41 Van Natta 194, 195 (1989). However, we have not done so where a claimant has not requested remand, nor indicated that the evidence was required for his case at hearing or on review or that the withholding of the document was unreasonable. See e.g., David R. Zimmerly, 42 Van Natta 2608 (1990). Here, claimant does not request remand, nor does he indicate either that the evidence was required for his case at hearing or on review, or that SAIF's withholding of the document was unreasonable. Absent some indication on the part of claimant that this matter might have an effect on the outcome of the case, we decline to entertain the dissent's recommendation.

In the Matter of the Compensation of
CHERYL A. TRASK, Claimant
WCB Case No. 93-06558
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of those portions of Referee Spangler's order which: (1) upheld the SAIF Corporation's denial of her fibromyalgia condition; (2) found that claimant's claim was not prematurely closed; and (3) declined to award any scheduled permanent disability for an alleged chronic left hand condition. On review, the issues are compensability, premature closure and, if closure was not premature, extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability of Fibromyalgia Condition

The Referee held that claimant failed to establish that her alleged fibromyalgia condition is compensably related to her accepted bilateral carpal tunnel syndromes (CTS).[1] Claimant contends that the medical evidence establishes that her compensable CTS condition and its sequelae were the major contributing cause of her fibromyalgia condition. Claimant further contends that such medical evidence is sufficient to establish the compensability of her condition under ORS 656.005(7)(a)(A) as a consequential condition.

Subsequent to the Referee's order, we decided Albert H. Olson, 46 Van Natta 1848 (1994). In that case, we held that the claimant's psychological condition was compensable as a "consequential condition" under ORS 656.005(7)(a)(A) because his compensable low back injury and its sequelae (including job loss and related loss of self-esteem) were the major contributing cause of his psychological condition. In support of our holding, we cited SAIF v. Freeman, 130 Or App 81 (1994), where the court held that a psychological condition remained compensable because the medical evidence established that the claimant became depressed and lost self esteem and confidence when his ability to work was diminished as a result of his compensable injury.

Here, Dr. Randle, claimant's treating neurologist, opined that the acute pain syndrome resulting from her CTS condition caused chronic sleep disturbance which, in turn, caused the fibromyalgia condition. (Exs. 23, 23A). In addition, Dr. Randle opined that the chronic, situational stress of being unemployed and without job opportunities was also a major contributor to claimant's chronic sleep disturbance and secondary fibromyalgia. (Exs. 26, 27, 28). In other words, we understand Dr. Randle's opinion to be that claimant's compensable CTS condition and its sequelae (pain, sleep disturbance, stress from unemployment and financial insecurity) are the major contributing cause of her fibromyalgia condition. Accordingly, relying on Dr. Randle's opinion, we conclude that claimant has established that her compensable condition and its sequelae are the major contributing cause of her consequential fibromyalgia condition. ORS 656.005(7)(a)(A).

Examining physicians offered different opinions. However, we find Dr. Randle's opinion most persuasive.

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[1] The Referee found, in the alternative, that claimant's fibromyalgia condition is not compensable as an occupational disease under ORS 656.802. In so holding, the Referee relied on SAIF v. Hukari, 113 Or App 475 (1992). However, subsequent to the Referee's order, the Supreme Court disavowed the Hukari analysis in its decisions in Mathel v. Josephine County, 319 Or 235 (1994) and DiBrito v. SAIF, 319 Or 244 (1994). Therefore, claimant need not prove that she has a compensable mental disorder in order to prove that her fibromyalgia condition is compensably related to the accepted condition.

Dr. Radecki examined claimant at SAIF's request. (Ex. 24A). He dismissed fibromyalgia as a "waste basket" diagnosis for claimant's otherwise vague physical findings and symptoms. He believed claimant never had any "real objective abnormalities." (Ex. 24A-5). To the extent this premise underlies Dr. Radecki's analysis, we find it unpersuasive, because that premise is contrary to the law of the case (i.e., claimant does have a compensable bilateral CTS condition). See Kuhn v. SAIF, 73 Or App 768, 772 (1985). Dr. Radecki concluded that claimant's present condition was more likely due to stress, anxiety, uncertainty about the future, and her present unemployment than to her past work activities. In this respect, we find Dr. Radecki's opinion to be consistent with Dr. Randle's.

Drs. Duff, Brooks and Kjaer also examined claimant at SAIF's request. They diagnosed chronic myofascial pain syndrome in the neck and upper extremities. They also noted that claimant's accepted CTS is stationary and not responsible for her current symptoms. They concluded that claimant's work activities were unrelated to the current condition, because claimant symptomatically worsened over the past year when she was not working. Claimant, however, contends that her compensable condition and its sequelae (pain, sleep disturbance and stress) caused her fibromyalgia condition. Thus, their opinions are not helpful, because they simply do not address claimant's theory of compensability.

After our review of the record, we find Dr. Randle's opinion to be thorough, well-reasoned, and more persuasive than the examiners' opinions. In addition, we find no persuasive reasons not to defer to Dr. Randle's opinion as the attending physician. See Weiland v. SAIF, 64 Or App 810, 814 (1983). We further find, relying on Dr. Randle's opinion, that claimant's consequential fibromyalgia condition is established by medical evidence supported by objective findings. ORS 656.005(7)(a); (Ex. 23A).

Premature Closure

Dr. Randle opined that when claimant's CTS condition was declared medically stationary in September 1992, she was not yet medically stationary with respect to the fibromyalgia condition. In order for her claim to be closed, all claimant's compensable conditions must be medically stationary. Therefore, inasmuch as claimant's compensable fibromyalgia condition was not medically stationary at the time of claim closure, we set aside the Determination Order as prematurely issued.

Extent of Scheduled Permanent Disability

Because we have set aside the Determination Order as prematurely issued, it is also premature to address the extent of disability at this time.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated May 10, 1994 is reversed. The SAIF Corporation's September 15, 1993 denial is set aside, and the claim is remanded to SAIF for processing in accordance with law. The October 29, 1992 Determination Order and June 3, 1993 Order on Reconsideration are set aside as prematurely issued. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
BARRY W. ALERTAS, Claimant
WCB Case No. 93-14907
ORDER ON REVIEW (REMANDING)
Robert E. Nelson, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Referee Davis' order that: (1) denied its motion to dismiss claimant's hearing request for lack of jurisdiction; and (2) set aside its "de facto" denial of claimant's proposed low back surgery request arising from a managed care organization (MCO) dispute. SAIF also moves for remand to the Referee for consideration of a post-hearing medical report. On review, the issues are jurisdiction, remand and, alternatively, medical services. We vacate and remand.

FINDINGS OF FACT

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

In lieu of the last paragraph on page one of the Opinion and Order, we find: Claimant sustained a compensable back injury in 1983. He had a laminectomy. The claim was closed in 1984.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Claimant sustained a compensable back injury in 1983. The claim was closed in 1984. Thereafter, claimant had numerous low back surgeries, the last of which was performed by Dr. Franks in 1991. In 1992, claimant reported low back and right leg pain. At the time, SAIF had contracted with CareMark Comp, an MCO, to provide medical services to injured workers. Thereafter, Franks requested authorization from CareMark Comp to perform another low back surgery. CareMark Comp disapproved the request. Its Medical Advisory Council upheld the disapproval, and advised Franks that he could appeal to the Medical Management Department within 30 days. Franks did not appeal the Council's decision.

Subsequently, claimant requested a hearing regarding SAIF's "de facto" denial of his surgery request. Arguing that exclusive jurisdiction over the dispute rested with the Director, SAIF moved for dismissal of the hearing request. The Referee denied the motion, and set aside SAIF's "de facto" denial. SAIF requested Board review. Thereafter, it filed a motion for remand, based on a post-hearing medical report in which Dr. Franks concluded that further surgery would not be advisable for claimant.

Subsequent to the Referee's order, the Board issued its decision in Job G. Lopez, 47 Van Natta 193 (1995). There, after the Director upheld an MCO's disapproval of the claimant's physician's surgery request, the claimant requested a hearing. The carrier moved for dismissal of the hearing request, arguing that the Director had exclusive jurisdiction over the dispute. The referee denied the motion, and the carrier requested Board review.

On review, the Board rejected the carrier's contentions that, under ORS 656.260(4)(d) and (6), and 656.704(3), the Director had exclusive jurisdiction over the dispute. 47 Van Natta at 194-200. Rather, the Board concluded that, in the MCO context, determining where jurisdiction lies depends on the nature of the medical services issue in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994) and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Board decided that, because the particular disputed medical treatment involved a proposed surgery, jurisdiction to review the dispute vested solely in the Hearings Division. Id. at 201. On the merits, the Board relied on the opinion of one of the claimant's treating physicians to find that the proposed surgery was appropriate. Id. at 201-202.[1]

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[1] Board member Haynes acknowledges that she is bound by the Lopez holding. However, she continues to disagree with that holding, and the underlying analysis, for the reasons stated in the dissent in that case. Id. at 202-206.

Here, SAIF presses essentially the same jurisdictional arguments that we rejected in Lopez. We adhere to our rejection of those arguments. Rather, in light of Lopez, we determine the nature of the disputed medical services issue in this case to ascertain who had jurisdiction to resolve that issue.

Here, as in Lopez, the dispute involves claimant's attending physician's request to perform spinal surgery. Because the request involves proposed curative medical services, under Martin v. City of Albany and Jefferson v. Sam's Cafe, jurisdiction to review the request is vested solely in the Hearings Division pursuant to ORS 656.283.[2] Accordingly, we affirm the Referee's decision denying SAIF's motion to dismiss.

Before we proceed further, we briefly address two arguments that SAIF raises on review. First, SAIF argues that ORS 656.260 exempts it from claims processing laws and that it is, by virtue of its contract with CareMark Comp, subject to the latter's dispute resolution processes. We disagree. ORS 656.262(1) states that "[p]rocessing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer. All employers shall assist their insurers in processing claims as required by this chapter." Because the statute requires all employers to assist in processing injured workers' claims, and because it makes no distinction between carriers that contract with MCOs and those that do not, we conclude that all carriers, whether or not they contract with MCOs, remain subject to the usual statutory claims processing duties.

Second, SAIF asserts that, because Dr. Franks did not exhaust the MCO review process by requesting review by CareMark Comp's Medical Management Department, the jurisdictional issue in the matter is not ripe for review. We disagree. In view of our decision in Job G. Lopez, and our conclusions that SAIF was obligated to process claimant's claim and that this case involves proposed curative medical services, we conclude that claimant was entitled to request a hearing at any time after the expiration of the 90-day period within which SAIF had to accept or deny the surgery request. See ORS 656.262(6); 656.283(1).

Remand/Medical Services

SAIF requests that we remand this matter to the Referee for consideration of Dr. Franks' post-hearing medical report. We grant the motion.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, the moving party must show good cause or a compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988). Although evidence that is not generated until after the hearing is "unavailable," it may still be "obtainable" at the time of hearing. Compton, supra, 301 at 648; James E. Gore, 45 Van Natta 1652 (1993).

Dr. Franks initially concluded that claimant's proposed low back surgery was reasonable and necessary. On September 2, 1994, approximately six months after the hearing record closed, however, Dr. Franks authored a chart note in which he analyzed claimant's onset of bilateral symptoms and an August 31, 1994 CT scan that revealed a new L2 compression fracture. Franks stated:

> "My overall impression is that [claimant] is an even more risky surgical candidate than what he was before * * *. I had hoped not to operate bilaterally; now this seems to be a necessity if one were to consider surgery. My overall impression has changed in that on the basis of the course of events, his bilateral symptoms, the result of his diagnostic

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[2] Claimant argues that jurisdiction vests in the Hearings Division by virtue of ORS 656.245(2). This Board has held that its Hearings Division has subject matter jurisdiction to determine the causal relationship between a compensable injury and the need for medical services. Michael A. Jaquay, 44 Van Natta 173 (1992). Here, SAIF's denial did not dispute that claimant's proposed surgery was causally related to his compensable injury. Therefore, ORS 656.245(2) is inapplicable.

study revealing a compression fracture that no matter what one does we are never really going to make this man that much functionally better and I would recommend that he be maintained on pain medication and not surgery. * * * I * * * am quite sure that I do not want to take this patient to surgery ever again unless there is an overwhelming objective clinical indication to do so."

This evidence concerns claimant's low back condition. Because the chart note did not issue until September 1994, it was "unavailable" at hearing. Furthermore, because it was based on claimant's post-hearing bilateral symptoms and CT scan, it was not "obtainable" at the time of hearing. Finally, because Dr. Franks has, by virtue of the September chart note, effectively recanted his earlier opinions regarding the necessity and reasonableness of further low back surgery for claimant, we conclude that the note is reasonably likely to affect the outcome of this case. Consequently, we find a compelling reason exists for remanding this case to the Referee, and we grant SAIF's motion for remand. Compton v. Weyerhaeuser Co., supra; Metro Machinery Rigging v. Tallent, supra; see Palmer v. Plaid Pantry #54, 76 Or App 405 (1985) (Board abused discretion in not remanding case to referee to consider post-hearing report that undercut treating physician's causation opinion).

Accordingly, we vacate the Referee's order and remand for admission of Dr. Franks' post-hearing chart note. The parties shall have the opportunity to present additional documentary and/or testimonial evidence regarding that chart note. Referee Davis shall have the discretion to proceed in any manner that will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated May 13, 1994 is vacated. The matter is remanded to Referee Davis for further proceedings consistent with this order.

March 2, 1995 Cite as 47 Van Natta 326 (1995)

In the Matter of the Compensation of
STEPHANIE A. ANDERSON, Claimant
WCB Case No. 94-04947
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Roberts, et al., Defense Attorneys

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

Claimant requests review of Referee Peterson's order which upheld the insurer's denial of her occupational disease claim for a neck, back, and right shoulder condition. On review, the issue is compensability.

We adopt and affirm the Referee's order.

ORDER

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

Board Member Gunn dissenting.

The majority affirms the Referee's finding that claimant failed to sustain her burden of proving that her occupational disease claim for a neck, back and right shoulder condition was compensable. In so doing, the majority adopts the Referee's finding that the medical opinion of the only physician to comment on the causation issue, claimant's attending physician, Dr. O'Donovan, was insufficient to establish that claimant's employment activities as a waitress were the major contributing cause of her neck, back and right shoulder condition. Because the majority erred in affirming and adopting the Referee's conclusion that claimant failed to prove her case by a preponderance of the evidence, I must respectfully dissent.

The parties do not dispute that claimant must prove that her work activities as a waitress were the major contributing cause of her neck, back, and shoulder condition. See ORS 656.802(2). The Referee, however, discounted Dr. O'Donovan's opinion mainly because he did not explicitly confirm that claimant's employment was the "major contributing cause" of her condition. Unlike the majority, I would find that Dr. O'Donovan's medical opinion is sufficient to satisfy claimant's burden of proof.

Claimant testified that she informed Dr. O'Donovan of a prior automobile accident and her previous low back problems. (Trs. 8, 9). Dr. O'Donovan's February 10, 1994 chart note confirms that he was informed of a prior motor vehicle accident . (Ex. 10-1). Dr. O'Donovan's chart note also contains a history that claimant had never had an injury to her cervical spine, neck and thoracic spine. This history is not entirely accurate, inasmuch as claimant sought treatment on August 21, 1990 for an "intercostal muscle strain" after she bent down to pick up something. (Ex. 3). Claimant also sought treatment at an emergency room on December 25, 1991 following a second motor vehicle accident. (Ex. 4). The diagnosis was "musculoskeletal back pain." However, the medical records only document brief treatment for claimant's prior injuries.

In fact, the record does not reflect any medical treatment from December 25, 1991 to February 4, 1994, when claimant reported a gradual onset of pain in her mid-back, neck and right shoulder beginning in late January 1994. Claimant credibly testified that symptoms from her prior injuries had resolved, with the exception of when she occasionally overworked and needed medication. (Tr. 10). Dr. O'Donovan apparently had prescribed medication to claimant six months to a year prior to her most recent flare-up of symptoms. (Tr. 15). Claimant also testified that her current symptoms were in an area different from that previously affected. (Trs. 8, 12).

Dr. O'Donovan took a detailed history of claimant's work activities and concluded that her cervical, thoracic and neck strain was secondary to an overuse syndrome. (Ex. 10). While Dr. O'Donovan never mentioned the words "major contributing cause," he explained in his July 12, 1994 letter to claimant's counsel that he had discussed claimant's condition with her and that he concluded it was a "work-related injury." Dr. O'Donovan emphasized that claimant's "injury" was the result of her job.

It is well-settled that a physician need not mimic statutory language in rendering a medical opinion. A physician need only provide an opinion from which it can reasonably be concluded that claimant's burden of proving medical causation has been satisfied. See McClendon v. Nabisco Brands, 77 Or app 412, 417 (1986).

In this case, I would find the language in Dr. O'Donovan's medical opinion more than sufficient to satisfy claimant's burden of proof. Considering Dr. O'Donovan's familiarity with claimant's condition and his knowledge of claimant's work activities, his opinion regarding the causation of her condition is persuasive.

While it is not clear that Dr. O'Donovan was entirely aware of claimant's prior back problems, this weakness in his opinion is not fatal. As previously noted, there was very little treatment documented concerning claimant's prior injuries. Moreover, claimant's testimony that these injuries had largely resolved and mainly affected a different region of the spine was unrebutted.

Inasmuch as claimant has satisfied her burden of proving by a preponderance of the evidence that her occupational disease claim is compensable, I would reverse the Referee's decision and set aside the insurer's denial. For this reason, I must respectfully dissent.

In the Matter of the Compensation of
MARK L. HADLEY, Claimant
WCB Case No. 90-18036
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Hadley v. Silverton Forest Products, 123 Or App 629 (1994). The court reversed our order, Mark L. Hadley, 44 Van Natta 690 (1992), that held that the Hearings Division lacked jurisdiction under ORS 656.327 to consider a medical services dispute concerning the use of a vehicle equipped with an automatic transmission. Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court has remanded for further proceedings.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured in March 1990, when his left arm was caught in a chain sprocket at the employer's mill. Claimant underwent surgery and physical therapy. Claimant's use of his left arm was restricted, and in April 1990, his treating doctor released him for light duty with activity limited to the right arm. Following the employer's offer of a light duty job as purchasing agent, claimant bought a used pickup, as he believed that he would have to provide his own transportation to work.

Sometime in late July 1990, claimant's treating doctor, Dr. Buehler, wrote a prescription providing that claimant needed "an automatic vehicle to transport himself while in case." On August 3, 1990, the employer wrote to claimant's attorney, informing him that it would not pay for the vehicle purchased by claimant as the vehicle was not a reasonable and necessary medical expense.

Determining that the Hearings Division had jurisdiction over claimant's request for hearing, the Referee found that the vehicle was a reasonable and necessary medical service. Accordingly, the Referee set aside the employer's "de facto" denial, and directed the employer to reimburse claimant in an amount equal to the cost of a vehicle leased during the time period that claimant was required to use an automatic transmission.

On review, we found that the Referee lacked jurisdiction over the issue of the reasonableness and necessity of the medical services. Relying on Stanley Meyers, 43 Van Natta 2643 (1991), we concluded that the medical services dispute was not a matter concerning a claim over which the Hearings Division had jurisdiction.

The Court of Appeals reversed our order in Meyers, determining that the Director acquired exclusive jurisdiction over medical treatment dispute only with a "wish" for review by the proper party. Meyers v. Darigold, Inc., supra, 123 Or App at 221-22. According to the court, if no "wish" for review was filed, jurisdiction remained with the Board. Id. Citing Meyers, the court has reversed our decision and remanded for reconsideration.

Here, no party has "wished" for Director review under ORS 656.327(1). Accordingly, we find that we have jurisdiction over this medical services dispute. Meyers v. Darigold, Inc., supra; Martin v. City of Albany, supra.

We agree with the Referee that, based on claimant's attending physician's unrebutted prescription for a vehicle equipped with an automatic transmission, claimant has proven that the medical service is reasonable and necessary. We adopt the Referee's "Conclusions of Law and Opinion" on the issue of compensability of medical services, with the following supplementation.

In Robert P. Holloway, Sr., 45 Van Natta 2036 (1993) on recon 46 Van Natta 537 (1994), we found that a claimant had proven that home health care was a necessary and appropriate medical

service resulting from the compensable injury and surgery. We concluded that the claimant had met his burden of proving that thehome health care he sought was for conditions resulting from the injury for such period as the nature of the injury or the process of the injury required. See ORS 656.245(1)(a); OAR 436-10-040(1)(a); Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993).

Similarly, in the present case, claimant underwent three reattachment surgical procedures involving his left arm, muscles and tendons, following the compensable injury. Claimant's left arm was placed in a splint. In April 1990, claimant was released by his treating physician for light duty work, with instructions that he perform work with only his right hand. In July 1990, claimant underwent his fourth surgery involving a tendon transfer, and was again placed in a cast for several months. By the end of October 1990, claimant had recovered sufficiently to operate a vehicle with a manual transmission.

Accordingly, we rely upon the unrebutted evidence in this case, which consists of claimant's testimony and the prescription from his treating physician which prescribed an automatic transmission while claimant was in a cast and unable to drive a car with a manual transmission. Therefore, we conclude that the medical services sought by claimant are for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires. Furthermore, we conclude that claimant has proven that the vehicle equipped with an automatic transmission is a necessary and appropriate medical service resulting from the compensable injury and surgery. See Robert P. Holloway, Sr., supra. Accordingly, we agree with the Referee that claimant has met his burden of proof on the compensability of medical services for the period of time set forth in the Referee's order.

On reconsideration, the Referee's order dated February 15, 1991 is affirmed.

IT IS SO ORDERED.

March 2, 1995 Cite as 47 Van Natta 329 (1995)

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

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee McCullough's order that affirmed the Director's order determining that claimant was 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 with the following supplementation.

When claimant was injured while working as a carpenter, he was earning $13 per hour and working 40 hours per week, resulting in an approximate weekly wage of $520. Subsequent to his compensable injury, while employed as a warehouseman, claimant earned $9.85 per hour and worked 40 hours per week, resulting in an approximate weekly wage of $394. Claimant's "post-injury" employment as an apartment manager paid $700 per month, resulting in an approximate weekly wage of $125.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable 1991 low back strain. Following claim closure, the insurer found claimant ineligible for vocational assistance. After claimant requested Director review of the insurer's decision, the Director issued an order also concluding that claimant was not eligible for vocational assistance. In particular, applying former OAR 436-120-025(1)(b), the Director determined that claimant was capable of performing "suitable employment" and, therefore, did not have a "substantial handicap to employment."

The Referee affirmed. First, the Referee found that claimant was employed as an apartment manager and as a warehouse worker. The Referee further determined that claimant's combined income from his two jobs slightly exceeded his wage at the time of injury. Therefore, like the Director, the Referee also concluded that claimant was capable of "suitable employment" and lacked a substantial handicap to employment.

Claimant asserts that the Referee improperly combined his wages. Claimant further contends that his wage at the time of injury was $13 per hour and that neither job, by itself, provides a wage within 20 percent of such income. Thus, claimant argues that he is not capable of performing "suitable employment." We agree.

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 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 its rules and its decision therefore may be modified. See ORS 656.283(2)(a); Keith D. Kilbourne, supra.[1]

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.

Claimant's customary employment, which he held at the time of the 1991 injury, was as a carpenter. Although there was evidence that, following his injury, claimant worked as a carpenter for several companies, (Tr. 19-20), there was no proof regarding his wage for such employment. However, the record shows that claimant earned $13 per hour for his at-injury job as a carpenter. (Ex. 2). Under such circumstances, we use claimant's at-injury wage as the "current wage" for purposes of determining "suitable employment." See former OAR 436-120-005(6)(a)(A); David M. Morris, 46 Van Natta 2316 (1994).

The insurer asserts that, based on evidence that claimant returned to his regular carpentry work following his injury, he failed to prove a substantial handicap to employment. We understand the insurer to argue that the very fact that claimant worked as a carpenter following his injury shows that such employment constitutes "suitable employment."

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[1] Specifically, the Director applied former OAR 436-120-025(1)(b), which provides for determining "suitable wage" when the "worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected[.]"

Alternatively, even if we found the rule relevant to claimant's eligibility for vocational assistance, we would continue to find that it is not applicable to claimant's case since there was no evidence that claimant at any time collected unemployment insurance benefits.

Even assuming that such evidence shows that claimant has the necessary capacities, knowledge, skills and abilities to be employed as a carpenter in satisfaction of former OAR 436-120-005(10), it is not sufficient to prove "suitable employment." In particular, because there was no evidence regarding claimant's wage for his post-injury carpentry work, there is no proof that such employment included a wage within 20 percent of regular employment. As discussed above, such evidence is necessary in order to determine "suitable employment" under former OAR 436-120-005(6)(a)(A).

The record does show that claimant worked as a warehouse worker and an apartment manager and the respective wages of such employment. We find that claimant's actual performance of such work shows that he had the necessary capacities, knowledge, skills and abilities to work in such jobs, thereby satisfying ORS 656.340(6)(b)(A) and former OAR 436-120-005(10). Therefore, pursuant to former OAR 436-120-005(6)(a)(A), we next compare the wages from such work against the regular work wage of $13 per hour to determine if the employment is "suitable."

We first agree with claimant that the Referee erred in combining the wages of both jobs to determine that claimant had "suitable employment." The rules uniformly used the term "suitable employment" in the singular, evidencing an intent that every job a worker is able to perform should be separately analyzed and compared to the wage of the regular employment to determine if is "suitable."

Separately comparing claimant's wage of $9.85 per hour, or $394 per week, as a warehouse worker, and $700 per month, or $125 per week, as an apartment manager, against claimant's weekly wage of $520 he received for his at-injury job, we find that neither wage is within 20 percent of his regular employment wage. Therefore, 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" and is eligible for vocational assistance. See ORS 656.340(6)(a); former OAR 436-120-040(3)(c).

ORDER

The Referee's order dated May 18, 1994 is reversed. The Director's order dated January 10, 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.

In the Matter of the Compensation of
IMRE KAMASZ, Claimant
WCB Case No. 94-03206
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Neal's order that: (1) declined to direct the SAIF Corporation to pay an earlier referee's interim compensation and penalty awards; and (2) declined to award an additional penalty for SAIF's allegedly unreasonable claim processing. In his reply brief, claimant seeks administrative notice of "post-hearing" events. On review, the issues are administrative notice, claim processing and penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Procedural Background

Pursuant to a November 17, 1993 Opinion and Order, Referee Schultz directed the SAIF Corporation to accept claimant's current asthma and osteoporosis conditions, upheld SAIF's de facto denial of an aggravation claim for the asthma condition, awarded interim compensation for the period from January 27, 1992 until October 20, 1993, and assessed penalties and attorney fees for SAIF's unreasonable claim processing.

On October 23, 1993, SAIF requested review of Referee Schultz's order. On January 21, 1994, while SAIF's appeal was pending, SAIF issued a Notice of Closure that awarded neither temporary nor permanent disability. Thereafter, SAIF withdrew its request for review of Referee Schultz's order. On February 3, 1994, we issued an order dismissing SAIF's appeal.

SAIF refused to pay the interim compensation and the penalty awarded by Referee Schultz. Claimant requested a hearing, seeking to enforce Referee Schultz's interim compensation and penalty awards. Referee Neal declined to do so, reasoning that SAIF initially properly stayed payment of claimant's interim compensation pending its appeal of Referee Schultz's order. See ORS 656.313(1)(a).

In addition, Referee Neal held that SAIF was not required to pay the interim compensation awarded by Referee Schultz following the dismissal of its appeal, because SAIF issued a Notice of Closure (which awarded no time loss compensation) before it withdrew its request for review of Referee Schultz's order. In this regard, Referee Neal reasoned that the Notice of Closure "superseded" Referee Schultz's prior award and thus claimant's lack of substantive entitlement to time loss compensation obviated any previous procedural entitlement he may have had. In this manner, Referee Neal concluded that she could not enforce Referee Schultz's award, because doing so would create an overpayment. We disagree.

Administrative Notice

As a preliminary matter, we address claimant's request that we take administrative notice of an August 2, 1994 Order on Reconsideration (which set aside SAIF's January 21, 1994 Notice of Closure) and SAIF's request for hearing from that order. SAIF opposes claimant's motion on two bases.

First, SAIF contends that these matters are not properly subject to administrative notice. It acknowledges that the August 2, 1994 Order on Reconsideration set aside its Notice of Closure. However, because matters arising from the Order on Reconsideration have not been litigated, SAIF asserts that the effect of the order is "up in the air" and not beyond dispute. Under these circumstances, SAIF contends that the "facts" offered by claimant are not properly subject to official notice.

We may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned." Rodney J. Thurman, 44 Van Natta 1572 (1992). The Department's August 2, 1994 Order on Reconsideration in this case is an act of a state agency, which satisfies the aforementioned criteria. See Phyllis Swartling, 46 Van Natta 481 (1994). Similarly, the existence of a docketed appeal is a matter whose accuracy cannot reasonably be questioned. See Mark A. Crawford, 46 Van Natta 725, 727 (1994) (Although a Request for Hearing is not an agency order, it is a document which has procedural significance which enables an evaluation of the evidence); David Hill, 46 Van Natta 526 (1994). Accordingly, because the Order on Reconsideration and SAIF's request for hearing regarding that order meet the aforementioned standard, we take administrative notice of them.

In addition, for the same reasons, we take notice of the following additional post-hearing events in this case: Referee Hazelett's November 15, 1994 order (in WCB Case No. 94-09929) arising from SAIF's request for hearing contesting the August 2, 1994 Order on Reconsideration; SAIF's appeal of that order (which dismissed the request for hearing as untimely filed); its withdrawal of the appeal; and our eventual dismissal of that appeal, on December 7, 1994.

SAIF also argues that post-hearing events are not relevant to the present dispute. In this regard, SAIF contends that the earlier order of Referee Schultz (which awarded procedural time loss) is "superseded" by its Notice of Closure which established no substantive entitlement to time loss. Thus, according to SAIF, its appeal of the Order on Reconsideration is not relevant and the prior Referee's order is unenforceable. We disagree.

SAIF is correct that the open or closed status of the underlying claim determines whether the claim for temporary disability benefits is properly evaluated as substantive or procedural. See SAIF v. Taylor, 126 Or App 658 (1994). Therefore, contrary to SAIF's position on review, the outcome of litigation which decided whether the claim was properly closed is directly relevant to the present dispute. Accordingly, we are not persuaded by SAIF's arguments opposing claimant's request that we take administrative notice of the above-described post-hearing events.

Interim Compensation and Penalties

Inasmuch as SAIF abandoned its challenge to the Order on Reconsideration and our order dismissing SAIF's request for review on the timeliness issue is final, claimant's underlying claim is open (for purposes of evaluating time loss at this point) and the interim compensation awarded by Referee Schultz is properly characterized as procedural. Moreover, because a challenge to claimant's substantive entitlement to time loss benefits is not ripe under these circumstances, there is no danger of awarding a "procedural overpayment" of time loss benefits. See Galvin C. Yoakum, 44 Van Natta 2403, on recon 44 Van Natta 2492 (1992) (The mere possibility of an overpayment is not the same as imposition of an overpayment). The essential question is (as claimant contends) whether Referee Schultz's interim compensation and penalty awards are enforceable.

As we have stated, Referee Schultz's order is final as a matter of law. Any stay authorization SAIF may have had under ORS 656.313 ended when our Dismissal Order became final and no appeal of Referee Schultz's order to pay interim compensations was pending. See Lucille K. Johnson, 45 Van Natta 1678, 1679 (1993) ("In other words, claimant's compensation was no longer stayed when the Board's order became final.").

SAIF must comply with Referee Schultz's order for another, more fundamental reason. That is, because a Referee's final order has the force of law.

SAIF does not argue that Referee Schultz lacked authority to decide claimant's entitlement to interim compensation and penalties. It also does not challenge the finality of Referee Schultz's order directing it to pay both. Instead, SAIF contends that it should be allowed to disregard Referee Schultz's unambiguous order simply because its Notice of Closure (which awarded no temporary disability) "superseded" the Opinion and Order. In effect, SAIF asks us to ignore (or effectively reverse) Referee Schultz's order, just as it attempted to do through its own claim processing decisions. We decline to do as SAIF requests.

Our review is limited to Referee Neal's order, which, in turn, is limited to determining whether Referee Schultz's order is enforceable. See Kenneth W. McDonald, 45 Van Natta 1252, 1254 (1993). Thus, the issue is limited to enforcement of Referee Schultz's awards of interim compensation (not substantive temporary disability) and related penalties.

The law is well-settled in this area. See Mischel v. Portland General Electric, 89 Or App 140, 144 (1987) (Where the question was whether the employer could disregard the referee's order to pay temporary disability and unilaterally adjust the amount of its temporary disability payments, the answer was, "It could not." (citations omitted)). Once Referee Schultz issued a litigation order directing SAIF to pay compensation and penalties, no further mandate was a prerequisite to enforceability. Theodore W. Lincicum, 40 Van Natta 1953, 1955 (1988), aff'd mem, Astoria Oil Sevice v. Lincicum, 100 Or App 100 (1990) ("The order is enforceable upon issuance."). Accordingly, claimant is entitled to interim compensation/temporary disability for the period from January 27, 1992 to the date of hearing (October 20, 1993), as awarded by Referee Schultz's order.

Similarly, because Referee Schultz's entire order is final, SAIF may not relitigate matters finally determined by that order. Under these circumstances, Referee Schultz's penalty assessment is also presently enforceable.

SAIF's only explanation for failing to comply with Referee Schultz's order is its contention that claimant is not (substantively) entitled to temporary disability. As we have explained, we find no merit in SAIF's position. Moreover, considering the caselaw establishing that a valid final referee's order is enforceable, SAIF's "defense" does not persuade us that it had a legitimate doubt regarding its duty to comply with Referee Schultz's order. See Karen S. McKillop, 44 Van Natta 2473, 2474 (1992) ("The insurer's apparent belief that the award of interim compensation was made in error may be grounds for an appeal in the first proceeding. It is not, however, a legitimate basis for the failure to comply with the order").

Under these circumstances, claimant would be entitled to an additional penalty of 25 percent of amounts due under this claim (for unreasonable failure to comply with Referee Schultz's order, a processing infraction distinct from its failure to pay interim compensation before Referee Schultz's order), but for the fact that Referee Schultz already awarded a 25 percent penalty on the same amounts then due. See Patrick H. Smith, 45 Van Natta 2340 (1993) (Only one penalty may be assessed on a single amount due). However, SAIF's unreasonable failure to comply with Referee Schultz's order is a processing infraction separate and distinct from its failure to pay claimant's interim compensation before that order. Accordingly, claimant is entitled to an attorney fee award under ORS 656.382(1), for SAIF's unreasonable refusal to comply with the referee's order (i.e., to pay the compensation ordered by Referee Schultz. Id.; see Glen D. Roles, on remand, 45 Van Natta 282, 284-85 (1993) (We decline to provide sanctuary for conduct which essentially defies the clear directive of a Referee's order); Oscar L. Drew, 38 Van Natta 934, 936 (1986).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services concerning SAIF's unreasonable refusal to pay claimant's compensation 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 appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 2, 1994 is reversed. The SAIF Corporation is directed to pay interim compensation and penalties as ordered by Referee Schultz's November 17, 1993 Opinion and Order. In addition, SAIF is directed to pay a penalty-related attorney fee of $1,000 to claimant's attorney.

In the Matter of the Compensation of
MARIE E. KENDALL, Claimant
WCB Case No. 93-10201
ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
J. Michael Casey (Saif), Defense Attorney

On January 20, 1995, we withdrew our December 29, 1994 Order on Review that: (1) concluded that the SAIF Corporation had no authority to terminate claimant's temporary disability benefits; and (2) awarded a 25 percent penalty for SAIF's unreasonable termination of temporary disability benefits. We took this action to further consider SAIF's contention that our decision was erroneous. Having received claimant's response, we proceed with our reconsideration.

To begin, claimant opposes SAIF's motion for reconsideration on procedural grounds. Claimant contends that it is unreasonable for SAIF to waive filing a respondent's brief to the Board and then to file a motion for reconsideration after the Board's order has issued. Claimant has not cited any authority for her argument that SAIF should be precluded from requesting reconsideration because it did not file a respondent's brief. Since SAIF has timely requested reconsideration of our order, and because the request contests findings and conclusions contained in that decision, we are authorized to consider SAIF's arguments. See Anthony Foster, 45 Van Natta 1997 (1993).

In our previous order, we held that, when SAIF provided notice to claimant of a modified job offer that did not reflect the duration of the job, SAIF was not entitled to terminate claimant's temporary total disability (TTD) when she failed to begin the modified job. Former OAR 436-60-030(5)(c) provided that the carrier's notice must include "the duration of the job, if known." In the event that the specific duration of the job was unknown to the carrier, we concluded that the rule mandated that claimant receive notification of that fact. We held that the employer's mere reference to a "temporary modified position" did not comply with the strict procedural requirements of the administrative rule.

SAIF contends that our order contradicts William J. Wilson, 43 Van Natta 288 (1991), rev'd on other grounds, Roseburg Forest Products v. Wilson, 110 Or App 72 (1991), on remand 44 Van Natta 724 (1992). In Wilson, the employer had offered the claimant physician-approved modified work. When the claimant arrived at the designated job site, he encountered a labor dispute and refused to cross the picket line. The issue before us was whether the claimant's failure to report for work was a "refusal" of employment within the meaning of former OAR 436-60-030(5). We concluded that the claimant did not "refuse" employment and, therefore, it was improper to terminate the claimant's TTD benefits. The Court of Appeals subsequently reversed our decision.

In Wilson, we also noted that the employer had not indicated the duration of the modified job offer and we commented that the employer had complied with the procedural requirements of the rule. Inasmuch as our decision in Wilson was not based on procedural grounds, SAIF's reliance on our comment is misplaced, because, as SAIF acknowledges, that comment was dicta.

For the reasons discussed in our previous order, we adhere to our conclusion that SAIF was not authorized to terminate claimant's TTD benefits. Strict compliance with the procedural requirements of the administrative rule is required before a carrier is authorized to terminate TTD benefits. See Fairway Care Center v. Douglas, 108 Or App 698 (1991); Safeway Stores, Inc. v. Little, 107 Or App 316 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

Former OAR 436-60-030(5)(c) provided that the carrier's notice must include "the duration of the job, if known." The rule is clear and specific in what is required before an employer may unilaterally terminate TTD benefits. The purpose of requiring the employer to notify a claimant of the duration of a job is to sufficiently apprise the claimant of the modified job offer. Since SAIF's notice merely referred to a "temporary" job, we reasoned that the notice neither specified the duration of the job nor whether the employer knew the duration of the job. We found, and on reconsideration we continue to find, that the record could support a conclusion that the position existed as long as the worker was restricted to modified work. See Marie E. Kendall, 46 Van Natta 2520, 2521 n.2 (1994). In other words, the employer could have complied with former OAR 436-60-030(5)(c) by informing claimant that the job would last as long as claimant required modified work. On reconsideration, we adhere to our conclusion that the notice's mere reference to a "temporary modified position" did not constitute compliance with the strict procedural requirements of the administrative rule.

SAIF argues that, in any event, the penalty for unreasonable termination of TTD benefits was not warranted. A penalty may be assessed when a carrier "unreasonably delays or refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

SAIF asserts that a carrier does not act unreasonably when it has relied on a previous Board decision to make claim processing decisions. Although the comments expressed in Wilson were dicta, they do support a conclusion that a carrier is not required to include in its modified work offer a statement regarding whether the job duration is known or unknown. Moreover, it was not until issuance of our initial opinion in this case that the meaning of the "duration" portion of former OAR 436-60-030(5)(c) was clarified. Under these circumstances, we conclude that SAIF's termination of temporary total disability payments was reasonable and that a penalty is not warranted. See 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). Consequently, we withdraw that portion of our prior decision which assessed a penalty for unreasonable claim processing.

Accordingly, on reconsideration, as modified herein, we republish our prior order effective this date. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAIGE McCULLOCH, Claimant
WCB Case No. 92-13189
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of Referee Mongrain's order that upheld the insurer's "back-up" denial of her aggravation claim for a right shoulder condition. On review, the issues are the propriety of the "back-up" denial and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

On review, claimant contends that she did not make a material misrepresentation to the insurer sufficient to support its "back-up" denial of her aggravation claim. Specifically, claimant argues that she was not directly asked about her competitive team penning activities and that her failure to volunteer this information does not constitute a material misrepresentation.

Claimant asserts that the Referee should have accepted her testimony and that of her mother that the examining physicians asked her only about housekeeping activities. Although the Referee stated that all witnesses appeared credible based on demeanor, for other reasons, the Referee chose not to believe the testimony of claimant and her mother that Drs. Marble (orthopedic surgeon) and Lohman (orthopedic surgeon) asked her only about housekeeping activities. In reaching his conclusion, the Referee relied primarily on the report of Dr. Marble and Dr. Lohman which contained the insurer's specific direction to: "[p]lease question the worker as to her everyday activities. Where does she spend her time? What does she do?" (Ex. 14-6).

In their July 16, 1992 report, Drs. Marble and Lohman indicated that they obtained little information about claimant's everyday activities and that it appeared that claimant had been relatively inactive for the last three months. (Ex. 14-6). Although not expressly stated by Drs. Marble and Lohman, the Referee concluded that it was probable that they questioned claimant concerning all of her off-work activities, not merely those activities associated with housekeeping. Based on that supposition, the Referee concluded that claimant's failure to discuss her competitive horseback riding with Drs. Marble and Lohman was a material misrepresentation.

Inasmuch as the record does not reveal whether Drs. Marble and Lohman actually inquired into the extent of claimant's off-duty horseback riding activities, we do not adopt the Referee's supposition. Nonetheless, we find that claimant made misrepresentations regarding her off-duty activities.

Specifically, claimant presented herself to Dr. Weinman with renewed shoulder complaints on April 9, 1992. Seventeen days later, on April 26, 1992, she entered a team horseback riding competition. Claimant was subsequently interviewed by Ms. Godin, the insurer's representative, on May 14, 1992. When questioned about her skiing and horseback riding hobbies, claimant characterized her current activities as "quite limited." (Tr. 22, 25-31). However, claimant's representation to Ms. Godin does not reconcile itself with the extrinsic evidence of her recent participation in competitive team horseback riding. At that April 1992 competition, claimant entered at least five events.[1] (Exs. 12A, 12B).

Consequently, we must determine whether claimant's statement to Ms. Godin manifests a material misrepresentation that could reasonably have affected the insurer's July 27, 1992 decision to accept her aggravation claim. See Ebbtide Enterprises v. Tucker, 303 Or 459 (1987).

In Ebbtide, the Supreme Court addressed the circumstances under which a "back-up" denial is properly issued. Specifically, the measure of materiality for justifying a "back-up" denial is whether the insurer has proven by a preponderance of the evidence that its decision to accept a claim could reasonably have been affected had it known of the fraud, misrepresentation or illegal activity. Ebbtide Enterprises v. Tucker, at 464. In conducting our review, we must first determine whether there has been fraud, misrepresentation or illegal activity. It is only if we answer this first issue affirmatively that we proceed to determine if the decision to accept could reasonably have been affected.

As an initial matter, we conclude that claimant's failure to disclose the extent of her horseback riding activities to Ms. Godin constituted a willful misrepresentation. Cf. Tom C. Reeves, 38 Van Natta 31 (1986) (Where the claimant's misrepresentation to the insurer was caused by following his supervisor's instructions, the Board held that the misrepresentation was not willfully negligent and set aside the insurer's "back-up" denial.) Claimant's failure to reveal that she had been engaged in competitive horseback competitions only two weeks earlier was more than negligent. See Andy J. Wright, 42 Van Natta 522 (1990) (Inasmuch as the claimant and his father had signed documents characterizing their business as a sole proprietorship when they knew it was a partnership, the Board found the claimant acted in a manner that was more than negligent and constituted a misrepresentation.) Thus, claimant's statement to Ms. Godin that she was "quite limited" in her horseback riding activities was an affirmative, misleading, declaration regarding her physical capacity; and, therefore, a misrepresentation. See Randy G. Harbo, 45 Van Natta 1676 (1993) (Board held that the claimant's failure to disclose a preexisting shoulder condition was a misrepresentation intended to induce the employer to accept his claim for that condition).

Next, in order to sustain a "back-up" denial based on claimant's misrepresentation, the insurer must prove by a preponderance of the evidence that it might not have accepted the claim had it known of the misrepresentation. Cf. Liberty Northwest Insurance Corp. v. Salyers, 91 Or App 538 (1988) (Where the claimant subsequently admitted an off-the-job incident, but maintained that his injury initially occurred at work, the court found that the carrier had failed to sustain its burden of proof that the claimant's misrepresentations could have reasonably affected its decision to accept the claim); but

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[1] There is evidence that claimant participated in at least two other competitions in June and August of 1992. However, for the purposes of determining whether claimant made a material misrepresentation to Ms. Godin concerning her horseback riding activities prior to the insurer's July 27, 1992 acceptance, only the April 26, 1992 competition prior to that interview has probative value.

see, Newport Elks Club v. Hays, 92 Or App 604, 607 (1988) (Where the claimant provided inconsistent histories to her treating physicians, one of which did not indicate that an industrial injury had occurred, the court upheld a "back-up" denial, reasoning: "it requires no elaboration to conclude that employer's acceptance could have been influenced by having the information that no industrial injury had occurred.")

Lastly, 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).

The persuasive medical evidence indicates that claimant could not have participated in the April 1992 horseback riding competition if her physical capacity was actually limited. Dr. Woolpert (orthopedic surgeon) and Dr. Marble are the only examining physicians in the record with a history of claimant's competitions. See Somers v. SAIF, 77 Or App 259 (1986). Based upon claimant's demonstrated abilities in those competitions, Dr. Woolpert opined that claimant had not sustained a worsening of her condition in April 1992 and was capable of performing her regular work. (Exs. 24-2, 25-9). Similarly, Dr. Marble opined: "I think it unlikely that [claimant] had a medical problem sufficiently severe to preclude working at her [job-at-injury] if she were able to ride competitively." (Ex. 17-2). Therefore, relying upon the opinions of Drs. Woolpert and Marble, we find that claimant made a material misrepresentation to Ms. Godin when she indicated that she was "quite limited" in her ability to ride horses.

Finally, we are persuaded that knowledge of claimant's competitive penning activities while she was off-work due to the alleged aggravation could reasonably have affected the insurer's decision to accept the claim. Claimant successfully participated in at least five horseback riding events during the April 1992 competition, but approximately two weeks later told Ms. Godin that she was "quite limited" in her capacity to ride horses. The insurer's claims examiner (Mr. Swan) testified, without contradiction, that knowledge of claimant's competitions could have affected the insurer's July 27, 1992 decision to accept her aggravation claim. (Tr. 36-37). Under these circumstances, we find that claimant made a material misrepresentation that could have reasonably affected the insurer's decision to accept her aggravation claim. See Ebbtide Enterprises v. Tucker, supra.

Accordingly, we hold that the insurer's "back-up" denial was appropriate. Turning to the compensability of claimant's aggravation claim, we adopt the Referee's finding that claimant failed to prove the compensability of her aggravation claim. See Tony N. Bard, supra.

ORDER

The Referee's order dated January 18, 1994, as supplemented January 19, 1994, is affirmed.

March 2, 1995 Cite as 47 Van Natta 338 (1995)

In the Matter of the Compensation of
TROY A. ROBERTSON, Claimant
WCB Case No. 94-04071
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Hoguet's order which: (1) declined claimant's request to postpone or continue the hearing to secure the testimony of claimant's co-worker; and (2) upheld the SAIF Corporation's denial of claimant's injury claim for facial injuries. On review, the issues are the Referee's procedural ruling and compensability.

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

Claimant contends that the Referee's findings of fact are erroneous because the Referee summarily rejected all of the hearing testimony in lieu of prior "out-of-court" statements. We do not agree. In addition to considering the contemporaneous statements of claimant and the co-worker involved in the fight, the Referee specifically relied on the testimony of another co-worker (a "third-party" witness) who witnessed the incident in reaching his conclusion that claimant was an active participant in an assault or combat. Furthermore, after our de novo review of the entire record, we agree with the Referee's reliance on the "third party" witness.

Claimant also contends that the Referee abused his discretion in failing to grant claimant's request for a continuance. We disagree.

Claimant's hearing request was received on April 1, 1994. A hearing was set for June 24, 1994, and the hearing was held on that date. On the morning of the hearing, claimant's attorney sought to serve a subpoena on an allegedly material witness who worked for the employer. Claimant was not able to serve the subpoena because the worker could not be located, and claimant contends that the employer intentionally misled claimant concerning the whereabouts of the witness. Therefore, claimant requested that the Referee grant a continuance of the hearing.

The Referee may continue a hearing "[u]pon a showing of due diligence if necessary to afford reasonable opportunity * * * for a party to respond to an issue raised for the first time at a hearing" or for "any reason that would justify postponement of a scheduled hearing under 438-06-081." OAR 438-06-091(3) and (4). The Referee shall not postpone a hearing except upon a finding of extraordinary circumstances beyond the control of the party. OAR 438-06-081. Incomplete case preparation is not grounds for postponement unless the Referee finds that completion of the record could not be accomplished with due diligence. OAR 438-06-081(4). The language in OAR 438-06-091 is permissive and the authority to continue a hearing is within the Referee's discretion. Nina J. Butler, 46 Van Natta 523 (1994).

Here, the Referee was not persuaded that claimant had been intentionally misled by the employer, and further found that there was no indication that the witness would provide relevant testimony. (Tr. 117-118). Moreover, the Referee concluded that claimant's decision to attempt to subpoena a witness the morning of the scheduled hearing did not constitute an extraordinary circumstance to warrant a continuance. See Gordon P. Kight, 46 Van Natta 1508, 1509 (1994) (on remand) (unavailability of an unsubpoenaed witness not an extraordinary circumstance). In light of these circumstances, conclude that the Referee did not abuse his discretion by declining to grant a continuance of the hearing. See OAR 438-06-081.

ORDER

The Referee's order dated July 13, 1994 is affirmed.

March 2, 1995 Cite as 47 Van Natta 339 (1995)

In the Matter of the Compensation of
MICHELE S. THOMAS-FINNEY, Claimant
WCB Case No. 93-13163
ORDER OF ABATEMENT
Pozzi, Wilson, et al., Claimant Attorneys
Moscato, Byerly, et al., Defense Attorneys

The self-insured employer requests abatement and reconsideration of our February 1, 1995 Order on Review that: (1) found claimant medically stationary on August 19, 1993; (2) found that claimant was entitled to substantive temporary disability benefits through August 19, 1993; (3) denied the employer's request to offset any portion of temporary disability benefits it paid between November 6, 1992 and September 3, 1993; and (4) affirmed the Referee's award of scheduled permanent disability. In its request, the employer asserts that, inasmuch as we found claimant medically stationary and entitled to temporary disability through August 19, 1993, we improperly denied its request to offset temporary disability benefits it paid from August 20, 1993 to September 3, 1993.

In order to allow sufficient time to consider the motion, we withdraw our February 1, 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.

March 2, 1995 Cite as 47 Van Natta 340 (1995)

In the Matter of the Compensation of
RICK C. WERTMAN, Claimant
WCB Case Nos. 93-13711, 93-08253, 93-10058, 93-11134, 93-14931 & 93-14930
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
William J. Blitz, Defense Attorney
Lundeen, et al., Defense Attorneys
Kevin L. Mannix, PC, Defense Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Whitaker Equipment and Haul (Whitaker), requests review of those portions of Referee Spangler's order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for bilateral carpal tunnel syndrome; (2) upheld Liberty's denial of responsibility, on behalf of Beaver State Ready-Mix, for the same condition; (3) upheld Liberty's denial of responsibility, on behalf of McGovern Metals Company, for the same condition; (4) upheld the SAIF Corporation's denial of responsibility, on behalf of Terrain Tamers, for the same condition; (5) upheld Liberty's denial of responsibility, on behalf of Terrain Tamers, for the same condition; and (6) upheld SAIF's denial of responsibility, on behalf of Whitaker, for the same condition. On review, the issues are responsibility and disclaimer notice. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

Claimant, a truck driver, has an accepted bilateral carpal tunnel condition, which was accepted by Liberty, on behalf of McGovern Metals, in April 1988. Claimant has changed employers several times. In April 1993, claimant was examined by Dr. Hayes and tests disclosed a "serious progression" in claimant's bilateral carpal tunnel syndrome (CTS).

The Referee found that claimant met his burden of proving compensability of the worsening of bilateral CTS. The Referee concluded that Liberty, on behalf of Whitaker, was barred from asserting responsibility as a defense because it failed to comply with the disclosure requirements of ORS 656.308(2). Alternatively, the Referee concluded that, under the last injurious exposure rule, Liberty (Whitaker) was responsible for claimant's current condition. Liberty, on behalf of Whitaker, argues that the Referee erred by concluding that ORS 656.308(2) barred it from asserting responsibility as a defense and also erred by concluding that it was the responsible carrier.

ORS 656.308(1) applies if a worker sustains a "new compensable injury" involving the same condition as that previously processed as part of an accepted claim. SAIF v. Yokum, 132 Or App 18 (1994). Responsibility is then assigned to the carrier with the most recent accepted claim for that condition. Smurfit Newsprint v. DeRosset, 118 Or App 368, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

In April 1988, Liberty, on behalf of McGovern Metals, accepted claimant's claim for bilateral CTS as a nondisabling injury. Inasmuch as claimant's current condition involves bilateral CTS, we conclude that it is the "same condition" as that which Liberty (McGovern Metals) accepted in 1988. See Smurfit Newsprint v. DeRosset, supra. Accordingly, ORS 656.308(1) applies.

ORS 656.308 is also intended to encompass occupational disease claims . Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993). Thus, in order to establish a new occupational disease, the carrier with an accepted claim has the burden of establishing that subsequent work activities were the major contributing cause of the claimant's disease or its worsening. See ORS 656.802(2); Senters, supra; Steven K. Bailey, 45 Van Natta 2114 (1993).

Here, because of the various possible causes of claimant's current bilateral CTS condition, including the prior compensable occupational disease and his continued work activities, we find that the causation issue is a complex medical question requiring expert medical opinion to resolve. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Dr. Patterson, a neurologist, performed nerve conduction studies on claimant in April 1988 and on May 19, 1993. In April 1988, Dr. Patterson reported that claimant had bilateral CTS, right more than left. (Ex. 5). In May 1993, Dr. Patterson reported that claimant had severe bilateral CTS and there had been "serious progression" since his previous examination. (Ex. 12). Dr. Patterson concluded that there was worsening in the electrophysiologic evidence for a CTS between the dates of the two examinations. (Ex. 31). Dr. Patterson reported that truck driving, in general, can worsen bilateral CTS.

Dr. Brown, a neurologist, and Dr. Donahoo, an orthopedic surgeon, examined claimant on behalf of Liberty on May 28, 1993. They reported that claimant had a worsening subjectively and objectively of his hands since March 1988. (Ex. 13). Furthermore, they reported that claimant's work activity was the major contributing cause of his symptoms. Dr. Hayes, an orthopedic surgeon, concurred with their report. (Ex. 14). In a deposition, Dr. Hayes said that the worsening in claimant's condition was due to subsequent work activities between 1988 and 1993. (Ex. 36).

Based on this evidence, we find claimant's current bilateral CTS condition to be a pathological worsening of the original occupational disease since Liberty (McGovern Metals) accepted the CTS claim in April 1988. We further find that the major contributing cause of this worsening was the subsequent work activities. Therefore, we find that Liberty, on behalf of McGovern Metals, has carried its burden of proving a "new occupational disease," and thus, responsibility for claimant's CTS condition shifts. See ORS 656.308(1).

Because there are several potentially responsible carriers for the "new" occupational disease claim for claimant's CTS condition and none have accepted the claim, it remains for us to determine which carrier is responsible for that condition. To resolve that question, we apply the last injurious exposure rule, which governs the initial assignment of responsibility for conditions that have not been previously accepted. See Steven K. Bailey, supra.

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); Steven K. Bailey, supra. The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

Liberty, on behalf of Whitaker, 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 his work activities as a truck driver with Terrain Tamers during the time it was Liberty's insured. 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); Maria Gonzales, 46 Van Natta 466 (1994).

Here, claimant relies on the last injurious exposure rule. Both Drs. Hayes and Patterson reported that since no nerve conduction studies were taken between 1988 and 1993, they could not pinpoint when claimant's CTS condition objectively worsened. (Exs. 31, 36-16, 36-17, 36-21). Although Drs. Brown and Donahoo apportioned 50 percent of the responsibility to Terrain Tamers (Liberty), they did so on the basis of claimant's history and they acknowledged there was no specific method to measure the progression of his symptoms. (Ex. 13). We conclude that actual causation has not been

established. Therefore, it is necessary to rely on the last injurious exposure rule to determine responsibility.

We agree with the Referee that responsibility is properly assigned to Liberty, on behalf of Whitaker, because claimant was working for Liberty's insured (Whitaker) when he first sought treatment for his "new" bilateral CTS condition. See Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Generally, the carrier which is initially assigned responsibility can shift responsibility to a prior carrier by showing that claimant's work exposure while a prior carrier was on the risk was the sole cause of claimant's condition, or that it was impossible for conditions while the assigned carrier was on the risk to have caused the current condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374 (1984), mod 73 Or App 223, rev den 299 Or 203 (1985). Here, however, the Referee held that Liberty (Whitaker) could not assert responsibility as a defense because it had failed to issue a timely disclaimer pursuant to ORS 656.308(2). Liberty (Whitaker) contends that ORS 656.308(2) does not bar a party that did not issue a timely disclaimer from asserting responsibility as a defense when claimant has filed a claim against the other carriers. We disagree.

ORS 656.308(2) provides that an insurer which intends to disclaim responsibility "shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim." (Emphasis added). If an insurer has given proper notice, 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." (Emphasis added).

In Donald A. James, 46 Van Natta 1898 (1994), the carrier argued that the claimant was not prejudiced by its untimely disclaimer of responsibility since all potentially responsible insurers were joined as parties to the proceeding. We held that a carrier which does not comply with the disclaimer requirements is precluded from asserting a responsibility defense. We concluded that, under ORS 656.308(2), prejudice to the claimant was not relevant to the analysis.

We reach the same conclusion in this case. Liberty, on behalf of Whitaker, stipulated that it did not issue a timely disclaimer of responsibility pursuant to ORS 656.308(2). Under ORS 656.308(2), a carrier which has failed to issue a proper disclaimer is precluded from asserting as a defense that the actual responsibility lies with another employer or insurer. See Donald A. James, supra. Here, the fact that claimant has filed a claim against the other carriers is not relevant to the analysis.

Liberty (Whitaker's) failure to comply with the disclaimer notice of ORS 656.308(2) precludes it from asserting as a defense that actual responsibility lies with another employer or insurer. Therefore, we conclude that Liberty (Whitaker) is responsible for claimant's bilateral CTS condition.[1]

Although compensability was not raised as an issue on review, it was an issue addressed in the Referee's order. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod 119 Or App 447 (1993). Consequently, claimant is entitled to an assessed fee for the services of his attorney on review. ORS 656.382(2).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by Liberty Northwest Insurance Corporation, on behalf of Whitaker Equipment and Haul. 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 30, 1994 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by Liberty Northwest Insurance Corporation, on behalf of Whitaker Equipment and Haul.

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[1] We note that, in any event, the evidence does not establish that a prior carrier was the sole cause of claimant's condition or that it was impossible that work activities during Liberty (Whitaker)'s coverage could have caused the condition. See FMC Corp. v. Liberty Mutual Ins. Co., supra. Accordingly, even if Liberty (Whitaker) had issued a timely disclaimer under ORS 656.308(2), responsibility for claimant's "new occupational disease" would remain with Liberty (Whitaker).

In the Matter of the Compensation of
MONTY R. DAVIS, Claimant
WCB Case No. 94-02630
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Spangler's order that upheld the insurer's denial of claimant's 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 comment.

Based on demeanor, the Referee found that claimant was a credible and reliable witness. We defer to that finding. See Bush v. SAIF, 68 Or App 230, 233 (1984). However, noting the absence of the November 1, 1993 off-work incident that precipitated claimant's pain in the history obtained by attending physician Brooks, the Referee found that claimant had not presented persuasive evidence of medical causation. On review, claimant relies on his credible testimony to establish that Dr. Brooks was aware of the off-work incident.

At hearing, counsel asked claimant if he had related the same information to Dr. Brooks to which he testified. Claimant could only respond: "I believe so." Thus, although claimant is credible, we find that his equivocal response coupled with such a significant omission in Dr. Brooks' chart notes tends to demonstrate that claimant did not relate his complete history to the doctor.

In order to find that Dr. Brooks had a complete and accurate history, we would have to assume that which is not evident in the record. We are not willing to do so. Accordingly, we find that claimant has not met his burden of proving that his work activities were the major contributing cause of his low back condition. See, e.g., Pamela A. Burt, 46 Van Natta 415 (1994) (Finding a doctor's opinion not sufficient to meet the claimant's burden of proof where there was no indication that the doctor was aware of, and therefore, was precluded from considering, other activities that could have contributed to the claimant's condition).

ORDER

The Referee's order dated June 16, 1994 is affirmed.

In the Matter of the Compensation of
SAMUEL MARTINEZ, Claimant
WCB Case No. 93-14145
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
James D. Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

The SAIF Corporation requests review of that portion of Referee T. Lavere Johnson's order which set aside its denial of claimant's claim for an electrical shock injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The parties stipulated that claimant received an electrical shock in the course and scope of his employment; that claimant experienced symptoms which he felt were related to the electrical shock; that claimant sought treatment for symptoms he experienced after the electrical shock; and that claimant does not contest the compensability of the specific condition denied by SAIF (tinnitus labyrinthitis). (Tr. 3). The dispute was submitted to the Referee based on the evidentiary record, the above stipulations and the arguments of counsel.

Claimant first sought medical treatment 10 days after his electrical shock, reporting that he had ringing in his ear. (Ex. 2). Claimant also stated that he had experienced dizziness after the electrical shock, but that this had gone away. Dr. Miller diagnosed tinnitus labyrinthitis of the ear, which the parties as well as Dr. Miller agree was not related to the electrical shock. (Ex. 4).

SAIF denied claimant's tinnitus labyrinthitis condition on October 15, 1993. However, the denial letter stated that SAIF would pay for Dr. Miller's treatment to the date of the denial on a diagnostic basis since it was appropriate for claimant to see a physician. (Ex. 3).

Dr. Miller subsequently agreed that, while it was "possible" for an electrical shock to produce a ringing in the ear, the shock was not a material cause of the labyrinthitis condition. (Ex. 4). Dr. Miller also agreed that, when examined, claimant's ears were plugged, but that this was not caused by the electrical shock. (Id.) Dr. Miller later acknowledged that it was reasonable for claimant to have sought medical treatment to determine the severity of his electrical shock, which was a material contributing factor in claimant's having received treatment. (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the denial of claimant's tinnitus labyrinthitis condition pursuant to the parties' stipulation. However, the Referee set aside SAIF's denial to the extent that it denied diagnostic medical services for claimant's alleged electrical shock injury. Reasoning that claimant experienced symptoms of dizziness and ringing in his ears after the electrical shock, for which Dr. Miller provided medical services, the Referee concluded that the electrical shock was causative of claimant seeking medical services. Thus, the Referee concluded that claimant had proved that he sustained a compensable injury.

On review, SAIF contends that the Referee erred in finding that claimant proved a compensable injury, citing Daniel L. Hakes, 45 Van Natta 2351 (1993). We agree with SAIF's contention.

In Hakes, the Referee set aside the employer's denial of a claim for blood exposure. There, the claimant, a pilot for an air ambulance company, had got blood on his hands while unloading a trauma patient. The claimant sought medical treatment for a variety of complaints, which his physician reported were unrelated to his blood exposure.

We reversed the Referee and reinstated the employer's denial, reasoning that, while claimant was exposed to blood, there was no evidence that claimant had been injured by his exposure or had a disease. We noted that ORS 656.005(7) had been amended, but that the requirement of an injury had not been eliminated.

The facts of this claim are similar. Claimant here experienced symptoms following his electrical shock, prompting him to seek medical services. However, the record indicates that claimant's dizziness resolved prior to his seeking medical services. Dr. Miller stated that it was only "possible" that an electrical shock could produce ringing in the ears. As was the case in Hakes, there is no medical evidence, to a degree of medical probability, that the symptoms claimant experienced after the shock were related to that incident. There is also no evidence that claimant was injured as a result of the electrical shock, although he reported symptoms after it occurred. The only condition that Dr. Miller diagnosed, tinnitus labyrinthitis, is not related to the electrical shock, both according to Dr. Miller and the express stipulation of the parties.

Therefore, while claimant did experience an electrical shock, and may have believed that he required medical services, he has not established that he was injured or sustained physical damage as a result of the shock. Therefore, we do not find that he sustained a compensable injury. See Johnsen v. Hamilton Electric, 90 Or App 161, 164 (1988) (compensable claim requires that there be an injury or disease; employer may pay for diagnostic services without accepting a claim.); Cf. Finch v. Stayton Canning Co., 93 Or App 168, 173 (1988) (diagnostic medical services compensable when medical evidence established that claimant suffered from a disease related to her employment). Thus, we reverse the Referee's decision on this issue and reinstate SAIF's denial in its entirety.

ORDER

The Referee's order dated June 21, 1994 is reversed in part and affirmed in part. That portion of the SAIF Corporation's denial which denied an electrical shock injury is reinstated and upheld. The Referee's $1,250 assessed attorney fee is also reversed. The remainder of the order is affirmed.

March 3, 1995 Cite as 47 Van Natta 345 (1995)

In the Matter of the Compensation of
HOWARD L. ROSE, Claimant
WCB Case No. 93-12264
ORDER ON REVIEW
Schneider, Hooten, et al., Claimant Attorneys
Steven D. Hallock, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Brown's order which declined to award an attorney fee under ORS 656.386(1) for claimant's counsel's services in obtaining the insurer's "pre-hearing" rescission of its denial of claimant's low back condition. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

Claimant has an accepted low back condition for an L5-S1 fusion. On May 6, 1993, the insurer issued a disclaimer of responsibility for treatment at L4-5 after an intervening injury in late 1992. Claimant requested a hearing.

At hearing on August 12, 1993, the insurer confirmed that the only issue was responsibility. (Ex. 4). On September 13, 1993, the Referee subsequently issued an order finding the insurer responsible for claimant's low back treatment after September 19, 1992. However, on August 27, 1993, prior to the issuance of the Referee's September 13, 1993 Opinion and Order, the insurer had issued another denial of responsibility and compensability for claimant's current low back treatment. (Ex. 3).

On October 14, 1993, claimant filed a hearing request concerning the August 27, 1993 denial. On December 1, 1993, the insurer withdrew its August 27, 1993 denial. (Ex. 9). A hearing on the record was held concerning entitlement to an attorney fee for obtaining a rescission of the August 27, 1993 denial.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's attorney was instrumental in obtaining rescission of the insurer's "responsibility" denial. However, the Referee further concluded that, because the August 1993 denial only denied responsibility, claimant's attorney was not instrumental in obtaining compensation. Therefore, the Referee did not award an attorney fee under ORS 656.386(1). We disagree.

At the initial hearing, the Referee addressed only the issue of responsibility, and the insurer was found responsible for claimant's condition. However, subsequent to the responsibility hearing, the insurer issued a denial of compensability and responsibility.

Specifically, the denial stated:

> "It appears that on September 19, 1992 while you were at work at the [new employer's], * * * you strained your back.
>
> Although we admit that the new injury is compensable because it did occur while you were on the job, we do deny responsibility because this was a new injury * * *."

In Linda K. Ennis, 46 Van Natta 1142 (1994), we held that the claimant was entitled to a ".386(1)" attorney fee because the responsibility disclaimer/denial letter did not expressly concede or address compensability, did not request the designation of a paying agent, contained "notice of hearing" provisions consistent with a denial of compensation, and denied the claimant's claim for benefits.

We find this case to be analogous to Ennis. Here, although the insurer's letter specifically admits that claimant's new injury is compensable, we interpret the statement to refer to being compensable as a new injury with the second employer, not compensable as to the aggravation insurer. Furthermore, the insurer did not expressly concede the compensability of claimant's aggravation claim. Finally, the insurer did not request a paying agent, and the disclaimer/denial contained "notice of hearing" provisions consistent with a denial of compensation. Accordingly, we conclude that the insurer's denial was also a denial of compensability as well as responsibility.

In reaching our conclusion, we distinguish James McGougan, 46 Van Natta 1639 (1994). In McGougan, we found that the claimant's counsel was not entitled to a carrier-paid fee under ORS 656.386(1) where the carrier had only denied responsibility and not compensability. In McGougan, the carrier's denial letter expressly stated that the claimant's claim was compensable, that it was only denying responsibility, and that a paying agent would be requested pursuant to ORS 656.307. Reasoning that compensability was not at issue, we held that ORS 656.386(1) was not applicable. James McGougan, supra.

Here, contrary to McGougan, the insurer's letter referred to compensability only in terms of a new injury with the second employer; there was no express concession of compensability of the aggravation claim; and the insurer did not request a paying agent. Accordingly, we find McCougan to be distinguishable.

Inasmuch as claimant's attorney was instrumental in securing the rescission of the compensability denial by requesting a hearing, we conclude that claimant is entitled to an insurer-paid attorney fee award under ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services in securing the "pre-hearing" rescission of the compensability denial is $300, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the recission issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated. Claimant is not entitled to an attorney fee award for services related to securing his attorney fee award for the rescinded compensability denial issue. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated July 20, 1994 is reversed. For services at hearing, claimant is awarded an assessed attorney fee of $300, payable by the insurer.

In the Matter of the Compensation of
FOU S. SAECHAO, Deceased, Claimant
WCB Case No. 93-03608
ORDER ON REVIEW
Stephen V. Piucci, Claimant Attorney
Shannon, et al., Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Gunn and Turner-Christian.

The decedent's beneficiary requests review of that portion of Referee Hazelett's order which: (1) found that the decedent's death did not arise in the course and scope of his employment; and (2) reversed a Determination Order which had awarded death benefits. Sunny's Market, the noncomplying employer, cross-requests review of that portion of the order that found the decedent to be a subject worker. In its brief, the employer objects to the admission of Exhibit 8, a transcript of the SAIF Corporation's investigator's interview with the noncomplying employer. On review, the issues are evidence, subjectivity and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of his second finding of ultimate fact. We supplement as follows.

Sunny's Market is a convenience store owned and operated by a husband and wife, Kyung Duk Son (Sonny) and Jum Chun Son (Angela). (Ex. 6).

Three years previously, the Oregon Liquor Control Commission refused to renew the liquor license of the prior business on the same premises. That rejection had been based on neighbors' complaints of drug dealers and prostitutes who practiced their trade in the parking lot. Since Sonny had begun operating the business, the neighborhood had continued to experience armed robberies and parking lot squabbles. (Ex. 4A-2).

The business premises had a front entrance, where the cash register is located, and a rear entrance that opened into the stockroom. The rear entrance was protected from intruders by a door with a metal bar and a screen as well as a guard dog. (Tr. 38, 39).

On May 22, 1992, the decedent, a stock clerk, arrived for work at 5:30 p.m. At about 8:20 p.m., a man entered the store carrying a .22 caliber rifle. Sonny was in front at the cash register. The decedent had just come out of the storeroom in the back of the store and started to do some cleaning. He moved a trash can out of the aisle next to the pop machines. The assailant looked at Sonny, walked past to where the decedent was working, said a few words to the decedent, and shot him twice. The assailant then fled the store. The decedent died of the gunshot wounds several hours later. (Exs. 1, 2, 3, and 4).

The assailant is a suspect in one other homicide and a burglary/attempted homicide. In neither case did the assailant know the victim. (Tr. 57).

The employer was not covered by workers' compensation insurance until May 30, 1992. (Ex. 6).

On November 23, 1992, the decedent's beneficiary filed a workers' compensation claim. (Ex. 5).

On December 30, 1992, the Department issued a Proposed and Final Order of Noncompliance during the period from May 8, 1992 to May 30, 1992 and submitted the claim to the SAIF Corporation for processing. (Ex. 7). The Order of Noncompliance was not appealed and became final.

On February 9, 1993, SAIF accepted the decedent's beneficiary's claim for benefits for a fatal injury. (Ex. 8A). A March 5, 1993 Determination Order issued closing the claim and awarding benefits for a fatal injury. (Ex. 9).

On March 23, 1993, the employer filed a request for hearing on the issue of compensability in response to SAIF's acceptance.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

The employer objects to the admission of Exhibit 8, a transcript of SAIF's investigator's interview with Sonny. The employer contends that the Referee erred in admitting Exhibit 8 on the basis that the interview was inaccurate, not properly authenticated and violated the "best evidence" and hearsay rules.

Referees are 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); Armstrong v. SAIF, 67 Or App 498 (1984). We review the Referee's evidentiary ruling for abuse of discretion. Rodney D. Jacobs, 44 Van Natta 417 (1992); Renia Broyles, 42 Van Natta 1203 (1990). We conclude that substantial justice allows the admission of Exhibit 8 into the record.

The employer objected to the admission of Exhibit 8 at the beginning of the hearing. (Tr. 3). Just prior to the hearing, SAIF had provided the employer a copy of the tape from which the transcription was made. (Tr. 4). In response to the employer's objection, the Referee admitted Exhibit 8, subject to authentication by SAIF's investigator, and continued the hearing on the record to allow the employer to review the tape and make changes or corrections. (Tr. 5, 7).

After the hearing reconvened, SAIF's investigator authenticated the exhibit (Tr. 123, 124) and was cross-examined by the employer's attorney (Tr. 126-138). Claimant offered the tape, which was admitted as Exhibit 12. (Tr. 137, 138). However, the employer failed to submit any changes or corrections to the record.

For the following reasons, we conclude that the Referee did not abuse his discretion in admitting Exhibit 8. First, the employer failed to submit any changes or corrections to the record when offered the opportunity to do so by the Referee. Second, the employer cross-examined SAIF's examiner regarding the transcript. Third, even though the "best evidence rule," ORS 40.550 to 40.585, does not apply in a workers' compensation proceeding, the employer's objection to the transcription on these grounds was cured by the receipt into evidence of the original tape from which the transcription was made. Moreover, evidence is not deemed inadmissible solely on the basis that it is hearsay. See ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498, 501 n.2. (1984). Finally, because Exhibit 8 consists, in part, of statements the employer made regarding the circumstances surrounding the decedent's alleged employment and his death, it is of probative value. For all of the above reasons, the Referee did not abuse his discretion in admitting the exhibit. Rodney D. Jacobs, supra; Renia Broyles, supra.

Subjectivity

The Referee concluded that the decedent was a subject worker at the time of his death. We affirm the result with the following supplementation.

The burden is on the decedent's beneficiary to prove that the decedent was a subject worker and that his death is compensable. Konell v. Konell, 48 Or App 551, 557 (1980), rev den 290 Or 449 (1991) (A claimant must prove the existence of an employment relationship and the existence of a claim to compensation benefits); Ballou v. State Indus. Acc. Comm., 214 Or 123 (1958) (A widow must prove not only that her husband was an employee but that his death was compensable); Douglas Fredinburg, 45 Van Natta 1060, 1061, on recon 45 Van Natta 1619 (1993) (A claimant must prove subject worker status).

The employer contends that, on the day of his death, the decedent was not engaged to furnish services, was not receiving remuneration, and was not subject to the direction and control of the employer. Specifically, the employer contends that claimant was performing work as a volunteer at the time of his death and was therefore not a "worker" and not subject to the Workers' Compensation Law. We disagree.

A "worker" means any person, including a minor, whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer. ORS 656.005(28); Liberty Northwest Ins. Corp. v. Church, 106 Or App 477 (1991).

The decedent had been hired by the employer to stock goods and clean up the store beginning in early 1991. The decedent worked Monday through Friday each week, arriving at 5:30 p.m. and working at least two to three hours or until his duties were completed. He was paid $5.00 an hour in cash or trade.

The beneficiary testified that the decedent worked the week prior to his murder according to his usual pattern. (Tr. 91, 92). Sonny testified that: (1) the decedent quit because he was too tired to work (Tr. 18); and (2) he told the decedent not to return to work after the previous Friday, May 15, 1992, because the employer lacked workers' compensation insurance (Ex. 8-7). Sonny also testified that the decedent returned on Thursday, May 21, 1992, to work, but was sent away because there was no workers' compensation insurance coverage for him. On Friday, May 22, 1992, the decedent was at the workplace, coming out of the stockroom and performing the same duties for which he had previously been receiving remuneration.

There is no evidence that the decedent had, as the employer contends, "volunteered" to perform his duties for no remuneration on the Friday night of his death. Moreover, the Department interviewed Sonny with the assistance of Sonny's brother as interpreter and in the presence of Sonny's attorney as part of its noncomplying employer investigation. Sonny's brother speaks fluent English and Korean. The Department's report states: "The employer admitted that the claimant, the deceased, was working part time at the store when he was shot. When he was shot, this was the first or second day on the job." The report concluded that the decedent was a subject employee, based on statements made by the employer. (Ex. 6-3).

We are not persuaded by the employer's testimony at hearing that he did not mean what he told the Department, and that, instead, the decedent was only volunteering his services that night. (Tr. 42). Our view is corroborated by SAIF's interview of Sonny, conducted under the same circumstances as the Department's, in which Sonny stated that the decedent was working part time putting deliveries away in the stockroom. (Ex. 8-2, 8-7).

Given the ongoing services provided by claimant for a year and a half for remuneration, Sonny's testimony that claimant was working at the time of the murder provided to two investigators in the presence of a translator and his own attorney, Sonny's conflicting reasons for the decedent's not working the week prior to the murder, no evidence that claimant had been discharged, and claimant's presence in the stockroom and performing work at the time the assailant came into the store, we are persuaded that the employer intended to continue his long-established employment relationship with claimant. Moreover, given the fact that the employer was not carrying workers' compensation insurance at the time of the murder, we are not persuaded by Sonny's testimony or the newspaper reports that the decedent was a volunteer in the store on the night he was killed.

Consequently, we agree with and adopt the Referee's conclusion that the decedent was a subject worker at the time of his death.

Compensability

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[.]" The Referee concluded that the injury did not arise out of and in the course of employment, based on his finding that there was no evidence that the murder arose out of the risks of robbery, assault or a shooting related to claimant's employment. We disagree.

In order for an injury to arise out of and be in the course of employment, there must be a sufficient relationship between the injury and the employment. Rogers v. SAIF, 289 Or 633, 642 (1980); see also Phil A. Livesley Co. v. Russ, 296 Or 25 (1983).

Seven factors have been identified to determine whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Id.

The issue to be decided is whether claimant's murder arose out of his employment as a stock clerk for a convenience store. We conclude that the answer is "yes."

First, we agree with the Referee's findings that claimant was performing his regular duties as a stock clerk as contemplated by the employer and employee, for the benefit of the employer, on the employer's premises, as directed by the employer. In addition, we agree with the Referee's finding that the risk of robbery, assault or a shooting was an ordinary risk of claimant's employment at a convenience store in that location. Moreover, we concluded above that claimant was working for pay. Thus, the sole remaining factor to be decided is whether the decedent was on a personal mission at the time of the incident. We find that he was not.

Claimant was performing his work activities when the incident occurred. He was exiting from the stockroom and moving a trash can from the aisle next to some pop machines in the store. The assailant, who was already in the store brandishing a loaded gun before the owner, heard the noise, moved past the front counter, stopped next to claimant, said a few words, and shot him. The assailant then fled the store.

Based on such circumstances, we find that, at a minimum, the assailant entered the store with an intent to rob or assault. The fact that the assailant did not subsequently turn the rifle on the owner or demand money is not determinative; if anything, it suggests that the assailant panicked after shooting the decedent and rapidly left the premises to elude capture. This suggestion is further supported by Detective Hill's testimony regarding her experience in homicide investigations in which a robbery is contemplated by an assailant, a shooting occurs, and the assailant leaves without completing the act originally intended. (Tr. 56).

Consequently, absent any evidence in the record suggesting a personal matter between the assailant and claimant, or that claimant brought the risk of assault to the work place, we conclude that claimant's death occurred as a result of the increased hazard of his work at a convenience store. Lacking such "non-work related" reasons for the attack, we hold that there was a sufficient relationship between the shooting and a risk connected with claimant's employment to conclude that the injury arose out of and in the course of his employment. Barkley v. Corrections Division, 111 Or App 48 (1992).

In Barkley, the claimant was a convenience store cashier who was sexually assaulted by a Corrections Division inmate on temporary leave. She argued that the assault did not "arise out of" her employment as a convenience store cashier because the assault was not work related, in that the inmate entered the store to sexually assault her, not to commit a robbery. The court, citing 1 Larson Workmen's Compensation Law 3-178, 11.00 and 3-196, 11.11(b) (1990 and 1991 supp), explained that, since the attack was not the result of a personal relationship between the claimant and the assailant, his motivation alone was not determinative of the compensability of her injury. Instead, the court reasoned that an assault by a third person is deemed to arise out of a claimant's employment when the assault is the result of the nature of the work or when it originates from some risk to which the work environment exposes the employee. Concluding that the claimant's work environment increased her exposure to those who might commit violent crimes, the court held that there was a sufficient relationship between the assault and a risk connected with the employment to determine that the injury arose out of and in the course of the claimant's employment.

Here, as in Barkley, claimant was employed in a convenience store. As noted above, claimant's work at the convenience store put him at risk of robbery, assault or shooting. Moreover, there was no evidence of a personal relationship between claimant and the assailant. Instead, the persuasive evidence regarding the assailant points to a suspect involved in other unexplained shootings in the same neighborhood. Thus, where the attack on claimant was not the result of a personal relationship between himself and the assailant, the assailant's motivation in shooting claimant, i.e., whether the assailant was engaged in a robbery, is not determinative of the compensability of claimant's injury. Instead, as in Barkley, we deem that the shooting by the assailant arose out of claimant's employment, given the fact that it originated from a risk provided by the work environment of a convenience store. Compare Robinson v. Felts, 23 Or App 126, 134 (1975) (A claimant's death did not arise out of her employment where the risk was not connected with the employment but instead arose out of a personal relationship); see also Robert A. Knudson, 45 Van Natta 1447 (1993); Oliver S. Brown, 35 Van Natta 1646 (1983).

The decedent's beneficiary is entitled to an assessed attorney fee for services rendered 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 attorney fee for claimant's current counsel's services at hearing and on review is $8,500, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have considered the time devoted to the case (as represented by the hearing record, the beneficiary's current and former attorney's statement of services at the hearing level and the appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that the beneficiary's counsels might go uncompensated. The manner in which the beneficiary's current attorney shall share this fee with the beneficiary's former attorney is a matter to be decided by them, not this forum. Gabriel Zapata, 46 Van Natta 403, n.1 (1994).

ORDER

The Referee's order dated January 19, 1994 is reversed in part and affirmed in part. The SAIF Corporation's acceptance is reinstated and the claim remanded to SAIF for processing according to law. The March 5, 1993 Determination Order is reinstated and affirmed. For services at hearing and on Board review, the decedent's beneficiary's current attorney is awarded an assessed fee of $8,500, to be paid by the SAIF Corporation on behalf of the noncomplying employer. The remainder of the Referee's order is affirmed.

March 3, 1995 Cite as 47 Van Natta 351 (1995)

In the Matter of the Compensation of
GAIL TAGGART, Claimant
WCB Case Nos. 93-06392 & 93-06391
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 that portion of Referee Davis' order which upheld the self-insured employer's denial of claimant's low back injury claim. The employer cross-requests review of those portions of the Referee's order which: (1) admitted into evidence a post-hearing concurrence letter from claimant's attending physician; (2) awarded claimant interim compensation; and (3) assessed a penalty for the employer's alleged failure to properly process the claim. On review, the issues are compensability, evidence, interim compensation, and penalties/attorney fees.

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

Compensability

On review, claimant contends that her low back condition is compensable as either an industrial injury or an occupational disease claim. The employer objects to our consideration of the alternative occupational disease theory on review, on the ground that this theory was not raised before the Referee. We need not address the employer's argument, since were we to consider claimant's occupational disease theory on review, we would still not find the claim compensable.

After our review of the record, we agree with the Referee's determination that a work-related lifting incident in September 1992 was not a material contributing cause of claimant's low back condition, a herniated disk which required surgery in December 1992. Nor do we find the medical evidence sufficiently persuasive to prove that claimant's work activities selling and editing college texts for a book publisher were the major contributing cause of her low back condition. (Compare Exs. 15, 56 and 57 with Exs. 31, 33, 38, and 55).

Evidence

The insurer contends that the Referee erred in admitting a concurrence letter from Dr. Berselli, submitted by claimant after the formal hearing but before the record closed. (Ex. 58). We disagree.

The Referee allowed a continuance in this case for the deposition of Dr. Berselli, requested by the employer. Neither party objected to the continuance. Later, the employer waived the deposition, and claimant submitted Dr. Berselli's concurrence letter (Ex. 58) for admission into the record. Exhibit 58 purports to explain why the doctor's deposition was not taken. The employer objected to the admission of Exhibit 58.

A referee may continue a hearing under certain conditions, within the exercise of his or her discretion. See OAR 438-06-091; Sue Bellucci, 41 Van Natta 1890 (1989). Furthermore, ORS 656.283(7) provides that the referee is not bound by common law or statutory rules of evidence, but may conduct a hearing in any manner that will achieve substantial justice. See e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). We review the Referee's evidentiary ruling for abuse of discretion. William J. Bos, 44 Van Natta 1691 (1992); James D. Brusseau II, 43 Van Natta 541 (1991). Referees have great discretion to allow and deny admission of evidence at hearing. Shirlene E. Volcay, 42 Van Natta 2773 (1990).

Here, the Referee continued the hearing for the deposition of Dr. Berselli, requested by the employer. Later, when the employer waived the deposition, claimant submitted a concurrence letter by Dr. Berselli purporting to explain why the deposition was not taken. The Referee admitted the document, reasoning that because resolution of the case was delayed by the record remaining open for the deposition, and because the document at least arguably addressed why the deposition did not occur, claimant should be allowed to place the exhibit in the record. We agree with the Referee's reasoning and find no abuse of discretion in the Referee's ruling. See Clifford L. Conradi, 46 Van Natta 854 (1994) (Referee did not abuse discretion in refusing to admit a document submitted untimely by the claimant, when the claimant's counsel had suggested the time limit).

Furthermore, the Referee left the record open for a specific purpose, the receipt of Dr. Berselli's deposition. Dr. Berselli's concurrence letter, submitted by claimant, is consistent with that purpose, in that it simply explains why the deposition did not occur. Compare Darrel L. Hunt, 44 Van Natta 2582 (1992) (where a referee leaves the record open for a limited purpose, it is within the referee's discretion to exclude evidence that does not comport with that purpose).

Moreover, assuming that the employer was prejudiced by the admission of Dr. Berselli's "post-hearing" concurrence letter, the appropriate relief would be allowing the employer to submit rebuttal evidence or to cross-examine the author. The employer declined cross-examination by waiving the opportunity to take Dr. Berselli's deposition, and the employer did not ask the Referee for the opportunity to submit rebuttal evidence in response to Dr. Berselli's concurrence letter. Accordingly, we find no error in the Referee's ruling.

Interim Compensation

On review, the employer contends that it is not liable for payment of interim compensation from February 9, 1993, because it did not have notice or knowledge of claimant's claim at that time. Rather, it only asserts that its processing agent had notice of the claim. (See Ex. 25). The employer contends that its relationship with the processing agent is too tenuous to impute the agent's knowledge to the employer. We disagree.

In Colvin v. Industrial Indemnity, 301 Or 743, 747 (1986), the Supreme Court agreed with Professor Larson's formulation that "in order that knowledge be imputed to the employer, the person receiving it must be in some supervisory or representative capacity, such as . . . insurance adjuster. . . ." (Emphasis added). We find that the self-insured employer's claims processing agent is in such a representative capacity. Thus, when the processing agent received notice of claimant's claim on February 9, 1993, its knowledge was properly imputed to the employer. Accordingly, we agree with the Referee that claimant is entitled to interim compensation from February 9, 1993 to the date of denial.

Penalty and Attorney Fee

We adopt and affirm the Referee's order regarding the penalty and attorney fee issue.

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) for services on review regarding the employer's cross-request. 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 employer's cross-request is $300, to be paid by the self-insured employer. In reaching this

conclusion, we have particularly considered the time devoted to the case (as represented by claimant's cross-respondent's brief), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services devoted to the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated May 17, 1994 is affirmed. Claimant's attorney is awarded $300 for services on Board review, to be paid by the self-insured employer.

March 3, 1995 Cite as 47 Van Natta 353 (1995)

In the Matter of the Compensation of
MYRNA J. TALBERT, Claimant
WCB Case No. 94-00972
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Carrol J. Smith (Saif), Defense Attorney

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

Claimant requests review of Referee Podnar's order which upheld the SAIF Corporation's denial of her injury/occupational disease claim for fume exposure. In addition, claimant requests that the record be reopened or that the claim be remanded to the Referee for additional taking of evidence. We treat such a request as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and compensability.

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

Remand

Claimant has submitted for consideration a September 15, 1994 medical report from Dr. Baker, a Seattle physician. Claimant avers that she was unable to see Dr. Baker until after the April 19, 1994 hearing. Thus, claimant contends that the medical report was not obtainable with due diligence at the time of the hearing and should be considered in determining whether claimant has proved a compensable claim.

We may remand a case to the Referee for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the referee. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Although Dr. Baker's report was not available at the time of the hearing, we are not persuaded that it was unobtainable with the exercise of due diligence prior to the hearing. Accordingly, we conclude that a remand is not appropriate. Moreover, we would conclude that claimant has failed to sustain her burden of proof even if the proffered evidence were considered.

Compensability

On or about October 28, 1993, claimant, a receptionist, began experiencing light-headedness, nausea, a metallic taste, difficulty breathing, balance problems and headaches after detecting an acrid odor at her work station. She later began experiencing eye irritation and swollen eyes. Similar symptoms were reported by other employees. The offensive odor was believed to have originated from recently painted steam heating pipes.

The Referee acknowledged that there was a strong temporal relationship between the onset of claimant's symptoms and her work exposure to acrid fumes. However, the Referee found that claimant had not established by a preponderance of the medical evidence that her exposure to fumes at work was the major contributing cause of her need for medical treatment or disability.

On review, claimant contends that she need only prove material causation inasmuch as her exposure to noxious fumes occurred during a discrete time frame. See Valtinson v. SAIF 56 Or App 186 (1982); Cf. Mathel v. Josephine County, 319 Or 235 (1994) ("injury" is an event; whereas "occupational disease" is ongoing condition or state of body or mind). In any event, claimant asserts that the medical evidence establishes medical causation regardless of whether she must prove material or major causation. We disagree.

Because of claimant's unusual reaction to paint fumes, the paucity of objective findings in physical examinations of claimant, and the lack of contaminants found in air quality samples taken from the workplace, we conclude that the causation issue is medically complex. Thus, the Referee properly required expert medical evidence to resolve the causation issue. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Like the Referee, we find Dr. Burton's opinion to be the most persuasive. A toxicologist from Oregon Health Sciences University, Dr. Burton attributed claimant's symptoms to functional causes. He noted that an industrial hygiene survey, which duplicated the conditions of claimant's alleged exposure, found no evidence of contaminants in sufficient concentration to result in toxicity. (Ex. 11-8).

Although claimant's liver function tests were elevated more than one week after her exposure to acrid fumes, Dr. Burton noted that these tests were initially normal. Inasmuch as the liver function tests were not elevated until November 11, 1993 and continued to rise for up to one month following exposure, Dr. Burton concluded that this temporal relationship was incompatible with a toxic exposure in late October 1993. According to Dr. Burton, the workplace was not responsible for claimant's continuing symptoms, disability or need for treatment, apart from claimant's perception of noxious odor. (Ex. 11-9). In further support of his conclusions, Dr. Burton provided several articles explaining how mass psychogenic illness can cause symptoms in large numbers of workers who perceive toxic exposure. (Ex. 20).

Inasmuch as it is well-reasoned and thorough, we find Dr. Burton's opinion to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986). In addition, we find the medical evidence from other physicians who have examined claimant to be insufficient to establish medical causation.

Dr. Zimmerman, a neurologist, concluded that, given the temporal association of claimant's symptoms with her work exposure, as well as minor changes in liver function reported in laboratory testing, it was "possible" that "some kind of an exposure" contributed to claimant's disability and need for treatment. (Ex. 18). However, Dr. Zimmerman admitted he was at a loss to explain the pathophysiology of claimant's condition. Since his medical opinion is couched in terms of medical possibility rather than probability, Dr. Zimmerman's opinion is insufficient to satisfy claimant's burden of proof. See Gormley v. SAIF, 52 Or App 1055 (1981).

As the Referee noted, the medical evidence from claimant's treating physician, Dr. Davis, comes the closest to satisfying her burden of proof. Dr. Davis concluded that functional overlay could not account for all of claimant's symptoms and that it was difficult for him to accept as a coincidence the fact that many other employees complained of similar symptoms following the alleged toxic exposure. (Ex. 19). However, we find Dr. Burton's research regarding mass psychogenic illness adequately addresses Dr. Davis' concerns regarding the symptoms reported by claimant's coworkers. Moreover, we agree with the Referee that Dr. Davis relies heavily on a temporal relationship between claimant's symptomatology and the alleged work exposure. For this reason as well, we find Dr. Davis's opinion unpersuasive. See Allie v. SAIF, 79 Or App 284 (1986).

Finally, Dr. Glass, an examining psychiatrist, also found it difficult to attribute claimant's symptoms to functional causes. Nevertheless, Glass conceded that there was no clear physical explanation for claimant's symptomatology. (Ex. 17-10). Inasmuch as Dr. Glass' report does not definitively address the cause of claimant's physical symptoms, we further conclude that this report also does not establish medical causation.

In summary, we find that claimant has not sustained her burden of proving that her work exposure to acrid fumes is a material or major contributing cause of her disability or need for medical

treatment.[1] We also note that this case is distinguishable from our recent decision in Patsy M. Brought, 46 Van Natta 766 (1994).

Unlike the medical evidence in Braught, which included a medical report from occupational medicine physician who concluded that there was a "very high probability" of a relationship between toxic exposure and the claimant's disease, the medical evidence in this case does not persuasively make the causal connection between the alleged work exposure and claimant's need for treatment and disability. In addition, whereas Dr. Burton did not address in Braught the causal implications of other employees reporting symptoms similar to the claimant's, we have determined that he has done so in this claim. Based on our de novo review of the record, we find that this claimant has not sustained her burden of proving a compensable industrial injury or occupational disease.

ORDER

The Referee's order dated April 28, 1994 is affirmed.

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[1] The dissent points to claimant's elevated liver enzymes as objective evidence that claimant was exposed to toxic substances. However, Dr. Burton persuasively explained that the temporal relationship of the elevated liver function tests was incompatible with a toxic exposure on October 27, 1993. (Ex. 11-8).

We likewise reject the dissent's contention that it must be more than coincidence that many other employees complained of similar symptoms. As previously noted, the articles Dr. Burton provided regarding psychogenic illness adequately explain the reasons why other employees were affected in ways similar to claimant. Moreover, we do not accept the dissent's argument that Dr. Burton explains claimant's symptomatology purely on the basis of mass psychogenic illness. It is clear from Dr. Burton's April 11, 1994 report that he finds claimant's symptoms are incompatible with an organic illness and are the product of functional causes unrelated to the workplace. (Ex. 20-4).

Finally, the dissent urges to find that claimant suffered a "psychological injury." There is insufficient evidence for such a finding. In fact, as a result of his psychiatric examination, Dr. Glass could not document that claimant had any diagnosable psychiatric condition and concluded that claimant's alleged fume exposure was not a cause of any psychiatric condition. (Ex. 17-10).

Board Member Gunn Dissenting.

The majority concludes that claimant failed to sustain her burden of proving that her work exposure to acrid fumes was a major or material contributing cause of her disability or need for medical treatment. In reaching that conclusion, the majority finds the medical opinion of Dr. Burton more persuasive than that of Dr. Davis, the attending physician. Because, I , like Dr. Davis, believe evidence of similar symptomatology in claimant's coworkers strongly indicates that claimant was exposed to a toxic substance in the work place, I must dissent from the majority's conclusion.

There is no dispute that claimant, along with her coworkers, experienced illness of some kind while at work. This was due either to a toxic exposure, as Dr. Davis opines, or to some mass psychogenic illness, as Dr. Burton apparently believes. Unlike the majority, which all too eagerly embraces the psychogenic theory, I find Dr. Davis' medical opinion to be quite persuasive.

Dr. Davis makes several salient points that are not adequately addressed by the majority. For instance, Dr. Davis correctly notes that claimant's symptoms of headaches, photophobia and nausea have for the most part been consistent. In addition, no physician has been able to sufficiently establish a nonoccupational cause for the elevation of claimant's liver enzymes. Moreover, Dr. Davis correctly observes that Dr. Glass, the examining psychiatrist, also could not explain claimant's symptoms on a purely functional basis. Lastly, Dr. Davis points out that it is difficult to accept as coincidence that many other employees also complained of similar symptoms of headache and nausea.

It is well-settled that, in cases where the medical evidence is divided, we give greater weight to the attending physician's opinion, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Inasmuch as there are no persuasive reasons why we should not defer to Dr. Davis' opinion, the majority erred in not relying on his conclusion that claimant was exposed to toxic substances in the workplace that caused her disability or need for medical treatment.

I also do not accept Dr. Burton's psychogenic illness explanation, given the objective finding of liver abnormality and the consistency of claimant's and her coworker's symptoms. Even assuming that Dr. Burton's theory is correct, I believe that claimant has still established a compensable injury claim

under Mathel v. Josephine County, 319 Or 235 (1994). The medical evidence establishes that, during an injurious "event," claimant was exposed to offensive odors that were a material contributing cause of her disability and need for medical treatment, even if the explanation for claimant's symptoms was psychological rather than organic. Therefore, at the very least, the medical evidence supports a finding of a psychological injury to claimant that should be compensable.

In conclusion, the majority does a great disservice to claimant by not finding that she sustained a compensable injury or occupational disease in light of the considerable medical evidence that supports the compensability of her claim. This evidence comes not only from claimant's physician, but from defense doctors as well.

Because there is considerably more than a preponderance of medical evidence to support a finding of compensability, I must conclude that the majority has erred in this case. I must, therefore, respectfully dissent from their decision.

March 3, 1995 Cite as 47 Van Natta 356 (1995)

In the Matter of the Compensation of
DARRELL W. VINSON, Claimant
WCB Case Nos. 91-05363, 91-08114, 91-08115 & 91-04982
ORDER ON REVIEW (REMANDING)
Schneider, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys
David L. Runner (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of that portion of Arbitrator Nichols' order that declined to award his counsel an assessed attorney fee under ORS 656.307(5) for services rendered prior to and during the responsibility arbitration proceeding. On review, the issue is attorney fees.[1] We remand.

We begin by setting forth the background of the claim as stated in the Arbitrator's orders.

Claimant compensably injured his low back on October 25, 1986, while employed by Amity Hardware and Repair (Amity), insured by Crawford and Company (Crawford). The claim was closed by Determination Order on November 12, 1987, with an award of 15 percent unscheduled permanent disability.

In August 1988, claimant began working for DeJong Products, Inc. (DeJong), insured by the SAIF Corporation. On March 12, 1991, claimant experienced severe low back pain while operating a metal drill. An acute low back sprain was diagnosed. Claimant filed a "new injury" claim with SAIF and an aggravation claim with Crawford.

In April 1991, both carriers issued letters denying responsibility for claimant's low back condition. Their denial letters stated that they had not requested the appointment of a paying agent pursuant to ORS 656.307. (Exs. 34, 36). Claimant's counsel subsequently requested the designation of a paying agent pursuant to ORS 656.307. Based on the carriers' agreement that responsibility was the only issue, the Department issued an order on June 21, 1991, designating SAIF as the paying agent and referring the matter to the Hearings Division for arbitration. (Ex. 38).

The only substantive issue at the arbitration proceeding was responsibility for claimant's low back condition. Claimant personally appeared at the arbitration proceeding, and his counsel actively participated in the proceeding, offering exhibits into the record and eliciting testimony from claimant. Claimant asserted through counsel that SAIF should be found responsible for his condition. It is undisputed that claimant would receive a higher rate of temporary total disability benefits under the SAIF claim than he would receive under the Crawford claim.

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[1] Claimant also requested review of that portion of the Arbitrator's order that declined to assess a penalty-related attorney fee against SAIF for failure to pay interim compensation. However, claimant subsequently withdrew that issue in his Reply Brief. (See Reply Br. 1).

Following a series of appeals and remand orders, the Arbitrator ultimately held that Crawford was responsible for claimant's condition; however, she did not award claimant's counsel an assessed attorney fee for services rendered prior to and during the arbitration proceeding.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that his counsel "actively and meaningfully" participated in the arbitration proceeding and, therefore is entitled to an assessed attorney fee pursuant to ORS 656.307(5). Claimant also contends that his counsel is entitled to an assessed fee for services rendered prior to the issuance of the Department's "307" order.

Arbitration Proceeding

When there is an issue of responsibility for payment of compensation, and the carriers admit the claim is otherwise compensable, the Director must issue a "307" order designating a paying agent. ORS 656.307(1). The Director must also request the Board to appoint a referee to act as an arbitrator to determine the responsible carrier. With one exception (which is not applicable here), the arbitrator's order is subject to review for questions of law only. ORS 656.307(2).

ORS 656.307(5) further provides:

> "The claimant shall be joined in any [arbitration] proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be the party responsible for paying the claim." (Emphasis supplied.)

It is undisputed that claimant's counsel "actively" participated in the arbitration proceeding. The dispute concerns whether counsel "meaningfully" participated in the proceeding.

Crawford first argues that claimant's current counsel lacks standing to seek an assessed fee for services rendered in the arbitration proceeding, because claimant had different counsel in the arbitration proceeding. Crawford contends that only claimant's former counsel has the right to collect the assessed fee. Crawford's argument lacks merit.

In support of its proposition, Crawford cites to Jane A. Volk, 46 Van Natta 681 (1994). That case is inapposite, however, because it addressed counsel's obligation to collect an out-of-compensation attorney fee from a claimant, where the fee was previously paid to the claimant. It has no bearing on the issue of whether claimant may retain new counsel on appellate review to seek a fee requested by former counsel in the original arbitration proceeding. In our view, there is no deficiency in claimant's standing to pursue a fee request made by former counsel. Should claimant ultimately prevail on the fee issue, the fee would be paid to claimant's current counsel for forwarding to former counsel.

Crawford also argues that, because the Arbitrator's authority to award an assessed fee is discretionary, and our review is limited to questions of law, we lack authority to review the Arbitrator's refusal to award a fee. Although we agree that an arbitrator's authority to award a fee is discretionary, the arbitrator is nevertheless bound to exercise that discretion within the limits of the law. In this regard, we have previously held that, "when a claimant actively and meaningfully participates in an arbitration proceeding, an insurer-paid fee should be awarded absent extraordinary circumstances." Daniel J. Bergmann, 42 Van Natta 949, 951 (1990) (Emphasis supplied.)

Hence, in all but extraordinary circumstances, the arbitrator is required to award a fee under ORS 656.307(5) if claimant's participation in the arbitration proceeding was active and meaningful. The standard by which a claimant's participation is found to be "active and meaningful" is a question of law. In this case, claimant contends that the Arbitrator failed to apply the correct legal standard in deciding not to award a fee. That amounts to an assertion that the Arbitrator committed an error of law. We are therefore authorized to review the Arbitrator's decision.

Turning to the merits, claimant argues that, because his counsel actively asserted that a carrier (SAIF) was responsible, his counsel's participation was "meaningful," even though SAIF was ultimately found not to be the responsible carrier. Crawford disagrees, arguing that claimant's counsel's participation was not meaningful because SAIF was not ultimately found to be responsible.

The statutes do not define the term "meaningfully," nor is there any explanation of why the language "actively and meaningfully participates" was added to ORS 656.307 in 1987. See Minutes, Senate Committee on Labor, June 9, 1987. See also Keenon v. Employers Overload, 114 Or App 344, 347 n 1 (1992). However, we have addressed the meaning of that term in prior cases. In Daniel J. Bergmann, supra, the claimant had a substantial interest in the outcome of the responsibility dispute, and he actively participated through counsel in the arbitration proceeding. The claimant and the carriers eventually entered into a stipulated settlement whereby one of the carriers agreed to accept the claim. However, the parties could not agree on whether the claimant's counsel was entitled to an assessed fee, so they submitted the assessed fee issue to the Arbitrator for resolution. On Board review, we concluded that the claimant had actively and meaningfully participated in the arbitration proceeding. Id.

We later revisited and clarified the Bergmann holding in Jean Novotny, 42 Van Natta 1060 (1990). We stated that, while there was no explicit finding in Bergmann that the claimant had actively asserted that the carrier which ultimately accepted the claim was the responsible party, such a finding was implicit in that decision. 42 Van Natta at 1061. We went on to review the facts in Novotny to determine if the claimant in that case had actively and meaningfully participated in the arbitration proceeding. Although the claimant's counsel participated in the proceeding by questioning a witness, we concluded that counsel's participation was not meaningful, because he had not advocated that any particular carrier was the responsible party. Id.

In Allen C. Moore, 42 Van Natta 2023 (1990), we found that, under circumstances where the claimant's counsel had argued that a particular carrier was responsible and that carrier was ultimately found responsible, counsel's participation in the proceeding was meaningful.[2] Under similar facts, in Kenneth Cage, 43 Van Natta 487 (1991), we again found that the claimant's counsel's active participation was meaningful.

These Board cases--Bergmann, Novotny, Moore and Cage--did not explicitly hold that, as a condition of "meaningful" participation, counsel must have successfully argued that a particular carrier was the responsible party. Those cases could just as easily support claimant's proposition that meaningful participation only requires counsel to argue (successfully or not) that a particular carrier is the responsible party. Claimant's proposition is further supported by the following language in the Court of Appeals' opinion in Keenon v. Employers Overload, supra:

> "The legislature intended ORS 656.307(5) to be applied restrictively to allow attorney fees only when a claimant has a material, substantial interest in deciding who is the responsible insurer or employer, that is, if the claimant's benefits can be affected by the outcome of the responsibility hearing. Unless a claimant has a material, substantial interest in deciding who is the responsible party and takes a position advocating that interest, participation by the claimant's attorney, even if helpful to the arbitrator, would be meaningless to the claimant. Because the claimant did not advocate that a particular employer is the responsible party, his participation was not 'meaningful'...." 114 Or App at 347 (Cite and note omitted; emphasis supplied).

The emphasized language suggests that if a claimant has a material, substantial interest in deciding who is the responsible carrier and takes a position advocating that interest, his counsel's participation would be deemed "meaningful" under ORS 656.307(5). At the same time, we recognize that, because the claimant in Keenon had not taken a position on the responsibility issue, it was unnecessary for the court to decide whether his counsel's participation would have been meaningful if his position had not prevailed.

Ultimately, we turn to the plain and ordinary meaning of "meaningfully." "Meaningful" is defined as "full of meaning; purposeful; significant." Random House Webster's College Dictionary 840 (Glencoe ed 1991). Crawford argues that, unless claimant's counsel actually prevailed in establishing that a particular carrier was responsible, his participation could not be "meaningful." Crawford essentially argues that it is the ultimate result of the arbitration proceeding that determines whether counsel's participation was meaningful. We disagree.

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[2] The interesting twist in that case was that the carrier which the claimant's counsel asserted was responsible (and which was ultimately found responsible) had the lower rate of temporary total disability benefits. That is, the claimant's counsel was instrumental in securing for his client a lower temporary total disability rate. Id. at 2025.

We believe it is the "significance" or "purpose" of counsel's participation that determines its meaningfulness, not the ultimate result of the arbitration proceeding. Given counsel's duty to protect and advance the interests of his client, we believe that the "significance" or "purpose" of counsel's participation in the arbitration proceeding must be viewed in the light of his client's best interests. That is, where counsel takes a position that, if adopted, would advance the interests of his client, it can safely be said that counsel's participation has "significance" and "purpose" and, therefore, has meaning. The fact that counsel's position does not ultimately prevail does not render his participation meaningless, although that fact may be considered in determining the amount of the fee award. Compare International Paper Co. v. Riggs, 114 Or App 203, 207 (1992) (held that the claimant was entitled to assessed fee under ORS 656.382(2) because compensation was not reduced on appeal, though the claimant's pursuit of unsuccessful argument may be taken into account in determining what assessed fee is reasonable).

Our interpretation of "meaningful" is entirely consistent with the court's opinion in Keenon. Furthermore, our interpretation has the beneficial result of encouraging claimants who have a "material, substantial interest" in deciding who is the responsible carrier to retain counsel to advocate their interest in the arbitration proceeding. Finally, had the legislature intended the "meaningfulness" of counsel's participation to turn on the ultimate result of the arbitration proceeding, it could have enacted more explicit language.[3] Because the legislature did not do so, we are persuaded that a counsel's active participation which advocates a position in the best interests of his client is "meaningful." To the extent our interpretation is inconsistent with prior Board decisions, those decisions are disavowed.[4]

Because our review is limited to questions of law, we are not authorized to find facts from which to determine whether claimant's counsel is, in fact, entitled to an assessed fee under ORS 656.307(5) and, if so, the amount of the fee. Accordingly, this matter must be remanded to the Arbitrator for further factfinding on the following issues: (1) whether claimant had a material, substantial interest in deciding which carrier was the responsible party; and (2) if so, whether claimant's counsel took a position advocating that interest. If the Arbitrator answers "yes" to both questions, barring a finding of extraordinary circumstances, the Arbitrator should award claimant's counsel a reasonable assessed fee under ORS 656.307(5). See Daniel J. Bergmann, supra.

Pre-Arbitration Proceeding

Claimant's counsel also seeks an assessed fee for services rendered prior to issuance of the "307" order. We have previously held that, if a claimant's counsel is found to be entitled to an assessed fee under ORS 656.307(5), a fee is also awardable for all services reasonably rendered in securing compensation prior to issuance of the "307" order. See Kenneth Cage, supra.

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[3] An example of that explicit language is found in ORS 656.386(1), which states that a claimant's counsel is entitled to an assessed fee if "claimant finally prevails... from an order or decision denying the claim for compensation..." (Emphasis supplied.)

[4] Before the current version of ORS 656.307(5) was enacted, our rules provided that, in a responsibility case where a "307" order had issued, the claimant's counsel shall receive no fee unless counsel "actively and meaningfully" participates at the hearing in defense of the claimant's rights. See former OAR 438-47-090. We had interpreted "active and meaningful" participation under that former rule to require that the claimant advocate a position adverse to one of the carriers and prevail in that position. E.g., Cynthia L. Malm, 38 Van Natta 585 (1986); Stanley C. Phipps, 38 Van Natta 13 (1986); Rhett J. Dennis, 37 Van Natta 1178 (1985); Steven G. Boyer, 37 Van Natta 981 (1985); Erwin L. Bacon, 37 Van Natta 205, 208 (1985); Robert Heilman, 34 Van Natta 1487 (1982).

Our interpretation of former OAR 438-47-090 does not compel the conclusion that the legislature intended the same meaning in enacting similar language in ORS 656.307(5). The courts have never adopted, either explicitly or implicitly, our interpretation of former OAR 438-47-090. There was one Court of Appeals case where our interpretation of former OAR 438-47-090 was placed directly at issue, but the court declined to address that issue. Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 571 (1985).

The Petshow decision nevertheless placed into question our interpretation of former OAR 438-47-090. The Petshow court stated that an attorney fee award is inappropriate in a responsibility case, "[u]nless the claimant takes a position concerning which of the insurers is responsible and actively litigates that point." Id. at 569. See also SAIF v. Phipps, 85 Or App 436 (1987). That statement leads to the conclusion that an attorney fee award is appropriate if the claimant takes a position on the responsibility issue and actively litigates that point. The court did not say that the claimant must also prevail on the responsibility issue to obtain an attorney fee award. Therefore, we believe that the Petshow decision overruled, at least implicitly, our prior decisions which required the claimant to prevail on the responsibility issue in order to receive an attorney fee.

Accordingly, on remand, if the Arbitrator determines that claimant's counsel is entitled to an assessed fee under ORS 656.307(5), the Arbitrator should also consider claimant's counsel's services rendered prior to the "307" order in determining the amount of the fee.

ORDER

The Arbitrator's order dated April 4, 1994 is vacated. This matter is remanded to Arbitrator Nichols for further proceedings consistent with this order. The Arbitrator may conduct those proceedings in any manner that would achieve substantial justice.

Members Neidig and Haynes dissenting.

The majority holds that a claimant's attorney is entitled to a carrier-paid attorney fee for participating in a responsibility arbitration proceeding, even if the carrier which claimant contends is responsible is ultimately found not responsible. Because we believe this decision is wrong and results in bad policy, we dissent.

It is important to emphasize that a claimant's entitlement to compensation is not in dispute in an arbitration proceeding under ORS 656.307. The arbitration proceeding takes place only after all potentially responsible carriers concede that the claim is compensable, and a paying agent is designated to pay compensation to the claimant pending the outcome of the arbitration proceeding. Typically, the only dispute in the arbitration proceeding is over which carrier is responsible for paying compensation. Because the temporary total disability rate may differ from carrier to carrier (due to differing wage rates and work hours), the responsibility determination often determines how much compensation claimant will receive. In cases where the claimant has a material interest in the outcome, the claimant may wish to actively participate through counsel in the proceeding.

If the attorney's participation is "active and meaningful," ORS 656.307(5) authorizes a carrier-paid attorney fee award. Prior to this decision, the Board would not find a claimant's attorney's participation to be "meaningful" unless the attorney prevailed in establishing that a particular carrier was responsible, thereby obtaining additional compensation for the claimant. In effect, the Board had construed "meaningful" participation to require that the claimant's attorney's participation result in the claimant receiving more compensation than he would have received had the attorney not participated. That construction makes sense in the responsibility context, because the claimant is already assured of receiving compensation, whether or not he actively participates in the proceeding.

We do not believe, as the majority does, that the "meaningfulness" of the attorney's participation can be divorced from the ultimate outcome of the arbitration proceeding. If the claimant's attorney does not ultimately prevail in establishing his client's entitlement to a higher rate of compensation, the claimant will receive the same amount of compensation that he would have received if his attorney had not participated.

Here, for example, claimant's attorney appeared at the arbitration proceeding and argued that SAIF was responsible, because that conclusion would result in a higher temporary total disability rate. However, Crawford was ultimately found responsible. Thus, claimant will receive the same amount of compensation that he would have received if his attorney had not participated. Since the result would have been the same whether or not claimant's attorney had participated, we would not find that his participation was meaningful.

The majority's holding is a bad policy decision because it will encourage claimants' attorneys to appear at arbitration proceedings and actively assert a position on the responsibility issue, even in cases where their participation is unnecessary. The reward is an attorney fee payable by the carrier in addition to compensation. Ironically, as a result of the majority's holding, the fee will often be paid by the carrier which the claimant asserted was not responsible for the claim. That result seems absurd to us. Therefore, we respectfully dissent.

In the Matter of the Compensation of
LANCE A. BANASZEK, Claimant
WCB Case No. 94-00901
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
James Thwing (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our December 15, 1994 Order on Review, which adopted and affirmed the Referee's order finding claimant's current left shoulder condition compensable as a resultant condition under ORS 656.005(7)(a) (B). SAIF contends that we erred in applying U-Haul v. Burtis, 120 Or App 353 (1993), rather than Dietz v. Ramuda, 130 Or App 397, rev allowed 320 Or 492 (1994) to analyze the compensability of this claim, and that claimant has accordingly failed to prove medical causation.[1]

On January 12, 1995, we withdrew our December 15, 1994 order for reconsideration. Claimant's response to SAIF's motion has been received. Accordingly, we proceed with our reconsideration.

In our original order we affirmed and adopted the Referee's order. The Referee analyzed claimant's current condition as "recurrent instability" or "anterior dislocation," which resulted from the combination of claimant's shoulder degeneration and the reaching incident at work, under ORS 656.005(7)(a)(B). Applying U-Haul v. Burtis, supra, the Referee concluded that claimant had proved that the major contributing cause of his current condition was the November 22, 1993 reaching incident at work

In Dietz v. Ramuda, supra, 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) to establish whether the work incident was the major contributing cause of the claimant's combined 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. Dietz v. Ramuda Supra, 130 Or App at 401.

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 resulting 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 find no conflict in the application of these cases to the instant case. In Dietz, the issue was whether a precipitating cause is necessarily the major cause and in Burtis, the issue was whether a treatment was noncompensable because it was directed to amelioration of a preexisting condition made symptomatic by a compensable injury. In both cases, 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 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.

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[1] Claimant argues that it would be inappropriate for us to apply the rationale in Dietz v. Ramuda, supra, as the Supreme Court has granted review of the Dietz decision. We disagree. Until Dietz is overturned, it is applicable law under the principle of stare decisis.

In the case before us, we conclude that the medical evidence establishes that the injury is the major contributing cause of claimant's disability and need for treatment.

Claimant experienced a left shoulder dislocation in 1986 that resulted in chronic instability and an eventual surgical repair in 1990. Ten months later, claimant experienced a minor subluxation while weightlifting. (Ex. 16). On November 22, 1993, claimant frankly dislocated his shoulder while working overhead in a forced abduction, external rotation maneuver while lifting, pulling and reaching overhead. Subsequently, claimant experienced persistent instability which required reconstructive surgery.

We find the opinion of Dr. Brenneke, claimant's treating physician, more persuasive than those of Drs. Duff, Wade and Fuller, who each examined claimant one time for SAIF. Weiland v. SAIF, 64 Or App 810, 814 (1983). Dr. Brenneke found that claimant had preexisting arthritic degeneration in his shoulder that resulted from wear and tear and instability. He evaluated the subluxation incident as minor and opined that claimant's work activity was the major contributing cause of the current dislocation and subsequent instability. He explained the mechanism of injury as claimant's working overhead in a forced abduction, external rotation maneuver while lifting, pulling and reaching, which was sufficient to cause stretching and tearing of the tissue in the front part of the shoulder, and which led to persistent instability thereafter. (Exs. 27A, 30 and 33). In contrast, Dr. Duff's opinion that claimant's work was not the major contributing cause of the need for reconstructive surgery is conclusory and thus not persuasive. (Ex. 22). Both Dr. Wade and Dr. Fuller attribute the major cause of claimant's current instability to his previous dislocations and the subluxation incident, but fail to explain why they think that the work incident was merely a minor precipitating cause of claimant's dislocation and subsequent instability. (Exs. 28, 29, 31 and 32).

Accordingly, based on Dr. Brenneke's well-reasoned opinion, we find that the November 1993 shoulder injury was the major contributing cause of claimant's resultant shoulder dislocation, subsequent disability and need for treatment. Burtis, supra; Dietz, supra. Therefore, we affirm the Referee's order setting aside SAIF'S January 7, 1994 denial.

Finally, claimant is entitled to an additional attorney fee for services on reconsideration. ORS 656.382(2); Rene G. Gonzalez, 45 Van Natta 499 (1993). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on reconsideration is $300, to be paid by SAIF. This fee is in addition to the attorney fee granted by our prior order. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 15, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ADELAIDA C. BOGARIN, Claimant
WCB Case No. 94-03018
ORDER ON REVIEW
H. Galaviz-Stoller, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Hazelett's order which: (1) upheld the insurer's alleged "de facto" denial of her cervical injury claim; and (2) declined to award penalties or attorney fees for the insurer's allegedly unreasonable failure to accept or deny the cervical injury claim. On review, the issues are compensability, penalties and attorney fees.

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

The Referee upheld the insurer's "de facto" denial of an alleged cervical condition, reasoning that the medical evidence did not establish that a cervical disc protrusion at C5-6 was related to claimant's compensable May 1993 injury. The insurer accepted the May 1993 injury as a low back strain, right shoulder strain and fractured right central incisor tooth.

On review, claimant contends that the Referee mistakenly limited her cervical claim to one for a cervical disc. Claimant cites medical evidence which she asserts establishes that she sustained a cervical injury as a result of her compensable May 1993 injury.

At the outset, we agree for the reasons cited in the Referee's order that the C5-6 cervical disc protrusion is not related to her compensable injury. The medical evidence supporting claimant's contention that she sustained some other cervical condition is also insufficient to establish medical causation.

Claimant notes a May 26, 1993 form 827 from an unidentified physician at the Eubanks Family Care Clinic. (Ex. 2). In the diagnosis portion of the form, the word "cervical" is present. However, the rest of the diagnosis is illegible. In light of this, we are unable to ascertain what, if any, cervical condition the physician was referring to.

We also do not consider the diagnosis of a cervical strain by a rehabilitation coordinator, Dr. Torkko, to be sufficient evidence that claimant sustained a cervical strain as a result of her May 1993 injury. (Ex. 15). Although Dr. Torkko stated that the strain was "from an on-the-job injury," this bare conclusion without further explanation does not establish a causal relationship between the alleged strain and claimant's accident. See Somers v. SAIF, 77 Or app 259, 263 (1986); Joyce C. Claridge, 46 Van Natta 2513, 2515 (1994).

Finally, claimant cites a January 25, 1994 report from Dr. Ordonez, a consulting neurosurgeon, who concluded that claimant's injury caused neck pain. (Ex. 20). Like the other medical evidence on which claimant relies, we do not find that this report establishes the presence of a cervical condition related to claimant's injury. Although the record indicates that claimant has experienced cervical pain on occasion, the majority of her complaints have centered around the right shoulder and low back. (Exs. 6, 7, 13, 18, 19, 20, 23, 24, 25, 28A). The mere statement that claimant has neck pain does not prove that claimant has a cervical "condition." Moreover, Dr. Ordonez provides no explanation for his statement that the neck pain is related to the compensable injury. Somers v. SAIF, supra; Joyce C. Claridge, supra.

Therefore, even assuming that the aforementioned medical records constitute a cervical "claim," there is insufficient evidence that claimant sustained a cervical condition that is materially related to the compensable May 1993 accident. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Thus, we affirm the Referee's decision upholding the insurer's "de facto" denial.

ORDER

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

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

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Peterson's order which affirmed the Director's order finding that claimant was not a subject worker. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, and we add the following facts.

Employee Dibrel worked at least 17 days from October 18 through November 5, 1993, at the Albertson's job site in Oregon.

Employee Savage worked at least eight days from November 14 through December 6, 1993, at the Albertson's job site in Oregon.

Employee Birdwell worked at least seven days from October 1 through November 8, 1993, at the Albertson's job site in Oregon.

Employee Dorr worked at least 12 days from the week ending December 5, 1993, through the week ending December 19, 1993, at the Albertson's job site in Oregon.

Mr. Croak, the owner and a salaried employee of the refrigeration company, was at the Albertson's job site in Oregon approximately 90 percent of the time from October 10, 1993 through the end of the calendar year.

FINDING OF ULTIMATE FACT

We do not adopt the Referee's finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Subjectivity

The Referee held that, under ORS 656.126, claimant was injured at the employer's "temporary workplace" in Oregon, because the injury occurred less than 30 days after work under the Oregon contract had begun. Therefore, the Referee concluded that claimant was not a subject worker and was not eligible for workers' compensation benefits under Oregon law. We disagree.

First, we briefly summarize the pertinent facts. The employer, a refrigeration service company, began work in October 1993, on a $133,000 contract to rebuild the refrigeration system at an Albertson's grocery store in Oregon. The parties do not dispute that the employer is a Washington company, and that it carried Washington workers' compensation coverage for its employees.

Claimant was hired in the employer's Washington office on October 25, 1993. He was immediately assigned to work on the Albertson's job in Oregon. (Tr. at 47-48). On October 26, 1993, claimant sustained an injury while working on the Albertson's job.

Mr. Croak, president and an employee of the refrigeration company, testified that he was at the Albertson's job site approximately 90 percent of the time between October 10, 1993, and the end of the calendar year. Croak confirmed that other people also worked at the Albertson's job site, for an accumulated total of at least 30 days in the 1993 calendar year. (Tr. 9-10).

ORS 656.126(2) provides, in pertinent part:

> "Any worker from another state and the employer of the worker in that other state are exempted from the provisions of this chapter while the employer has a temporary workplace within this state and the worker is within this state doing work for the employer:
>
> a) If that employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of a state other than Oregon so as to cover that worker's employment while in this state;
>
> (b) If the extraterritorial provisions of this chapter are recognized in that other state; and
>
> (c) If employers and workers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state." (Emphasis added).

In this case, whether or not claimant was a subject worker turns on whether the employer had a temporary workplace in Oregon when claimant was in Oregon working for the employer. If claimant was working at his employer's "temporary workplace" in Oregon, claimant would be a nonsubject Oregon worker, since there is no dispute that the specific conditions under ORS 656.126(2)(a)-(c) have been met. ORS 656.126(6) defines "temporary workplace" as follows:

> "For the purpose of this section, "temporary workplace" does not include a single location within this state where the employer's work is performed by one or more workers for more than 30 days in a calendar year."

Thus, the key question here is whether the employer's workplace at the Albertson's job site was or was not a "temporary workplace."

When interpreting a statute, our task is to discern the legislature's intent. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The best evidence of the legislature's intent is the text of the statute. Id. at 610-11. If the intent of the legislature is not clear from the text and the context of the statute, we then consider the legislative history of the statute. Id. 611-12.

Here, we find that the text of the statute is clear. The focus of inquiry is on the employer's workplace, not on the individual worker. If the employer's workplace is a single location within this state where the employer's work is done by one or more workers for more than 30 days in a calendar year, then the workplace is not "temporary." ORS 656.126(2) further provides that if the workplace is not temporary, then the employer is not exempt from providing Oregon workers' compensation coverage for its workers.

Although we do not find it necessary to resort to legislative history in order to discern the legislature's intent, we nevertheless note that the legislative history supports our interpretation. The current version of ORS 656.126 was adopted in 1989, at which time subsection (2) was amended and subsection (6) was added. 1989 Oregon Laws ch 684, HB 3176. The language adopted by the legislature was proposed by the Workers' Compensation Division. House Labor Committee, March 31, 1989, Tape 86, Side A at 240 and Exhibit A; House Labor Committee, April 7, 1989, Tape 97, Side A at 316-99 and Exhibits D, F.

The purpose of the amendments was to change the workers' compensation extraterritorial reciprocity agreements with other states in such a way as to address a perceived crisis in Oregon border communities. Specifically, the legislature sought to stem the flow of construction, logging and other contracts out of state due to lower workers' compensation costs in neighboring states. Contractors in border communities complained that they were being outbid on Oregon jobs due to the higher cost of workers' compensation coverage in Oregon. House Labor Committee, March 31, 1989, Tape 85, Side B at 245 to end and Tape 86, Side A; Senate Labor Committee, June 6, 1989, Tape 166, Side B at 391 (Reps. Shoemaker and Nelson).

To address the crisis, the Workers' Compensation Division proposed amendments to ORS 656.126 that would require Oregon workers' compensation coverage on all longer-term (more than 30 days) projects in this state. Larry Young, manager of the Workers' Compensation Division, explained how the proposed amendment would affect reciprocity agreements with other states:

> "What it does, it retains the current extraterritorial provisions as they are, with one exception: An out-of-state employer comes into the state is going to have workers at a single work site for more than 30 days in a calendar year, the extraterritorial provisions do not apply, and the employer is an Oregon employer subject to our laws."

House Labor Committee, March 31, 1989, Tape 86, Side A at 254-77. Later, Mr. Young explained that the Division's proposed amendment "identifies [a] condition under which extraterritorial coverage provisions will not apply, by changing the emphasis to the employer being in the state with employees, as opposed to the worker being in the state." House Labor Committee, April 7, 1989, Tape 97, Side A at 43.

In response to Representative Mannix's question regarding the clarity of the definition of "temporary workplace," Mr. Young said, "The intent of the language was to provide that where work is being performed for 30 days with the employer's workers - if a project takes 30 days or more to complete in a calendar year ," then the workplace would not be temporary. Id. at 170. Expressing concern that employers might try to avoid the statute by rotating workers, Representative Mannix stated, "The legislative intent is that - and we'll say it on the record - that people should not be able to get around this by moving people across state lines every 29 days." Id. at 190.

Thus, we find that the legislative history of the amendments is consistent with our interpretation of the statute. The focus is on the employer's workplace, and if the employer has workers working at a single location in this state for more than 30 days, then the employer is not exempt from providing Oregon workers' compensation coverage for his workers.

Here, after our review of the record, we conclude that the employer employed workers at the Albertson's job site for an accumulated total of more than 30 days in the 1993 calendar year. Therefore, the Albertson's job site was not a "temporary workplace," and the employer was not exempt under ORS 656.126(2) from providing Oregon workers' compensation coverage for its employees while they were working at the Oregon job site.

In reaching this conclusion, we are persuaded that the employer's workers performed work at the Albertson's job site in Oregon for at least approximately 46 days in the 1993 calendar year (Dibrel - 17 days, Savage - 8 days, Birdwell - 7 days, Dorr - 12 days, and claimant - 2 days).[1] In further support of our conclusion, we note that the owner-employee, Mr. Croak, spent approximately 90 percent of his time from October to the end of 1993 at the Albertson's job site in Oregon.[2] (Tr. 38).

We consider it immaterial that the injury occurred during the first 30 days on the job site. The Albertson's project itself took more than 30 workdays to complete. The length of the project itself is the key consideration, as expressed in the legislative history of the statute. The employer even concedes that he had workers on the job site more than 30 days in a calendar year. Whether Oregon workers' compensation coverage is required depends on the length of the project, not on when during the project a worker was injured.

Accordingly, we find that claimant was a subject worker of a subject employer under the Oregon Workers' Compensation Law. ORS 656.126(2).

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[1] Mr. Croak contends that some of his "employees" were independent contractors, rather than employees, during a portion of the time they worked for Croak on the Albertson's job site. In arriving at the number of days worked by each employee, the time that Croak alleged was worked as an "independent contractor" was not counted. Thus, whether a worker's status was "employee" or "independent contractor" is moot, since the accumulated total number of days worked at the Oregon job site exceeds 30 days even when the alleged "independent contractor" days are excluded from the calculation.

[2] Mr. Croak contends that his time at the Albertson's job site should not be included because he is the principal owner of the corporation, not an employee. In totaling the number of days worked at the Albertson's job site, Mr. Croak's time was not included. Even without considering Mr. Croak's time, the number of days that workers performed work at the Albertson's site in Oregon exceeds 30. Thus, it is not necessary to determine whether Mr. Croak is or is not an employee.

Penalty - Attorney Fee

In his appellant's brief, claimant seeks a penalty or penalty-related attorney fee. Claimant raised this issue for the first time on review. Inasmuch as this issue was not addressed at hearing, we decline to consider it for the first time on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Attorney Fees

Claimant seeks an assessed attorney fee under ORS 656.386(1) for his services at hearing and on review. That statute is not applicable. An assessed attorney fee may be awarded pursuant to ORS 656.386(1) when a claimant finally prevails over a denial of compensability of a claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988); see also O'Neal v. Tewell, 119 Or App 329 (1993); Gloria J. Shelton, 44 Van Natta 2232 (1992).

Here, the hearing did not pertain to compensability or address the merits of compensability of a claim. Rather, the hearing arose from a director's decision that claimant was not a subject worker and solely addressed whether claimant was a subject worker at the time of his injury. Consequently, claimant is not entitled to an attorney fee under ORS 656.386(1). Stephen M. Olefson, 46 Van Natta 1762, 1762 (1994); Michael A. Haggenson, 45 Van Natta 2323 (1993).

However, it is possible that claimant's claim eventually may be accepted by the SAIF Corporation should the Department issue a noncomplying employer order under ORS 656.052 and refer the claim to SAIF under ORS 656.054. If that is the case, claimant's attorney's efforts at this subjectivity hearing will have ultimately resulted in the payment of compensation to claimant. In light of such circumstances, we conclude that claimant's attorney is entitled to an "out-of-compensation" attorney fee payable from the temporary disability compensation, if any, that eventually results from this order. Stephen M. Olefson, supra. This fee shall equal 25 percent of the increased temporary disability, if any, eventually resulting from this order, not to exceed $3,800. See OAR 438-15-055.

ORDER

The Referee's order dated May 16, 1994 is reversed. The Director's subjectivity determination dated January 12, 1994 is reversed. Claimant's counsel is awarded 25 percent of the temporary disability compensation, if any, eventually resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

March, 6, 1995 Cite as 47 Van Natta 367 (1995)

In the Matter of the Compensation of
DONALD HOLCOMB, Claimant
WCB Case No. 93-04299
ORDER ON REVIEW
David Force, Claimant Attorney
Brian Pocock, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee Brown's order that: (1) found claimant permanently totally disabled; and (2) assessed a penalty for an allegedly unreasonable failure to pay a permanent disability award. On review, the issues are permanent total disability and penalties. We affirm.

FINDINGS OF FACT

On July 5, 1975, claimant sustained an injury to his left hip and low back. A January 1980 Determination Order awarded 15 percent unscheduled permanent disability. (Ex. A31). Claimant appealed the order in a hearing before Referee Peterson.

In January 1981, Referee Peterson issued an order finding claimant permanently totally disabled. (Ex. A34). In making his conclusion, Referee Peterson adopted claimant's counsel's written closing argument stating that, at age 10, claimant sustained an injury to his right eye that permanently reduced the vision and, in 1957, was in a motorcycle accident that resulted in the loss of bone and shortening of the left leg. (Id. at 4). The closing argument further indicated that, following the 1975 injury, claimant developed hyperthyroidism and Graves' disease. In his order, Referee Peterson specifically found that such condition was a "compensable residual" of the 1975 injury. Referee Peterson further found, however, that claimant had not proved any psychological disability that resulted from the injury. (Id. at 2).

In February 1982, the Board affirmed and adopted Referee Peterson's order, with an additional comment rejecting the employer's assertion that claimant was not permanently totally disabled because he had the potential to be employable. (Ex. A35).

In December 1992, upon the employer's request for redetermination, the Department issued a Determination Order finding claimant no longer permanently totally disabled and awarding 14 percent unscheduled permanent disability, as well as 21 percent and 4 percent scheduled permanent disability in the hips. (Ex. A61). The order further provided that the insurer was not required to pay the award if such amount had already been paid.

The Referee in this proceeding found claimant permanently totally disabled. Specifically, the Referee determined that claimant's ability to perform work was "largely irrelevant" since the record showed that any work he could perform earned less than his income from social security and, therefore, was not "profitably remunerative." The Referee also found that claimant proved a willingness to work.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

Permanent total disability (PTD) is a loss "which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1). "Suitable occupation" is that "which the worker has the ability and the training or experience to perform." ORS 656.206(1)(a). "Gainful occupation" is one providing "profitable remuneration." Tee v. Albertsons, Inc., 314 Or 633, 643 (1992). Along with permanent physical incapacity, the worker may prove PTD with the "odd lot" doctrine, under which a combination of medical and non-medical disabilities effectively foreclose the worker from performing gainful and suitable employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

We first note that, based on the previous litigation before Referee Peterson and the Board, we consider claimant's hyperthyroidism and Graves' disease to be compensable consequences of the 1975 injury. See Drews v. EBI Companies, 310 Or 134, 140-41 (1990). Therefore, any disability from such conditions is included in determining whether claimant proved PTD.

According to claimant, Referee Peterson also found claimant's "chronic anxiety-nervousness condition" to be a compensable consequence. In his order, Referee Peterson concluded that claimant did not have any "psychological disability," although he noted that there was "evidence of nervousness." We construe the order as having determined that, whether or not due to the injury, claimant had no disability from any emotional condition, including "nervousness." Thus, the effect of the 1981 litigation is to bar claimant from asserting that his "nervous condition" was disabling as of that date. Drews v. EBI Companies, supra.

With regard to claimant's present disability, there was testimony from claimant's treating internist, Dr. Berven, that claimant suffered from a variety of conditions, including premature ventricular contractions, nervousness and anxiety, chronic fatigue, and a lack of visual depth perception. (Tr. 55, 58 (Day 2)). Dr. Berven stated that, in view of claimant's orthopedic and visual impairment, as well as chronic fatigue, he would have difficulty working and be frequently absent from a job. (Id. at 62).

Claimant also was examined by several physicians at the employer's request. Dr. Howell, osteopath, found no orthopedic impairment in claimant's low back and left hip, the areas injured in the 1975 accident. (Ex. A52-12). However, Dr. Howell provided some recommendations for improving "gait abnormalities" caused by the shortening of the left leg. (Id).

Dr. Musa, endocrinologist, addressed claimant's thyroid condition; he first noted the development of hyperthyroidism and Graves' disease following the 1975 accident and that the thyroid was subsequently destroyed with iodine treatment. (Ex. A54-1). He further indicated that claimant then developed hypothyroidism and takes thyroid replacement medication. (Id). Dr. Musa found that claimant's thyroid condition was well-controlled with medication and produced no disability. (Id. at 3).

Dr. Fay, ophthalmologist, diagnosed several conditions relating to claimant's eyes, including a history of Graves' disease, now stable, exotropia (skewing) of the left eye, and a cataract in the left eye. (Ex. A55-1). Dr. Musa found claimant was "legally blind" in the left eye and some "cosmetic impairment" from a minor condition of exophthalmos (eye bulging). (Id. at 2; Ex. A68-6). According to Dr. Musa, claimant presently had no impairment from the Graves' disease and, with correction, claimant's vision in the right eye was normal. (Ex. A68-8, -10). Although recommending caution when working around heavy equipment or machinery, Dr. Musa felt that claimant was able to perform most functions using only his right eye. (Id. at 10-11).

Finally, Dr. Rich, neurologist, and Dr. Donahoo, orthopedic surgeon, examined claimant, finding that, from an "orthopaedic and neurologic standpoint," claimant could perform light to sedentary work activities. (Ex. A59-4, -5). The panel indicated that claimant's visual problems were more disabling than his orthopedic conditions. (Id).

Steven Cardinal, vocational rehabilitation counselor, provided vocational analysis on behalf of the employer. According to Mr. Cardinal, claimant was "imminently employable * * * in unskilled, light work activities[.]" (Ex. B45-1). In particular, Mr. Cardinal provided six job analyses that he found was suitable employment for claimant. These jobs included retail sales clerk, light maintenance, cashier, electromechanical technician, alarm protective signal operator, and general delivery driver. Mr. Cardinal then submitted each job analysis to Drs. Fay, Musa, Howell, and Donahoo for approval.

Dr. Musa approved all of the jobs, again indicating that claimant had no disability from his thyroid condition. (Ex. B51). Dr. Fay approved the jobs of retail sales clerk, cashier, and alarm protective signal operator. (Ex. B50-9, -27, -45). However, for the light maintenance and electromechanical technician positions, Dr. Fay noted "poor depth perception" and that it "may be dangerous" for claimant to work around mechanical or moving equipment. (Id. at 10, 28). Although not disapproving of the general delivery driver job, Dr. Fay noted that claimant was legally blind in the left eye. (Id. at 46).

Dr. Howell approved, without comment, the job analyses for light maintenance, electromechanical technician, general delivery driver, and alarm protective signal operator. (Ex. B52-18, -36, -45, -54). However, he indicated that the retail sales clerk position had to be modified to provide for a period of sitting 5 minutes every hour and that the cashier position had a standing requirement that was beyond claimant's abilities. (Id. at 9, 19).

Dr. Donahoo approved, without comment, the positions of retail sales clerk, cashier, alarm protective signal operator, and general delivery driver. (Ex. B54-9, -36, -45, -54). However, he indicated that the "awkward position/lifting" required by the light maintenance job was out of claimant's light/sedentary range. (Id. at 18). Furthermore, like Dr. Howell, he also found that the "prolonged standing" required by the cashier job was beyond claimant's light/sedentary range. (Id. at 27).

On Dr. Berven's referral, claimant also underwent a work capacity evaluation to test his physical capacities, which found that claimant could perform in the light work range. (Ex. A67-4). The evaluation also included a work assessment whereby claimant simulated the work activities of the job analyses provided by Mr. Cardinal. The report found that claimant was unable to perform the job duties for the positions of general delivery driver and light maintenance because they were beyond his physical capabilities. (Id. at 7). With regard to the jobs of retail sales clerk and cashier, the report indicated that claimant had "significant difficulty" performing on the cash register and stocking items. (Id). Specifically, the report stated that claimant "could conceivably perform these two jobs on a part-time basis, not to exceed four hours daily although he would not be productive * * * and would require frequent rest breaks and opportunities to change activities." (Id). The report found that an "ideal employment setting with a fully cooperative employer" would be necessary for claimant to perform the two jobs. (Id).

For the positions of electromechanical technician, the report indicated that modifications would be necessary, including a magnifying glass and fully adjustable chair. (Id. at 8). The report also identified modifications necessary for the alarm protective signal operator technician, including large screened monitors and sitting breaks. (Id). It was also found that claimant could perform both jobs for a maximum of four hours per day with frequent rest periods. (Id). Finally, the report indicated that claimant's level of productivity "would also be significantly below entry level." (Id).

During the hearing, Dr. Howell and Dr. Donahoo testified regarding the work capacity evaluation. Both physicians stated that they gave the report little weight because the testing results relied upon subjective findings. (Tr. 34, 102 (Day 3)). Both physicians also testified that they took the same hand dexterity tests that claimant underwent during the evaluation; the evaluators found that the tests showed that claimant's general fine coordination and dexterity were impaired because of poor depth perception and large callused hands. (Ex. A67-3). Dr. Howell criticized the report for lacking information regarding the number of trials and the population to which claimant's test results were compared. (Tr. 34-35 (Day 3)). However, in describing his own testing experience, Dr. Howell testified that monocular vision made a significant difference with the Purdue test and that large hands would increase the difficulty with manipulating fine objects. (Id. at 36). Similarly, in discussing the Purdue test, Dr. Donahoo stated that, given the large size of claimant's hands, he would expect claimant to perform poorly on the test and Dr. Donahoo "would not put him in charge of that very fine work." (Id. at 106-07).

Based on the medical evidence alone, we are not persuaded that all of the positions proposed by Mr. Cardinal are suitable employment. First, with regard to the positions of light maintenance and electromechanical technician, both Dr. Fay and Dr. Donahoo essentially disapproved of the job, citing to claimant's lack of depth perception and the awkward positions required. Dr. Howell and Dr. Donahoo also disapproved of the job analysis for cashier, stating that modifications were necessary before claimant could perform it.

Although Dr. Howell recommended a modification for the job of retail sales clerk, due to the sufficiently minor nature of the modification, we find that all of the examining physicians initially approved that particular analysis. However, we find proof supporting the work capacity evaluation report that claimant was unable to perform the job because of his inability to work on a cash register. We base this finding on the testimony of Drs. Howell and Donahoo that claimant would not be able to perform fine dexterity, either because of his monocular vision or large hands. Therefore, we also discount this position with regard to its suitability.

The remaining positions are that of general delivery driver and alarm protective signal operator technician. For the following reasons, we also find them not to qualify as suitable employment. First, there was testimony by Areta Sturges, a vocational rehabilitation counselor who provided services on behalf of claimant, that the general delivery driver fell in the medium range and, therefore, exceeded claimant's lifting capacity. (Tr. 102 (Day 1)). Mr. Cardinal, who subsequently testified, agreed with Ms. Sturges that most of the jobs in this category were not within claimant's lifting restrictions. (Id. at 166-67). Based on this testimony, we find the job analysis provided to the examining physicians to be inaccurate and, therefore, give little weight to their approval of the position. Furthermore, because the position exceeds the work category of light to sedentary indicated by Dr. Donahoo and the work capacity evaluation, we find that it is not suitable.

With regard to the alarm protective signal operator technician position, Ms. Sturges testified that claimant did not meet the SVP of 5. (Id. at 103). Moreover, Ms. Sturges stated that the job was not "reasonably available" because there were only 48 such positions in the entire state. (Id. at 105). Ms. Sturges' testimony regarding availability was disputed by Mr. Cardinal, who testified that Medford had two alarm companies employing 14 monitors and there was an opening in Klamath Falls, where claimant lives, at Basin Alarm. (Id. at 158, 161). Ms. Sturges then submitted a report describing her findings after further researching the position of alarm protective signal operator technician. Specifically, Ms. Sturges indicated that she contacted the two alarm companies in Klamath Falls and discovered that one did not and would not hire any other persons but family members and the other, Basin Alarm, had no employees since all monitoring was performed through an 800 number outside the state. (Ex. B67-1).

Based on Ms. Sturges' report, which contains the most recent information regarding the position of alarm protective signal operator technician, we find that the job essentially is not available to claimant since there are no such positions in Klamath Falls, where he lives, or within reasonable commuting distance. Hence, we also find this job not to be suitable employment. See James D. Terry, 44 Van Natta 1663, 1664 (1992) (opinion concerning suitability of employment is not persuasive in absence of proof that such work is available to the claimant).

According to Dr. Berven, Ms. Sturges, and the work capacity evaluation, claimant is unable to regularly perform any work. We find that such evidence was not overcome by the employer's contention that claimant is able to work in the six proposed positions since, as explained above, we find a lack of proof that they constitute "suitable employment." Hence, we conclude that the preponderance of evidence shows that claimant is permanently incapacitated from regularly performing suitable employment. Thus, we do not reach the issue of whether claimant is capable of performing "gainful employment."

The employer also asserts that claimant failed to prove a willingness to seek regular gainful employment or that he made reasonable efforts to obtain such employment, as required by ORS 656.206(3). In particular, the employer asserts that evidence from Mr. Cardinal shows that claimant "sabotaged any attempts to return him to gainful employment."

In May 1992, Mr. Cardinal arranged for claimant to interview for positions as a hotel desk clerk and light maintenance. (Ex. B47-2). In his report, Mr. Cardinal described the interview as "most discouraging and depressing" because claimant "passively resisted" against securing a position or "actively engage" the interviewer "in any meaningful conversation" concerning the work. (Id. at 3).

Following this interview, Mr. Cardinal completed an application with a newspaper company, which claimant refused to sign. (Ex. B49-2). Nevertheless, Mr. Cardinal turned in the application. (Id). Mr. Cardinal then received a telephone call from claimant, during which claimant expressed anger concerning Mr. Cardinal's actions and informing Mr. Cardinal that he had been called for an interview. (Id). Mr. Cardinal then contacted the interviewer at the paper, who stated that claimant failed to express "any serious interest" in the job or in returning to work as a general matter. (Id).

Although such evidence shows that claimant did not exhibit an enthusiastic attitude during the two interviews described by Mr. Cardinal, we do not find it sufficient proof that claimant failed to show a willingness to perform or make reasonable efforts to obtain gainful employment. The record also shows that claimant repeatedly showed a desire to work as a night watchman for the employer. For instance, a vocational rehabilitation counselor who met with claimant before he moved to Klamath Falls, testified that claimant stated to her that he was physically able to perform such work and requested that the counselor "check into that." (Tr. 206-07 (Day 1)). Mr. Cardinal provided similar testimony, stating that claimant was "most emphatic" about speaking with the employer concerning such a position. (Id. at 193). Furthermore, Mr. Cardinal stated that claimant never failed to attend meetings or respond affirmatively to any request and that he dressed appropriately when necessary. (Id. at 170).

Based on such evidence regarding claimant's behavior following the Determination Order that rescinded claimant's permanent total disability award, we find a willingness by claimant to perform gainful employment, especially as a night watchman for the employer. Furthermore, in view of claimant's cooperative attitude and behavior he exhibited with Mr. Cardinal, we are also persuaded that he made reasonable efforts to obtain gainful employment.

Finally, the employer asserts that we should find claimant not credible on the basis that he exhibited discrepant behavior during examinations and provided untruthful testimony regarding his driving activities. We agree that, according to Dr. Howell, claimant exhibited "atypical behavior" during his examination with the physician by tensing his left leg and thoracolumbar muscles along the spine. (Ex. A52-8, -9). Dr. Howell interpreted this behavior as "an effort to persuade me that disability or a degree of disability is present which is not actually experienced by [claimant]." (Id. at 10).

Despite his observations, Dr. Howell found some low back and left hip impairment and indicated that two of the six positions proposed by Mr. Cardinal had to be modified before claimant could perform them. Thus, even assuming that Dr. Howell correctly observed and interpreted claimant's behavior, we find evidence that he believed that claimant had at least some actual impairment.

There also was testimony from an investigator who performed surveillance contradicting claimant's testimony that he stopped a number of times during a trip between Klamath Falls and Medford, as well as videotape showing claimant lifting some groceries, lifting a large piece of plywood and working in his wife's shop. Dr. Howell testified that such evidence had no effect on his opinion concerning claimant's condition. (Tr. 70 (Day 3)). Dr. Donahoo testified that, because claimant exhibited fluid motion during the videotape, he found evidence that he did not have back pain. (Id. at 91-93). However, Dr. Donahoo also stated that he and Dr. Rich had found no abnormal pain behavior or functional overlay during their examination. (Id. at 136).

Even assuming that such evidence is sufficient to show that claimant exaggerated his condition, we find no effect on the determination concerning claimant's permanent total disability status. As provided above, Dr. Howell's opinion was not effected by such evidence. Although there is some indication that Dr. Donahoo doubted claimant's testimony regarding his low back pain, we find no evidence that Dr. Donahoo retracted his earlier opinion that claimant was impaired to the point of placing him in the light to sedentary range. In short, because we find that the evidence relied upon by the employer as showing claimant to be not credible did not influence the medical opinions of Drs. Howell and Donahoo, we also find it to be insufficient to change our previous findings regarding claimant's capacity to perform suitable employment.

In conclusion, because we find claimant to be permanently incapacitated from performing suitable employment and that he showed a willingness to seek gainful employment and made reasonable efforts to obtain such employment, we agree with the Referee that claimant proved he is permanently totally disabled.

Claimant's attorney is entitled to an assessed fee for prevailing over the employer's request for hearing regarding the PTD issue. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $5,850, 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 and counsel's statement of services), the complexity of the issue, and the great value of the interest involved.

Penalties

The Referee found that it was unreasonable for the employer to fail to pay the 14 percent unscheduled permanent disability awarded by the 1992 Determination Order and assessed a penalty on that basis. The employer asserts that its action was not unreasonable because the Determination Order expressly provided that, if the award had "already been paid as a result of prior orders, the insurer is not required to pay any further benefits for permanent partial disability." (Ex. A61). The order further provided that the "insurer is ordered to pay you any unpaid portion of $5,866.00." (Id).

Whether or not the employer was reasonable in relying on the language in the Determination Order that in effect allowed the employer to offset its prior PTD payments against the permanent partial disability awards, the employer has not offered any evidence that it had already paid more than the amount awarded by the Determination Order. Thus, we have no basis for determining whether it correctly "offset" such awards by failing to pay the amount provided by the Determination Order. Consequently, in the absence of any other explanation for the employer's action in failing to pay the award, we agree with the Referee's assessment of a penalty.

ORDER

The Referee's order dated April 28, 1994 is affirmed. For services on review regarding the PTD issue, claimant's attorney is awarded an assessed fee of $5,850, to be paid by the self-insured employer.

In the Matter of the Compensation of
SCOTT C. RICE, Claimant
WCB Case No. 94-02667
ORDER ON REVIEW
H. Galaviz-Stoller, Claimant Attorney
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee T. Lavere Johnson's order that: (1) "approved" the insurer's denial of right carpal tunnel syndrome; and (2) upheld the insurer's denial of his occupational disease claim for overuse syndrome of the right upper extremity. 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 two exceptions. We do not adopt the Referee's finding in the third paragraph on page 2 that neither Dr. Daniels nor Dr. Gail treated claimant. Similarly, we do not adopt the Referee's finding of fact in the second full paragraph on page 3 that claimant has not received medical treatment.

CONCLUSIONS OF LAW AND OPINION

Right Carpal Tunnel Syndrome

The insurer issued a denial of a claim for right carpal tunnel syndrome on February 11, 1994. At hearing, claimant asserted that he had never a made a claim for right carpal tunnel syndrome. The insurer contended that there was a claim for right carpal tunnel syndrome that was formally denied. The Referee found that the insurer's denial was moot and "approved" the denial.

Claimant can establish that the denial is premature if he can show that no claim for carpal tunnel syndrome was made. William H. Waugh, 45 Van Natta 919 (1993). Here, the record does not support a finding that the insurer's denial of right carpal tunnel syndrome was premature. Dr. Daniels examined claimant on November 16, 1993 and diagnosed probable carpal tunnel syndrome. On November 19, 1993, claimant was examined by Dr. Gail, who diagnosed probable carpal tunnel syndrome and referred claimant to another physician. Nothwithstanding claimant's attempt to withdraw a claim for carpal tunnel syndrome, the reports from Drs. Daniels and Gail constituted a claim, which the insurer had a legal duty to accept or deny. See William H. Waugh, supra; Michael C. Holt, 44 Van Natta 962 (1992). Claimant requested a hearing on the denial. The Referee, therefore, correctly declined to set aside the employer's denial based on an assertion by claimant's attorney at hearing that the claim was not a claim, or that the claim, if legally constituted, was being withdrawn. See Michael C. Holt, supra.

Overuse Syndrome of the Right Upper Extremity

Claimant argues that the Referee erred by finding that claimant had not received any medical treatment for his right upper extremity condition. We agree.

Claimant must show that his occupational disease required medical services or resulted in disability. ORS 656.802(1). Claimant's "827 form," which described right hand pain, reflected that Dr. Daniels examined claimant on November 16, 1993 and diagnosed probable carpal tunnel syndrome. (Ex. 1). Dr. Daniels marked "8-12 Weeks" as "Estimate Length of Further Treatment."

On November 19, 1993, claimant was examined by Dr. Gail, who diagnosed probable carpal tunnel syndrome and referred claimant to another physician. (Ex. 2). Claimant testified that Dr. Gail restricted his work to light duty, although claimant was not working at that time. (Tr. 22). Although claimant was initially diagnosed with carpal tunnel syndrome, he was later diagnosed with a right upper extremity overuse syndrome. In light of the reports from Drs. Daniels and Gail and claimant's testimony, we find that claimant's condition of right overuse syndrome required medical services and resulted in disability.

Claimant contends that the Referee erred by concluding that his claim was not compensable because his work activity caused symptoms only and did not affect the underlying pathology. We agree.

Claimant must prove that work activities were the major contributing cause of his right upper extremity overuse syndrome. See ORS 656.802(2). Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. See Weller v. Union Carbide, 288 Or 27 (1980). However, if the medical evidence establishes that the claimant's symptoms are the disease, 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, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

Dr. Strum and Dr. Wilson examined claimant on behalf of the insurer. They diagnosed claimant with "nonspecific overuse syndrome of the right upper extremity." (Ex. 6). They reported that claimant's right shoulder flexion, extension and internal rotation were diminished in comparison to the left. In addition, claimant's range of motion in the right elbow was diminished when compared with the left, as was the right wrist extension, radial deviation and grip strength. The physicians also found decreased sensation in the right forearm. They concluded that claimant's work activities, mainly the repetitive usage of his right upper extremity, were the major contributing cause of the development of his symptoms. Dr. Gail concurred in their report.

In a subsequent "check-the-box" report, Dr. Wilson said that there "was no identifiable, underlying, pathology associated with [claimant's] right upper extremity that would explain his symptoms." (Ex. 10). Dr. Wilson did not explain any distinctions between the overuse syndrome and the underlying pathology. Furthermore, Dr. Wilson did not explain what underlying pathology would normally be associated with this type of overuse syndrome. In the absence of an explanation from Dr. Wilson, we do not find his subsequent conclusory "check-the-box" report persuasive. See Marta I. Gomez, 46 Van Natta 1654 (1994).

We are satisfied that the January 11, 1994 report of Drs. Strum and Wilson, which was concurred with by Dr. Gail, establishes that claimant's symptoms are the disease. See Georgia Pacific Corp. v. Warren, supra. Drs. Strum and Wilson reported that their motion measurements were valid for rating and disability and they concluded that claimant's work activities were the major contributing cause of the development of his symptoms. (Ex. 6). There is no indication that claimant's condition was related to non-work activities. We conclude that claimant has established that his right upper extremity overuse syndrome is compensable.

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

ORDER

The Referee's order dated July 26, 1994 is reversed in part and affirmed in part. The insurer's denial of claimant's claim for overuse syndrome of the right upper extremity is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review regarding the right upper extremity overuse syndrome claim, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
CLINTONIA M. BRYANT, Claimant
WCB Case No. 94-04259
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Peterson's order which: (1) declined to admit Exhibit 40; and (2) declined to award permanent total disability. On review, the issues are evidence and permanent total disability.

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

Evidence

Claimant contends that the Referee abused his discretion in refusing to admit Exhibit 40, a June 14, 1994 letter from the owner of the ceramics shop where claimant completed her training program. Claimant contends that the evidence is relevant to establish her ability to perform ceramics work in a normal labor market. The Referee excluded the exhibit on the ground that the letter was hearsay and the author of the letter, a lay witness, was not available for cross-examination.

We review the Referee's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). Hearsay evidence is generally admissible in worker's 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).

After our review of the evidence, we conclude that the evidence is not particularly relevant to, and not determinative of, the issue of claimant's employability. Whether or not claimant is employable is based on her ability to sell her services in a hypothetical normal labor market. Thus, claimant's ability to work in one particular ceramics shop does not equate with a "hypothetical"' normal labor market. Furthermore, in light of the medical and vocational evidence concerning claimant's employability, we conclude that, even if the exclusion of the evidence was error, consideration of the exhibit would not alter our conclusion. Accordingly, the Referee did not abuse his discretion in excluding Exhibit 40.

Permanent Total Disability

Relying on the opinions of Dr. Gehling and vocational consultant Hank Lageman, the Referee found that claimant was employable, at least on a part-time basis. Therefore, the Referee concluded that claimant was not permanently and totally disabled.

ORS 656.206(1)(a) provides that a claimant is permanently totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." Claimant contends that she is entitled to permanent total disability (PTD) under the "odd-lot" doctrine. Under that doctrine, claimant is permanently totally disabled due to a combination of her physical condition and nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the condition of the labor market. Clark v. Boise Cascade Co., 72 Or App 397 (1985). However, unless claimant's physical incapacity in conjunction with her nonmedical disabilities renders a work search futile, she must also establish that she has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3); SAIF v. School, 92 Or App 594 (1988). Even if a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, she is willing to work. SAIF v. Stephens, 308 Or 41 (1989).

In Allethe P. Yngsdahl, 46 Van Natta 111 (1994), we held that, in determining whether a claimant is permanently and totally disabled, the initial inquiry is whether claimant is employable, i.e., capable of regularly performing work in any suitable occupation in a hypothetically normal labor market. The claimant in Yngsdahl, supra, worked as an employee entrance watch guard, which consisted of the claimant sitting on a stool near the entrance to the employer's store to ensure that only authorized personnel entered the store. The claimant worked 3 hours a day for 4 days a week and was paid $8.40 per hour. Since the claimant was only employable in a specialized position crafted for her physical limitations, the claimant was not employable in a suitable occupation in the "normal" labor market. Therefore, we found that she was permanently and totally disabled.

Here, claimant is 54 years old, has a 5th grade education, and has dyslexia. Claimant's prior work experience included production line worker, cook, kitchen helper, motel maid, tree planter and housekeeper. Although claimant is physically unable to perform her previous heavy work due to her compensable injury, claimant has the physical capacity to perform sedentary to light work. Claimant has completed a one year on-the-job vocational training as a ceramics assistant, as well as completed training to be a certified ceramics instructor. (Ex. 22).

Hank Lageman, vocational evaluator, opined that claimant was able to work four to five hours, five days a week as an agriculture sorter, entry level cashier, packager, photo lab assistant, quality control worker, day care worker, companion, food production worker or small products assembler. (Exs. 28, 29, 31). Based on claimant's physical and vocational capabilities, and on actual jobs listed with the Oregon Employment Service from employers in claimant's geographical area, Mr. Lageman opined that there were reasonable employment opportunities available to obtain employment. (Ex. 31).

Based on Mr. Lageman's evaluation and on medical evidence that claimant was capable of returning to work, claimant's vocational counselor, Willie Davis, determined that claimant was capable of maintaining permanent employment on a part-time basis. Labor market information and aptitude test results indicated that claimant was employable in the areas of small parts assembly, cashier and day care attendant. However, considering claimant's length of absence from the labor market, her perceptions of her physical and learning disabilities, her presentation, and her entitlement to full Social Security benefits, Mr. Davis concluded vocational assistance would be futile and recommended that vocational assistance end. (Exs. 27C, 30, 39).

Based on the preponderance of the medical evidence and on the aforementioned vocational evidence establishing that suitable work was available, we find that claimant is employable. We next determine whether claimant is willing to seek work and has made reasonable efforts to do so. SAIF v. Stephens, supra.

Claimant has not worked since March 1988. Her work search was limited to ceramic jobs, but she would tell employers that she could not lift ceramic molds. Claimant has not looked for work in the last year. Claimant's minimal efforts to seek work are insufficient to meet the requirements of ORS 656.206(3).

We also find that it would not be futile for claimant to seek work. Claimant contends that her dyslexia limits her adaptability to perform nonphysical labor. However, her dyslexia did not make it futile for her to look for and obtain work before the injury. The vocational evaluations and labor market surveys by Mr. Lageman and Mr. Davis established a list of available jobs that claimant could perform within her limitations. Claimant, therefore, has not shown that, but for her injury-related physical condition, she is or would be willing to work or that it would be futile to seek work. See SAIF v. Stephens, supra.

We, therefore, agree with and adopt the Referee's determination that claimant is employable. We further find that claimant has failed to prove that she is willing to seek work, has made reasonable efforts to seek work, or that it would be futile for her to do so. Consequently, claimant is not entitled to an award of permanent total disability.

ORDER

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

In the Matter of the Compensation of
RICHARD R. ELIZONDO, Claimant
WCB Case No. 94-03664
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Haynes[1] and Gunn.

The SAIF Corporation requests review of those portions of Referee Bethlahmy's order that: (1) declined to grant its motion to dismiss claimant's request for hearing based on lack of jurisdiction; (2) awarded an assessed attorney fee; and (3) assessed a penalty for allegedly unreasonable claims processing. On review, the issues are jurisdiction and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF Law AND OPINION

Jurisdiction

Claimant has a compensable right leg injury claim. In May 1993, claimant's treating orthopedic surgeon, Dr. Grewe, requested authorization to perform right knee surgery from claimant's managed care organization (MCO), CareMark Comp. CareMark denied the request on the basis that the proposed surgery was not necessary or appropriate. After Dr. Grewe requested reconsideration of its decision, CareMark's medical advisory council also disapproved the surgery.

In August 1993, Dr. Grewe performed the right knee surgery. Claimant then filed a request for hearing, in part alleging that SAIF "de facto" denied medical services.

SAIF first disputes the Referee's denial of its motion to dismiss claimant's request for hearing. In making the motion, SAIF asserted that the Hearings Division lacked jurisdiction because, inasmuch as claimant's medical services were governed by an MCO contract, his sole remedy to contest the denial of treatment lay in requesting review from the Director of CareMark's denial. Therefore, according to SAIF, claimant's request for hearing was not based on a "matter concerning a claim." In denying the motion, the Referee disagreed, finding that ORS 656.260(6), upon which SAIF relied, was not applicable and that claimant's entitlement to knee surgery, which was the subject of his request for hearing, constituted a "matter concerning a claim." Thus, the Referee concluded that the Hearings Division had jurisdiction. With regard to the merits, the Referee also found that claimant proved that the knee surgery was reasonable and necessary and, accordingly, compensable. See ORS 656.327(1).

On review, SAIF continues to assert that the Hearings Division lacked jurisdiction over claimant's request for hearing. SAIF relies on ORS 656.260(6), which provides that "[u]tilization review, quality assurance and peer review activities" conducted by an MCO are subject "solely to review by the director," and ORS 656.704(3), which gives the Board jurisdiction over "matters concerning a claim", excluding "any proceeding for resolving a dispute regarding medical treatment * * * for which a procedure is otherwise provided in this chapter." According to SAIF, the legislature provided a "proceeding for resolving a dispute regarding medical treatment" in the MCO setting by enacting ORS 656.260(6) and, therefore, such a dispute is not a "matter concerning a claim" under ORS 656.704(3), thus vesting the Director with exclusive jurisdiction.

Subsequent to the Referee's order, we issued Job G. Lopez, 47 Van Natta 193 (1995). In Lopez, we considered the issue of whether, by virtue of ORS 656.260 and 656.704(3), the legislature intended to vest the Director with exclusive jurisdiction over an MCO's disapproval of an attending physician's request for authorization of medical services. In particular, we found that resolution of the issue depended on whether the terms "[u]tilization review, quality assurance and peer review activities" included such a dispute.

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[1] Although a signatory to this order for purposes of stare decisis, Board Member Haynes directs the parties' attention to her dissent in Job G. Lopez, supra.

Our construction of the terms found that they did not include actions respecting a request for authorization of an attending physician's medical services, proposed or otherwise, concerning an injured worker whose treatment was provided pursuant to an MCO contract. Id. at 194-200. Thus, we found that the terms of ORS 656.260(6) did not vest the Director with exclusive jurisdiction to review an MCO's decision regarding an attending physician's request for authorization of medical services. Id.

We then addressed the issue of what forum has jurisdiction to determine such an issue, finding that the answer depended on the type of medical services in dispute. Id. at 200. With regard to the reasonableness or necessity of curative care that a worker "is receiving," we noted that review was governed by ORS 656.327(1). In particular, citing to Meyers v. Darigold, Inc., 123 Or App 217, 222 (1993), we discussed its holding that, if there has been a "wish" for Director review, then exclusive jurisdiction vested with the Director; otherwise, the Hearings Division has jurisdiction to review the matter ab initio pursuant to ORS 656.283. Id. at 200.

In this case, based on the holding in Lopez, we first find that the Director does not have exclusive jurisdiction to review CareMark's disapproval of Dr. Grewe's request for authorization to perform the knee surgery. Furthermore, inasmuch as the dispute concerns the reasonableness and necessity of the surgery which has already been performed, and there is no evidence of a "wish" for Director review, we further agree with the Referee that the Hearings Division had jurisdiction over claimant's request for hearing.

Finally, SAIF does not dispute the Referee's conclusion that claimant proved the reasonableness and necessity of the knee surgery. Consequently, we also affirm the Referee's finding that such medical treatment is compensable.

Penalty and Attorney Fee

SAIF also asserts that the Referee's attorney fee award was improper. Relying on SAIF v. Allen, 124 Or App 183 (1993), SAIF contends that, because the dispute related to the reasonableness and necessity of medical treatment rather than the compensability of claimant's injuries, he is not entitled to an assessed fee under ORS 656.386(1).

Subsequent to the Referee's order, the Supreme Court reversed the Court of Appeals' decision in SAIF v. Allen, supra. SAIF v. Allen, 320 Or 192 (1994). The Court held that a claim for medical services is a "claim for compensation" under ORS 656.386(1) and that the Board did not err in determining that the insurer denied the claim when it failed to timely accept or deny it. Id. at 200-16. The Court also concluded that a carrier-paid attorney fee is available under ORS 656.386(1) if a medical treatment claim has been denied (either expressly or de facto) and it is not possible to determine whether the denial encompasses the compensability of the condition or injury for which treatment is sought, and the claimant's attorney succeeds in gaining acceptance of the treatment. Id. at 222; SAIF v. Blackwell, 131 Or App 519 (1994).

Applying Allen and Blackwell to this case, we first note that SAIF does not challenge the Referee's finding that claimant filed with it a claim for medical services. SAIF denied the claim when it failed to timely deny or accept it. Finally, inasmuch as SAIF did not indicate that it was not challenging the compensability of claimant's injury, compensability remained at issue. Therefore, ORS 656.386(1) is applicable, warranting an assessed attorney fee award at hearing.

The Referee also assessed a penalty for "SAIF's failure to process claimant's claim" and concluded that such an action was unreasonable. SAIF contends that, under its construction of ORS 656.260, it had no authority to accept or deny the request for surgery and that such action could only be taken by the MCO. According to SAIF, because its conduct was based on its reasonable interpretation of a statute that had not been construed by the Board or appellate courts, it had a legitimate doubt as to its liability and, thus, its action in failing to accept or deny the request for authorization of surgery was reasonable.

We agree. Although, in Job G. Lopez, supra, we rejected SAIF's interpretation of ORS 656.260 as providing the sole remedy for deciding medical services disputes when an attending physician's request for authorization from an MCO is denied, it was not on the basis that the statute unambiguously held to the contrary. Instead, we explicitly stated that the exact meanings of the terms "utilization review," "quality assurance", and "peer review" were not obvious. 47 Van Natta at 196. In view of the ambiguity of the statute, we find that SAIF was not unreasonable in determining that the medical

services dispute was confined to claimant and the MCO, thus exempting it from the requirements of ORS 656.262(6) to accept or deny the request for surgery. Hence, we conclude that SAIF did not unreasonably delay acceptance or denial of the claim and, therefore, reverse the Referee's imposition of a penalty under ORS 656.262(10)(a).

Finally, claimant is entitled to an assessed attorney fee for services on review because she prevailed over SAIF's request for review and we did not disallow or reduce her compensation. 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 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. We further note that this award does not include services regarding the attorney fee and penalty issues. See Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

ORDER

The Referee's order dated July 14, 1994 is affirmed in part and reversed in part. That portion of the order assessing a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

March 7, 1995 Cite as 47 Van Natta 379 (1995)

In the Matter of the Compensation of
DIANA M. HAFEMANN, Claimant
WCB Case No. 93-13095
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Menashe's order that dismissed for lack of jurisdiction claimant's hearing request regarding the SAIF Corporation's "de facto" denial of her request for low back surgery arising from a managed care organization (MCO) dispute. Claimant also requests that, if we conclude that the Referee had jurisdiction, the matter be remanded to the Referee to address the medical services issue. On review, the issues are jurisdiction, remand and medical services. We reverse the dismissal, deny the request for remand, and uphold SAIF's "de facto" denial.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

Jurisdiction

Claimant argues that the Referee erred in concluding that, under ORS 656.260(4)(d) and (6) (and the rules promulgated thereunder), and 656.704(3), the Director had exclusive jurisdiction over this dispute. We agree.

In 1974, claimant compensably injured her low back. Thereafter, she had several low back surgeries. In May 1993, she began treating with Dr. Treible, who was a member of CareMark Comp, an MCO with whom SAIF had contracted to provide medical services to injured workers. Treible requested authorization from CareMark Comp to perform further low back surgery. CareMark Comp disapproved the requested surgery. (Ex. 41). CareMark Comp's Medical Advisory Council upheld the disapproval. (Ex. 47).

Claimant was examined on CareMark Comp's behalf by Drs. Smith and Flemming. Smith concluded that, although he was not optimistic about the outcome, in view of claimant's strong desire to have surgery, the proposed surgery would be reasonable. (Exs. 37-2, 38, 39). Smith's conclusion was contingent on treatment and medical support stopping within four months after surgery. (Exs. 38, 39;

see Ex. 37-2). Flemming recommended that claimant undergo steroid injections and rigid bracing before surgery was considered. (Ex. 48-3). He further concluded that, if the rigid bracing was effective, the proposed surgery would be reasonable. (Id. at 4).

After Dr. Smith issued his opinions, Dr. Treible continued to recommend surgery based on his belief that, notwithstanding the overall poor prognosis in patients with numerous back surgeries, claimant "may have partial relief of her symptomology[.]" (Ex. 40; emphasis added). Dr. Treible believed that the treatment Dr. Flemming proposed would be, at most, only transiently helpful. (Ex. 51-7; see Ex. 49). Because CareMark had disapproved the surgery request, in October 1993, Treible withdrew as claimant's treating physician. (Id). Thereafter, Dr. Treible concluded that, although it was different than his, the opinion of the "Caremark [sic] Comp panel * * * should be respected." (Ex. 51-6).

Subsequent to the Referee's order, the Board issued its decision in Job G. Lopez, 47 Van Natta 193 (1995). There, after the Director upheld an MCO's disapproval of the claimant's physician's surgery request, the claimant requested a hearing. Arguing that exclusive jurisdiction over the dispute rested with the Director, the carrier moved for dismissal of the hearing request. The referee denied the motion, and the carrier requested Board review.

On review, the Board rejected the carrier's contentions that, under ORS 656.260(4)(d) and (6), and 656.704(3), the Director had exclusive jurisdiction over the dispute. 47 Van Natta at 194-200. Rather, the Board concluded that, in the MCO context, determining where jurisdiction lies depends on the nature of the medical services issue in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994) and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Board decided that, because the particular disputed medical treatment involved a proposed surgery, jurisdiction to review the dispute vested solely in the Hearings Division. Id. at 201. On the merits, the Board relied on the opinion of one of the claimant's treating physicians to find that the proposed surgery was appropriate. Id. at 201-202.

Here, SAIF presses essentially the same jurisdictional arguments that we rejected in Lopez. We adhere to our rejection of those arguments. Rather, in light of Lopez, we determine the nature of the disputed medical services issue in this case to ascertain who had jurisdiction to resolve that issue.

Here, as in Lopez, the dispute involves claimant's attending physician's request to perform spinal surgery. Because the request involves proposed curative medical services, under Martin v. City of Albany, and Jefferson v. Sam's Cafe, we conclude that jurisdiction to review the request is vested solely in the Hearings Divisions pursuant to ORS 656.283. Accordingly, we reverse the Referee's decision granting SAIF's motion to dismiss.

Remand/Medical Services

Claimant requests that we remand this matter to the Referee for a decision on the merits. We may remand a case to the Referee if we determine that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). As the moving party, claimant bears the burden of establishing a basis for remand. Because we find that there are opinions regarding the medical services issue already in the record, we conclude that claimant has failed to meet her burden of proof. Accordingly, we deny the request for remand, and proceed to analyze the evidence pursuant to our de novo review.

On the merits, we conclude that claimant has failed to establish that the proposed low back surgery is reasonable or necessary. 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).

Dr. Treible recommends additional surgery. We find persuasive reasons not to rely on his opinion. Claimant has a history of back problems that dates back nearly two decades, yet Dr. Treible treated claimant for only approximately six months in 1993. Under the circumstances, we are not inclined to afford Treible any deference as a treating physician. However, even if we did, we would find his opinions unpersuasive.

Treible speculated that claimant "may" obtain partial relief of her symptoms. Because that opinion is couched in terms of a possibility, versus a probability, that the surgery would be effective, we conclude that it is insufficient to establish the surgery is reasonable and/or necessary. See Gormley v. SAIF, 52 Or App 1055 (1981).

We find other reasons to discount Dr. Treible's opinions. He admitted that, although he had had success in some cases (Ex. 40), patients with extensive back surgery histories generally have poor prognoses. Furthermore, Treible stated that credence should be given to the opinion of CareMark Comp's "panel", which arguably includes the opinions of Dr. Flemming, who recommended further nonsurgical treatment. Last, Dr. Treible failed to explain, in any detail, why he disagreed with Dr. Flemming's recommendations. For these reasons, we find Dr. Treible's opinions insufficient to establish the reasonableness and/or necessity of claimant's proposed low back surgery.

The only other opinions that arguably support claimant's position are authored by Dr. Smith. We likewise decline to rely on those opinions. Dr. Smith appears to be capitulating to claimant's desire to have surgery, rather than expressing an independent opinion regarding the reasonableness and/or necessity of the proposed procedure. Cf. Mike Sepull, 42 Van Natta 970 (1990) (physician's opinion discounted when he acted as advocate, rather than as medical expert). Furthermore, Smith's opinions are contingent on a limited post-operative recovery period, which contingency could be established only after claimant recovered from the proposed surgery. Under the circumstances, we find that Smith's opinions warrant minimal probative weight.

For these reasons, we conclude that claimant has failed to establish that the proposed back surgery is either reasonable or necessary. Accordingly, we uphold SAIF's "de facto" denial of that procedure.

ORDER

The Referee's order dated April 4, 1994 is reversed. Claimant's hearing request is reinstated. The SAIF Corporation's "de facto" denial is upheld in its entirety.

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

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Neal's order that: (1) declined to award claimant temporary partial disability (TPD); (2) declined to assess a penalty for the self-insured employer's allegedly unreasonable failure to request reclassification of claimant's low back injury claim; and (3) declined to award an attorney fee out of increased compensation for claimant's counsel's services in obtaining the reclassification of the claim. On review, the issues are temporary partial disability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Entitlement to TPD

Claimant asserts that the Referee erred in concluding that, in view of the fact that claimant's at-injury and post-injury wages were the same, he was not entitled to TPD benefits. We agree.

Claimant sustained a compensable low back injury on July 14, 1993. On July 16, Dr. Reynolds, treating physician, released claimant to modified work. On July 22, 1993, the employer deferred the claim and classified it as nondisabling. (Ex. 5). Claimant performed light duty work until September 17, 1993, when he was discharged for reasons unrelated to his injury. Claimant was paid $6/hour for his regular and light duty work.

On October 4, 1993, claimant's counsel requested that the Workers' Compensation Division reclassify claimant's claim as disabling. (Ex. 10A). A November 16, 1993 Determination Order granted the request. (Ex. 11).

In mid-1994, claimant obtained employment similar to his regular work with the employer. He was paid $5.50/hour for this work, but other, more highly-paid work was available. Claimant testified that sometime in the beginning of 1994, his physician released him to regular employment. (Tr. 43-44).

When a claimant is released to modified work at or above his or her regular wages, the claimant is temporarily and partially disabled, 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 on July 16, 1993, although at his regular 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.

In reaching this conclusion, we note that the Referee compared claimant's at-injury and post-injury wages to conclude that claimant was not entitled to TPD. That comparison may be proper when calculating the rate of TPD, but not in cases such as this, which concern a claimant's entitlement to TPD. See OAR 436-60-030; Stone v. Whittier Wood Products, 124 Or App 117 (1993).

Because claimant is entitled to TPD, he is now entitled to a calculation of the TPD rate by the employer based on his proportionate loss of earning power at any kind of work. OAR 436-60-030; Stone v. Whittier Wood Products, supra. Accordingly, we reverse the Referee's decision regarding TPD, and remand the matter to the employer for that calculation.

Penalty and/or Attorney Fee for Failure to Seek Reclassification

Claimant asserts that the Referee erred in concluding that he was not entitled to penalties and/or attorney fees for the employer's allegedly unreasonable failure to request that claimant's claim be reclassified. We agree.

In view of claimant's release to modified work on September 16, 1993, claimant's claim should have originally been classified as disabling. See Sharman R. Crowell, supra, and cases cited therein. Accordingly, we conclude that the employer's misclassification of the claim was unreasonable. See Dennis R. Lewis, 46 Van Natta 2408, on recon 46 Van Natta 2502 (1994) (carrier's conceded misclassification of claim held unreasonable). Therefore, a 25 percent penalty is appropriate. ORS 656.262(10). The amount will be determined when the employer calculates temporary partial disability in accordance with OAR 436-60-030 and will be based on the amounts "then due" from July 22, 1993 (the date the employer misclassified the claim) until the November 16, 1993 Determination Order reclassified the claim. See Linda M. Akins, 44 Van Natta 108, 111 (1992) (penalty based on "amounts then due" when unreasonable conduct is corrected).

Attorney Fee for Obtaining Reclassification

Claimant asserts that the Referee erred in concluding that he is not entitled to an attorney fee under ORS 656.386(2) for his counsel's services that led to the reclassification of his claim from nondisabling to disabling. Specifically, claimant invites us to award a fee based on any future temporary or permanent disability awards that may flow from the reclassification. We agree that the Referee erred, but decline claimant's invitation.

ORS 656.386(2) authorizes the award of attorney fees "paid from the claimant's award of compensation[.]" (Emphasis added). A claimant is entitled to an "out-of-compensation" fee under ORS 656.386(2) for his counsel's services in obtaining claim reclassification. See Raymond B. Terrell, 45 Van Natta 2179 (1993). The question claimant raises is this: What is the proper source of the "out-of-compensation" fee?

In awarding "out-of-compensation" fees, we have uniformly limited the award to a portion of the compensation created by the order awarding the fees. See OAR 438-15-055(1) (authorizing fee award out of increased compensation when the claimant requests review regarding issue of temporary or permanent disability).

Here, claimant requested review regarding his entitlement to temporary disability compensation. Therefore, we conclude that an "out-of-compensation" fee for claimant's counsel's services in obtaining the reclassification of claimant's claim must be limited to claimant's temporary disability benefits, if any, resulting from the employer's processing of this claim pursuant to this order. See Gustavo Cantu-Rogriguez, 46 Van Natta 1801, 1804 (1994) (Board awarded "out-of-compensation" fee to be paid out of the claimant's future temporary disability benefits, if any, resulting from any subsequent conclusion that the claimant was entitled to vocational services).

Accordingly, we reverse the Referee's decision declining to award an attorney fee pursuant to ORS 656.386(2). Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased temporary disability compensation, if any, created by this order, not to exceed $3,800.

ORDER

The Referee's order dated July 19, 1994 is reversed. The self-insured employer is directed to pay temporary partial disability benefits beginning July 16, 1993 and continuing until such benefits may be terminated pursuant to law. For the employer's unreasonable claim misclassification, claimant is awarded 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. The penalty shall be paid in equal shares to claimant and his attorney. 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.

March 7, 1995 Cite as 47 Van Natta 383 (1995)

In the Matter of the Compensation of
JUDY W. LOUIE, Claimant
WCB Case No. 94-02189
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Stoel, et al., Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Mills' order that upheld the self-insured employer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. The employer has moved for an order dismissing claimant's request for Board review on the ground that a copy of the request was not timely served on all parties. On review, the issues are motion to dismiss and compensability. We deny the motion and affirm.

FINDINGS OF FACT

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

The Referee's Opinion and Order issued on June 27, 1994. Parties to that order were claimant and her employer (First Interstate Bank), a self-insured employer.

On August 1, 1994, the Board received claimant's request for Board review of the Referee's order. Claimant's request had been mailed by certified mail to the Board on July 26, 1994. Included with that request was claimant's counsel's certification that copies of the request had been mailed on July 26, 1994 to claimant, the employer, the employer's claims administrator (SIMS) and the employer's attorney.

On August 2, 1994, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for review.

CONCLUSION OF LAW

Motion to Dismiss

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). (Emphasis supplied.)

"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).

Here, claimant's request for Board review included her counsel's certification that copies of the request were mailed to each of the parties on July 26, 1994. The employer challenges that representation. In support of that challenge, the employer's counsel has submitted a copy of an envelope bearing a July 28, 1994 postmark and her affidavit stating that she "obtained the envelope which contained claimant's request for Board review." In response, claimant has filed an affidavit of claimant's attorney's paralegal in which the paralegal states that she personally prepared claimant's request for review to the Board with copies to the employer, its claims processing agent and the employer's attorney and placed the envelopes containing the copies in a mailbox on July 26, 1994.

Based on claimant's attorney's certification and the firm's paralegal's affidavit, we are persuaded that copies of claimant's request for review were mailed to the employer and its legal representative on July 26, 1994. In doing so, we note that the fact that the envelope containing the employer's attorney's copy of the request has a July 28, 1994 postmark does not necessarily establish that the employer's copy of the request was untimely mailed. As previously noted, an attorney is not a "party." Robert Casperson, supra.

In any event, even assuming that the employer's copy of the request was postmarked on the 28th of July, this does not necessarily establish that the request was not timely mailed. In this regard, the envelopes containing the request could have been deposited in the mail on July 26, 1994 and, for some unexplained reason, not have been postmarked until the 28th of July. In any case, we need not resolve such a discrepancy because the employer provides no evidence rebutting claimant's counsel's paralegal's representations that a copy of the request was also mailed to the employer and its claims administrator on July 26, 1994.

In light of such circumstances, we conclude that notice of claimant's request for Board review was mailed within 30 days of the Referee's order to the other parties. See OAR 438-05-046(2)(a), and (b); Franklin Jefferson, 42 Van Natta 509 (1990). Accordingly, we deny the motion to dismiss.

Compensability

We adopt the Referee's conclusion and reasoning concerning the compensability issue as set forth in his order.

ORDER

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

In the Matter of the Compensation of
TAMMY RENFRO, Claimant
WCB Case No. 94-02465
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Mongrain's order that set aside its denial of claimant's right shoulder occupational disease claim. On review, the issue is compensability.

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

Claimant's right shoulder condition was diagnosed as myofascial pain syndrome. Dr. Cronin, treating physician, concluded that the disorder was not caused, in major part, by claimant's work activities. (Ex. 13-1, -2). In reaching that conclusion, Cronin noted that there is a correlation between emotional stress and the development of that disorder. (Id. at 1). He agreed that claimant's "nonwork-related stressors include the divorce process, serious illness of a significant other, and death of another significant other. These nonwork-related stressors had caused [claimant] to miss time from work." (Id. at 2).

Drs. Potter and Rich, examining physicians, concluded that claimant's work activities were the major contributing cause of her myofascial pain disorder. (Ex. 12-7). They disagreed with the assertion that emotional difficulties and stress can bring on myofascial pain syndrome. Rather, they stated that "[i]t is well-recognized * * * that myofascial-type syndromes can occur in individuals with emotional problems and stress, where control individuals who do not have emotional problems had stress, but the same type of micro-trauma, i.e., activities of daily living, do not get myofascial syndromes." (Id. at 6). In their opinion, emotional difficulties and stress can aggravate and amplify myofascial syndrome, but they know of no report in the medical literature that emotional difficulties and stress alone can precipitate myofascial syndrome. (See id.) Potter and Rich were aware of claimant's divorce, but not her other nonwork stressors. (See id.)

The employer argues that, because Drs. Potter and Rich were unaware of all of claimant's nonwork stressors, their opinion is entitled to little weight. We disagree.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

We find persuasive reasons not to rely on Dr. Cronin's report. His assertion regarding the correlation between stress and the development of myofascial pain disorders is unexplained; accordingly, we give it little weight. Rather, we find more persuasive Drs. Potter's and Rich's well-reasoned assertion that myofascial pain syndrome may be aggravated, but not precipitated, by stress.

In any event, we find no evidence that claimant's nonwork stressors caused (i.e., precipitated) her myofascial pain disorder. At most, Dr. Cronin asserts that those stressors caused claimant to miss work; he does not specifically address the causal relationship, if any, between those stressors and claimant's right shoulder disorder.[1] Accordingly, we conclude that Drs. Potter's and Rich's lack of awareness of all of claimant's nonwork stressors does not undercut the persuasiveness of their report.

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[1] In arguing that there is evidence that claimant's condition was caused by nonwork stressors, the employer urges us to rely on an October 1993 report by Dr. Self, one of claimant's treating physicians, which indicated that claimant's low back musculoskeletal problems at the time could have been related to stress. (Ex. C-2). Because claimant's right shoulder condition did not manifest itself until January 1994, and Dr. Self rendered no opinion regarding the cause of the right shoulder condition, and because his report concerned claimant's low back condition in October 1993, we do not consider his report probative of any issue concerning the cause of claimant's right shoulder condition.

For the reasons stated in the Referee's order, as supplemented here, we conclude that claimant has established the compensability of her right shoulder condition. Accordingly, we affirm the Referee's decision setting aside the employer's denial of that condition.

Claimant is entitled to an attorney fee for her 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 the employer. In reaching this conclusion, we have particularly considered the time devoted 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 15, 1994 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the self-insured employer.

March 7, 1995 Cite as 47 Van Natta 386 (1995)

In the Matter of the Compensation of
MARY H. ROBERTSON, Claimant
WCB Case No. 94-05029
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

The self-insured employer requests review of Referee Myzak's order that increased claimant's scheduled permanent disability for loss of use or function of the left leg from 19 percent (28.5 degrees), as awarded by Order on Reconsideration, to 32 percent (48 degrees). 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

Finding that claimant was entitled to awards of scheduled permanent disability for left knee joint instability and for a chronic condition of her left knee, the Referee increased claimant's scheduled permanent disability from 19 to 32 percent. On review, the employer contends that claimant has failed to establish entitlement to an increased award of scheduled permanent disability.

The employer argues that claimant is not entitled to an award of permanent disability for left knee joint instability under former OAR 436-35-230(3). Although Dr. Cooper concludes that there is no significant instability present, he does make findings of instability in the left knee joint and those findings support an award of 10 percent under the standards. See OAR 436-35-230(3). Accordingly, based on Dr. Cooper's findings, we conclude that claimant is entitled to an award of 10 percent for left knee joint instability.

The employer next contends that claimant has not established entitlement to a chronic condition award. We agree. Former OAR 436-35-010(6) provides that a worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. That rule requires medical evidence of at least a partial loss of ability to repetitively use the body part. Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995); Donald E. Lowry, 45 Van Natta 1452 (1993).

Here, the medical evidence addressing claimant's impairment comes from Dr. Cronk, claimant's attending physician, and from Dr. Cooper, the medical arbiter. Upon finding claimant medically stationary, Dr. Cronk advised that, for at least three months, claimant should avoid all squatting and

kneeling activity, as well as repetitive stair climbing. (Ex. 16-2). After three months, Dr. Cronk indicated that claimant could probably do these activities on an occasional basis. Dr. Cronk did not believe that claimant had any permanent impairment. (Ex. 18). Dr. Cooper, medical arbiter, noted that claimant had limited range of motion in the left knee. Dr. Cooper also noted that claimant reported she was able to squat, but required assistance to recover and was unable to kneel. The record contains no other evidence concerning an inability to repetitively use her left knee. Neither physician stated that claimant is unable to repetitively use her left knee, nor did either physician make findings from which we can conclude that claimant is at least partially unable to repetitively use her left knee.

Claimant cites Danny L. Wedge, 46 Van Natta 183 (1994) and Rose L. Dixon, 46 Van Natta 715 (1994), as support for her argument that she is entitled to a chronic condition award. However, those cases are factually distinguishable. In Dixon, there was evidence from a medical arbiter that the claimant's "wrist would not stand up to any activity which required repetitive use of the wrist or hand." Here, unlike Dixon, there is no evidence from a physician that claimant cannot repetitively use a body part.

In Wedge, the carrier had relied on statements from the claimant's attending physician to make an award in its Notice of Closure for bilateral chronic conditions limiting repetitive use. The carrier then contended at hearing and on Board review that the attending physician's statements were not sufficient to support a chronic condition award. On Board review, we noted that the claimant's attending physician had stated that the claimant should "avoid any significant heavy repetitive use of his hands." We concluded that the record as a whole supported a chronic condition award.

We find the present case distinguishable from Wedge. Here, the employer had not made a chronic condition award in a Notice of Closure relying on a statement from claimant's attending physician. More importantly, claimant's attending physician had made no statements that claimant should permanently avoid any repetitive activities with her left knee. Although Dr. Cronk advised that claimant should avoid all squatting and kneeling activity, as well as repetitive stair climbing for at least three months, Dr. Cronk also concluded that claimant did not have any permanent disability. The standards provide for permanent disability awards only for those findings of impairment that are permanent. Former OAR 436-35-007(1). After reviewing the record, we find no medical evidence which would support a chronic condition award for the left knee.

ORDER

The Referee's order dated August 15, 1994 is modified. In lieu of the Referee's award and in addition to the Order on Reconsideration award of 19 percent (28.5 degrees), claimant is awarded 10 percent (15 degrees) scheduled permanent disability, for a total award to date of 29 percent (43.5 degrees) for loss of use or function of the leg. Claimant's counsel's out-of-compensation attorney fee award as awarded by the Referee is adjusted accordingly.

March 7, 1995 Cite as 47 Van Natta 387 (1995)

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

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Daughtry's order that reduced her scheduled permanent disability award for the loss of use or function of her right arm from 2 percent (3.84 degrees), as granted by an Order on Reconsideration, to zero. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

In March 1988, claimant filed a claim for tennis elbow in her left arm, which was accepted by the insurer. Claimant continued to have problems with her left elbow. Dr. Bird requested authorization

for a removal of a left epicondyle exostosis. On March 29, 1993, the insurer accepted claimant's aggravation claim and authorized the surgery. (Ex. 12). Thereafter, Dr. Bird performed the surgery.

In June 1993, Dr. Bird reported that claimant was medically stationary. (Ex. 21). On August 5, 1993, the insurer issued a Notice of Closure awarding no permanent disability. (Ex. 23). Claimant requested reconsideration and an examination by a medical arbiter panel.

On March 9, 1994, claimant was examined by a panel of medical arbiters consisting of Dr. Gritzka, orthopedist, Dr. Dinneen, orthopedist, and Dr. Platt, neurologist. The medical arbiters reported that claimant's elbows "flexed to 145 degrees on the right and 150 degrees on the left." (Ex. 27). The arbiters also concluded that there was no objective evidence of any inability to repetitively use her left arm. The April 18, 1994 Order on Reconsideration awarded claimant 2 percent (3.84 degrees) scheduled permanent disability for her right arm. (Ex. 28). The insurer requested a hearing.

The Referee concluded that the 2 percent permanent disability award was erroneous since the right arm was not part of claimant's compensable injury. The Referee also held that claimant was not entitled to a 5 percent award for a chronic condition limiting repetitive use of her left arm.

CONCLUSIONS OF LAW

Relying on Rosario Felix, 45 Van Natta 1179 (1993), claimant contends that the reference in the medical arbiter's report stating that claimant's elbows "flexed to 145 degrees on the right and 150 degrees on the left" was a scrivener's error. She requests that we correct the award in the Order of Reconsideration by substituting "left" for "right," and awarding her 2 percent scheduled permanent disability for her left arm.

In Rosario Felix, supra, we found that the Order on Reconsideration had correctly rated the claimant's chronic condition as 5 percent of the whole arm, rather than the forearm. Although the parties did not raise the issue, we concluded that the Referee's award for the forearm, rather than the arm, constituted a scrivener's error. We increased the Referee's award accordingly.

In the present case, claimant had surgery on her left elbow in March 1993. The medical reports since claimant's 1988 injury, including the treating surgeon's reports, refer to symptoms in claimant's left elbow. None of those reports refer to symptoms in her right elbow or arm. Consistent with claimant's medical history, the medical arbiter panel's report described claimant's complaint as "[p]ain, left arm" and described her condition as "[s]tatus post tennis elbow release, left arm." (Ex. 27). The report does not mention any complaints or previous problems with claimant's right arm or elbow. Nevertheless, the arbiters reported that claimant's elbows "flexed to 145 degrees on the right and 150 degrees on the left." Claimant testified that, during the arbiter's examination, her right arm flexed better than her left arm. (Tr.10).

In light of claimant's 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 conclude that the arbiter panel's reference to "right" arm constituted a scrivener's error. See Rosario Felix, supra. Since the award in the Order of Reconsideration was based on the medical arbiter panel examination, we correct the Order on Reconsideration to award claimant 2 percent scheduled permanent disability for her left arm rather than her right arm.

Claimant also argues that she is entitled to a 5 percent award for a chronic condition limiting repetitive use of her left arm. OAR 436-35-010(6) provides:

> "A worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition as follows. 'Body part' as used in this rule means the foot/ ankle, knee, leg, hand/wrist, elbow and arm."

The rule requires medical evidence of at least a partial loss of ability to repetitively use the body part. Donald E. Lowry, 45 Van Natta 1452 (1993). It is not necessary that the record contain an express medical finding that the condition is "chronic." Weckesser v. Jet Delivery Systems, 132 Or App 325, 328 (1995). It is sufficient if the record contains a medical opinion of claimant's attending physician, or one in which the attending physician has concurred, from which it can be found that claimant is unable to repetitively use a body part "due to a chronic and permanent medical condition." Id.

Although claimant testified that her pain limited her ability to engage in activities involving repetitive use of her left arm, lay testimony is insufficient to establish "impairment" under the standards. See ORS 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991).

The medical arbiters concluded that there was "no objective evidence of any inability to repetitively use the left arm due to the February 17, 1988 incident." (Ex. 27). Furthermore, Dr. Bird's reports do not establish that claimant is unable to repetitively use her left arm. Based on this record, we conclude claimant has failed to prove that she has a permanent chronic condition that has limited her ability to repetitively use her left arm.

The insurer requested a hearing, seeking elimination of the Order on Reconsideration award. By this order, we have found that claimant's award (as granted by that Order on Reconsideration) should not be disallowed or reduced. Under such circumstances, claimant is entitled to an attorney fee award under ORS 656.382(2) for successfully defending her scheduled award 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 $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 the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Because we have reversed the Referee's order which eliminated claimant's permanent disability award and we have reinstated the scheduled award made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is also entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order, not to exceed $3,800. See ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated July 22, 1994 is reversed. The Order of Reconsideration is reinstated but corrected 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. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. Claimant's attorney is also awarded a fee of $1,000 for services at hearing regarding the permanent disability issue, payable by the insurer.

March 8, 1995 Cite as 47 Van Natta 389 (1995)

In the Matter of the Compensation of
RANDALL D. COGGER, Claimant
WCB Case No. 93-08971
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Peterson's order which: (1) upheld the self-insured employer's denial of his cervical and thoracic injury claim; (2) declined to award a penalty for the employer's allegedly unreasonable claim processing; and (3) upheld the employer's "de facto" denial of claimant's aggravation claim. On review, the issues are compensability, penalties and aggravation.

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

At the outset, we make a minor correction in the Referee's factual findings. The Referee stated that, prior to his return to his attending physician, Dr. Davis, on June 24, 1993, claimant last treated with Dr. Davis on July 13, 1992. However, the record indicates that Dr. Davis examined claimant on August 18, 1992. (Ex. 15a). With that correction, we adopt the Referee's findings of fact.

Turning to the merits, the Referee upheld the employer's denials of claimant's cervical/thoracic condition and related aggravation claim on the grounds that claimant's current spinal conditions are not related to his compensable May 12, 1992 injury, accepted as a lumbosacral strain. In reaching this conclusion, the Referee relied on the medical opinion of Dr. Davis, who treated claimant for his original compensable injury and after his alleged worsening in May 1993. Both in a December 13, 1993 medical report and in his deposition, Dr. Davis opined that claimant's current mid and upper back condition was not related to his compensable May 1992 low back injury. (Exs. 25, 26-32).

On review, claimant contends that the Referee erred in relying on Dr. Davis' medical opinion. Claimant asserts that Dr. Davis did not fully take into account the fact that claimant reported and was treated for thoracic complaints shortly after the May 12, 1992 injury. Thus, he alleges that Dr. Davis' medical opinion is fatally flawed. Claimant urges us instead to rely on the medical opinion of claimant's chiropractor, Dr. Dawson. Dr. Dawson began treating claimant in May 1993 and opined that the May 12, 1992 injury was the major contributing cause of claimant's need for treatment. (Ex. 24).

Claimant's contentions notwithstanding, we agree with the Referee that Dr. Davis' medical opinion is the most persuasive. Although conceding that claimant did receive treatment for thoracic complaints in May 1992 that were related to his compensable injury, Dr. Davis explained that it is not unusual in cases of lumbosacral strain to have some involvement higher in the spine. However, Dr. Davis emphasized that claimant did not suffer a separate thoracic spine strain as a result of the compensable injury. (Ex. 26-35). Moreover, Dr. Davis agreed that the condition that he treated in 1992 was a lumbosacral strain.[1] (Ex. 26-34).

After thoroughly reviewing claimant's medical records during cross-examination by claimant's counsel, Dr. Davis later reiterated his opinion that claimant's cervical and thoracic condition in 1993 was not related to the compensable May 12, 1992 low back injury. (Ex. 26-32). Dr. Davis characterized claimant's original injury as a relatively minor lumbosacral strain that resolved in 1992. (Ex. 26-30). Dr. Davis agreed that, in cases of minor injury, one could not necessarily attribute all subsequent pain complaints to the original injury. (Ex. 26-30). Given Dr. Davis' clear and unambiguous opinion that claimant's 1992 injury resolved, we do not believe the fact of claimant's treatment for thoracic spine complaints in May and June 1992 compels a finding that claimant's current cervical and thoracic condition is injury-related.

Inasmuch as Dr. Davis treated claimant for his original injury in 1992 and also treated claimant for his "worsening" in 1993, we agree with the Referee that he was in the best position to determine the causal relationship, if any, between claimant's current condition and his original May 1992 injury. Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986). Because of this, we find Dr. Davis' opinion to be more persuasive than that of Dr. Dawson, who only began treating claimant in May 1993.

Accordingly, we conclude that the Referee correctly upheld the employer's denials. Claimant further contends, however, that the employer's denial of his current cervical and thoracic condition was unreasonable. We disagree.

The reasonableness of a denial is determined on the basis of whether the employer had a "legitimate doubt" about its liability for a claim based on information available at the time of the denial. See Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). We agree with the Referee that the employer's July 8, 1993 denial of claimant's cervical and thoracic condition was reasonable when issued.

Claimant had gone without treatment for the May 12, 1992 injury from August 1992 to May 1993, prior to resuming treatment with Dr. Dawson. Dr. Davis' August 18, 1992 chart note had stated that claimant's May 1992 lumbosacral strain had "fully resolved." (Ex. 15A). Moreover, claimant's cervical and thoracic diagnoses in 1993 were entirely different from Dr. Davis's diagnosis of lumbosacral strain in 1992. Under these circumstances, we conclude that the employer had a "legitimate doubt" regarding its liability for claimant's treatment in May 1993 and thereafter when it issued its July 8, 1993 denial.

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[1] In this regard, we note that the area of injury identified on the May 14, 1992 form 801 was "lower back." In addition, Dr. Davis testified that claimant filled out a May 14, 1992 pain diagram. (Ex. 26-5). It showed that claimant's pain complaints were limited to the lumbosacral area. (Ex. 4A-1).

ORDER

The Referee's May 25, 1994 order is affirmed.

Board Member Hall Specially Concurring.

While I agree that the employer's denial of claimant's thoracic and cervical condition should be upheld, I would not do so on the basis of Dr. Davis' medical opinion. I find Dr. Davis' medical opinion unpersuasive because his December 13, 1993 report erroneously states that claimant never complained of thoracic pain during the period he treated claimant from May 12, 1992 to July 14, 1992. Claimant did report thoracic complaints in May and June 1992 for which he received treatment. I do not believe that Dr. Davis' deposition testimony fully accounts for this history.

Although I do not find Dr. Davis' opinion persuasive, I, nevertheless, agree that claimant did not satisfy his burden of proving that his cervical/thoracic condition is compensable because the only other medical opinion to address causation is also unpersuasive. Dr. Dawson did not begin treating claimant until a year after the compensable low back injury, and his conclusion that the May 12, 1992 injury is the major contributing cause of claimant's medical treatment is unexplained. (Ex. 24).

Inasmuch as there is no persuasive medical evidence linking claimant's current cervical and thoracic condition to the May 1992 injury, claimant has failed to sustain his burden of proof.

March 8, 1995 Cite as 47 Van Natta 391 (1995)

In the Matter of the Compensation of
JOAN C. GILLANDER, Claimant
WCB Case No. 92-03284
ORDER ON REVIEW
Nancy F. A. Chapman, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

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

The SAIF Corporation requests review of Referee Galton's order that: (1) found that claimant had established "good cause" for failing to timely file her hearing request from its denial of claimant's back injury claim; and (2) found that claimant was a subject Oregon worker. On review, the issues are timeliness and subjectivity. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, we do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's mistaken belief that her Washington workers' compensation claim had been accepted constituted "mistake" as that term is used in ORCP 71B. On this basis, the Referee found that claimant had established "good cause" for failing to timely appeal SAIF's denial of her claim in Oregon for a low back injury. We disagree.

Claimant first argues that no Oregon claim was made which SAIF could deny in its October 25, 1991 denial. We disagree. A claim is a "written request for compensation from a subject worker or someone on the worker's behalf." ORS 656.005(6). Here, SAIF received a form 827 from doctors treating claimant for the injury which notified it of a claim for benefits against the employer. (Ex. 8). Thus, we conclude that a claim for compensation was made.

A request for hearing must be filed no later than 60 days after claimant is notified of a denial of a claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, is timely if claimant establishes good cause for the late filing. ORS 656.319(1)(b). "Good cause" within the context of ORS 656.319(1)(b) means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B(1). Hempel v. SAIF, 100 Or App 68, 70 (1990). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Claimant testified that she was not concerned when she received SAIF's October 25, 1991 denial because she was receiving compensation under her workers' compensation claim in the State of Washington and believed her Washington claim had been accepted. (Tr. 28-29, 38; Exs. 14; 15). Claimant had received time loss compensation under a temporary decision in her Washington claim, but that claim was denied on January 27, 1992. (Exs. 14; 20). Shortly thereafter, claimant retained counsel, who filed a hearing request regarding SAIF's denial on February 6, 1992.

We have previously held that the receipt of interim compensation, either before issuance of a denial or at the time a denial is received, and any consequent confusion regarding the status of the claim, is not "good cause." Mary M. Schultz, 45 Van Natta 393 (1993) on recon 45 Van Natta 571 (1993); Harold D. Wolford, 44 Van Natta 1779 (1992); Bonnie J. Santangelo, 42 Van Natta 1979 (1990). We have also previously held that a claimant's choice to pursue a claim in another state does not constitute "good cause" for failing to timely request a hearing on a denial. Michael F. May, 42 Van Natta 1308 (1990).

In Bonnie J. Santangelo, supra, the claimant had filed an aggravation claim with Liberty. Liberty denied the claim, but the claimant did not appeal Liberty's denial. Instead, the claimant filed a claim for a new injury with SAIF. SAIF paid interim compensation, but subsequently denied the claim. The claimant contended that she had established good cause for failing to timely request a hearing on Liberty's denial on the basis that she believed that SAIF had accepted her claim when it began paying interim compensation. On Board review, we held that the claimant's assumption that SAIF had accepted her claim when it began paying interim compensation did not constitute good cause for failing to timely file a request for hearing on Liberty's denial.

Here, based on her testimony, claimant believed that her Washington claim had been accepted because she was receiving compensation under that claim. Thus, claimant did not pursue her claim in Oregon. We find this case factually similar to Santangelo where the claimant did not pursue her aggravation claim with Liberty because she believed that her claim with SAIF was accepted since she was receiving interim compensation. As in Santangelo, claimant in this case believed she had an accepted claim as a result of her receipt of temporary disability benefits. Thus, as in Santangelo, claimant did not pursue her other claim.

The dissent argues that William P. Stultz, 34 Van Natta 170 (1982), supports a finding of good cause in the present case. We disagree. In Stultz, the Board found that the claimant was caught in a "cross-fire" between two carriers which gave him a sense of security about the claim. We noted that the carrier which paid temporary disability benefits had "deferred" action on the claim, finding that a worker should not be expected to conclude that such an action provided the possibility that the claim ultimately would be denied. Concluding that the claimant was receiving temporary disability benefits from one carrier and that there was no reason for the claimant to take action on the other carrier's denial, we held that the claimant had established good cause for his failure to timely request a hearing from that other carrier's denial.

We find Stultz factually distinguishable from the present case. Here, claimant had received a "Notice of Claim Arrival" from Washington which specifically informed claimant that, in some cases, time-loss benefits would be received while a decision was being made on the claim. The notice further stated that, if the claim was later denied, claimant would not be eligible for benefits and would, in fact, be "required to repay any benefits you've received" if the claim was later denied. (Ex. 3). In addition, the Washington decision which awarded claimant time loss benefits stated that it was a "temporary" decision. (Ex. 14).

In Stultz, unlike in the present case, there was no such evidence that claimant had specifically been informed that the claim could be denied even after temporary disability benefits were received. In addition, in the present case, the decision awarding time loss benefits specifically stated that it was a "temporary" decision. Given these facts, we find the present case distinguishable from Stultz.

Based on holdings of Santangelo and the other cases cited herein, we are not persuaded that claimant's belief, due to the receipt of temporary disability benefits, that her Washington claim had been accepted, constituted "good cause" for her failure to timely request a hearing on SAIF's October 25, 1991 denial. See Mary M. Schultz, supra; Harold D. Wolford, supra; Bonnie J. Santangelo, supra.

Accordingly, claimant has not established good cause. Because we find that claimant lacked good cause for her failure to timely request a hearing, we do not reach the issue of subjectivity.

ORDER

The Referee's order dated January 31, 1994 is reversed. Claimant's hearing request is dismissed as untimely. The Referee's award of an attorney fee is also reversed.

Board Member Hall dissenting.

In 1965, the legislature adopted a statute requiring an injured worker who objected to a claim denial to request a hearing within 60 days after notification of the denial. In 1969, that statute was amended to allow a hearing on a denial where the hearing request was filed more than 60 days, but fewer than 180 days after notification of the denial, if the worker established good cause for the failure to timely file. See ORS 656.319(1)(b).

In interpreting ORS 656.319(1)(b), as in interpreting any other portion of the Workers' Compensation Law, we should liberally construe the statute in favor of the injured worker. See Stovall v. Sally Salmon Seafood, 306 Or 25, 38-39 (1988); Holden v. Willamette Industries, 28 Or App 613 (1977) (The workers' compensation law is a remedial statute and is therefore to be liberally construed in favor of the injured worker). Notwithstanding the remedial nature of the workers' compensation statutes, our decisions interpreting "good cause" have drastically narrowed the definition of this phrase. In determining whether "good cause" exists, we have cited to the same court cases and used the same boilerplate language to consistently find that good cause does not exist. I submit that the 1969 statutory amendment establishing a "good cause" exception to the 60-day requirement has been rendered meaningless by our overly narrow case law. Under our current interpretation of good cause, that standard is almost never satisfied.

The present case is an example of a situation where good cause should be found. The worker, who was seriously injured in Washington state was confused by receipt of a denial from the Oregon insurer. Believing that her claim had been accepted, there was no reason to contest the SAIF denial. For this claimant, the situation was understandably confusing; workers' compensation carriers in two states were involved, claimant was receiving benefits under a "temporary" decision in Washington, and she was recovering from a very severe injury. As soon as it became evident that the Washington claim had been denied, claimant obtained counsel and challenged the SAIF denial. The concept of "good cause" should not be so narrow that, under these facts, "good cause" may not be found.

In a factually similar case, William P. Stultz, 34 Van Natta 170 (1982), good cause was found to exist where a claimant was caught in a cross-fire between two carriers which gave him a sense of security about his claim. The claimant in Stultz was receiving temporary total disability benefits from one insurer and there was no reason to take any action on the other carrier's denial. Within a reasonable time after the claimant's benefits ceased, he requested a hearing. Under those circumstances, the Board found that good cause had been established.

While the majority urges us to distinguish Stultz from the present case factually (a narrow distinction at best), the majority does not offer any valid policy reason why we should do so.

Given the holding in Stultz, and the remedial nature of the statute, I would find that claimant has established good cause for her failure to file within 60 days. Finally, I do not believe that the carrier would be prejudiced by allowing claimant to go forward on the merits. Because I believe that good cause has been established, I respectfully dissent.

In the Matter of the Compensation of
JAMES HOFFMAN, Claimant
WCB Case No. 94-06458
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Turner-Christian.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a noncompensable left knee injury, when a horse fell on him on February 6, 1994. A March 16, 1994 arthroscopy revealed partially torn medial and lateral menisci, articular surface softening of the medial femoral condyle, and a tear of the anterior half of the left medial cruciate ligament (ACL). Claimant treated with physical therapy, home exercise, and a knee brace. By May 9, 1994, claimant's left knee was doing fairly well, but it was still symptomatic.

On May 14, 1994, claimant (a car salesman) worked for the first time without his knee brace. While descending stairs at the employer's place of business, he experienced left knee pain and giveway. He reached for the handrail, jumped or fell three or four steps, and landed on his left leg. He felt severe left knee pain and collapsed to the floor.

Drs. Whitney, treating physician, and Woolpert, examining physician, agree that claimant's partial left anterior cruciate ligament tear became a full tear when claimant landed from this fall.

The Referee found that claimant's fully torn left medial cruciate ligament resulted from a combination of his preexisting partially torn ligament and his May 14, 1994 fall at work. Reasoning that the full tear actually resulted from impact after the fall, rather than pre-fall pain and giveway, the Referee concluded that claimant established that the fall at work was the "major component" of claimant's resulting condition.

SAIF argues that claimant's knee injury (which occurred at work) is not compensable because it did not arise out of his employment as required by ORS 656.005(7)(a). Specifically, SAIF contends that claimant's preexisting knee condition caused the injury. We agree.

In Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1993), the Supreme Court explained that there are two elements of the single work-connection inquiry required by ORS 656.005(7)(a). The single inquiry is

> "whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Each element of the inquiry tests the work-connection of the injury in a different manner. The requirement that the injury occur 'in the course of employment' concerns the time, place, and circumstances of the injury. The requirement that the injury 'arise out of' the employment tests the causal connection between the injury and the employment. In assessing the compensability of an injury, we must evaluate the work-connection of both elements; neither is dispositive."

318 Or at 363 (citations omitted).

In this case, it is clear that claimant's May 14, 1994 injury happened in the course of his employment and SAIF does not argue otherwise. The dispute concerns the "arising out of" element of the work-connected test, which measures the causal connection between the injury and the employment. Id.

In our view, the medical evidence, which is consistent with claimant's testimony regarding the circumstances of the injury, establishes that his preexisting left knee weakness was the primary cause of the May 14, 1994 work injury. Dr. Whitney observed that, "by history it sounds like the patient's knee gave way and he fell due to weakness as a result of the preexisting injury to the knee." (Ex. 16-1). Dr. Whitney opined: "This was probably already in the cards and probably not a fault of the stairs, although it did happen on [the employer's] property. [Claimant's] ACL was grossly weakened from the previous injury." (Ex. 13). Dr. Woolpert also opined that claimant's preexisting knee condition was the major cause of his fall at work. (Ex. 15-5).

On this evidence, we conclude that pain and weakness related to the prior off-work injury caused claimant's fall at work. Thus, although impact with the floor was the "precipitating" event, which caused the partially torn ACL to tear completely (and that event happened in the course and scope of claimant's employment), the injury actually resulted from claimant's preexisting condition. See Dietz v. Ramuda, 130 Or App 397, rev allowed, 320 Or 492 (1994) (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).

Other than the fact that the fall occurred on the employer's premises, we find no "risk" connected with claimant's employment in this case. See William F. Gilmore, on remand, 46 Van Natta 999 (1994) (Where the claimant's parking lot injury did not occur as a result of a hazard or condition associated with his work, the causal relationship between the claimant's employment and his injury was insufficient to establish compensability). Neither the circumstances of claimant's fall nor the medical evidence relates this injury to claimant's work activities. See Joe H. Rodgers, 46 Van Natta 479 (1994) (Where the claimant fainted at work due to flu-related weakness, fell, and injured his head striking it on the floor, the fall was not work-related). Here, as in the above-cited cases, we find no causal relationship between claimant's fall, his resulting injury, and his employment.

Accordingly, recognizing that the May 14, 1994 injury happened at work, we nonetheless conclude that claimant has not established that this injury was sufficiently related to his employment so that it is compensable. See Norpac Foods, Inc., v. Gilmore, supra. Consequently, SAIF's denial must be upheld.

ORDER

The Referee's order dated September 6, 1994 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

March 8, 1995 Cite as 47 Van Natta 395 (1995)

In the Matter of the Compensation of
KATHLEEN A. WILFONG, Claimant
WCB Case No. 94-03815
ORDER ON REVIEW (REMANDING)
Schneider, Hooten, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Peterson's order which dismissed her request for hearing from a Determination Order which declined to reclassify claimant's bilateral wrist claim from nondisabling to disabling. On review, the issues are jurisdiction and claim reclassification. We reverse and remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the finding that claimant's attorney wrote the Department on January 8, 1994 to request claim reclassification. Instead, we find that claimant's attorney wrote the Department on January 18, 1994.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's hearing request on the basis that the Hearings Division had no jurisdiction to consider claimant's request for reclassification of her claim from nondisabling to disabling. We conclude that the Referee had jurisdiction to consider the reclassification issue and remand for further proceedings.

Jurisdiction

Claimant experienced the gradual onset of bilateral wrist symptoms in October and November 1991. Claimant first sought medical treatment for right wrist symptoms on October 30, 1991. She filed her claim on October 2, 1992. On December 30, 1992, the insurer accepted the claim for bilateral wrist strain as a nondisabling claim. On January 18, 1994, claimant requested reclassification of her claim to disabling by filing a request with the Department.

A March 4, 1994 Determination Order found that the claim should remain classified as nondisabling. Claimant then requested a hearing contesting the Determination Order. See Walter T. Driscoll, 45 Van Natta 391 (1993) (the claimant can request a hearing directly from a Determination Order addressing claim reclassification.)

The Referee dismissed claimant's hearing request, reasoning that, under Robert Wolford, 45 Van Natta 435 (1993), claimant had one year from the date of acceptance of claimant's occupational disease claim within which to reclassify her claim from nondisabling to disabling. Inasmuch as claimant's reclassification request was made on January 18, 1994, more than one year after the acceptance of the claim on December 30, 1992, the Referee concluded that the Hearings Division did not have jurisdiction to decide the reclassification issue.

On review, claimant cites Donald G. Stacy, 45 Van Natta 2360 (1993), as support for her contention that the Referee had jurisdiction to consider the classification issue. In Stacy, we determined the "date of injury" for an initial occupational disease claim for purposes of determining aggravation rights. Specifically, we disavowed Wolford, which had held that, in the case of an occupational disease claim, the "date of injury" for purposes of determining a claimant's aggravation rights is the date that the insurer accepts the occupational disease claim. Relying on Papen v. Willamina Lumber Company, 123 Or App 249 (1993), we held that, for the purposes of determining aggravation rights, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought. Our decision in Stacy was recently affirmed by the Court of Appeals. Stacy v. Corrections Division, 131 Or App 610 (1994).

In this case, claimant first sought medical treatment on October 30, 1991. Thus, her "date of injury" was October 30, 1991. The insurer classified the bilateral wrist claim as nondisabling on December 30, 1992, more than one year after the injury. Because claimant did not object to the nondisabling classification within one year from the date of injury, the Department lacked authority to address claimant's reclassification request. See ORS 656.262(6)(c); 656.268(11); Donald R. Dodgin, 45 Van Natta 1642 (1993). As a result, the March 4, 1994 Determination Order was improperly issued and, therefore, invalid.

Where, as here, claimant is precluded, through no fault of her own, from seeking reclassification by the Department because the claim was classified as nondisabling more than one year after the date of injury, claimant may request a hearing on the matter pursuant to ORS 656.283(1). Donald R. Dodgin, supra. While Dodgin was an injury, not an occupational disease, claim, we find no reason not to apply the Dodgin rationale to this claim. Thus, the classification issue was properly before the Referee.

Remand

Because the Referee found that the Hearings Division lacked jurisdiction over claimant's reclassification request, he declined to reach the merits. Although claimant was present at hearing with her attorney, no witnesses testified. In light of the Referee's ruling (granting the insurer's motion to dismiss for lack of jurisdiction), the record was not sufficiently developed for our review. See ORS 656.295(5); Douglas B. Robbins, 45 Van Natta 2289 (1993). Under such circumstances, we find a compelling reason to remand this matter to the Referee for the taking of additional evidence concerning the classification issue. Douglas B. Robbins, supra.

Accordingly, the Referee's order dated June 24, 1994 is vacated. This matter is remanded to Referee Peterson for further proceedings, at which time each party shall be permitted to present additional evidence regarding the reclassification issue. Such evidence may be presented in any manner that the Referee determines achieves substantial justice. Thereafter, the Referee shall issue a final, appealable order concerning the matter at issue.

IT IS SO ORDERED.

March 9, 1995 Cite as 47 Van Natta 397 (1995)

In the Matter of the Compensation of
GERALD ARMSTRONG, Claimant
WCB Case No. 93-14325
ORDER ON REVIEW
Annette Himmelbaum, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Peterson's order that upheld the insurer's denial of claimant's claim for a psychological condition. On review, the issue is compensability.

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

Claimant is a supervisor at a storage facility operated by the employer, an airline based at Portland airport. Beginning in the late 1980's, various supervisors observed a communications problem between claimant's department and the maintenance department. The problem reached a critical point in 1993, when, for the third time, a supervisor (Hall) from the airline's home base in Atlanta was required to fly to Portland to investigate the communications problem.

Claimant was advised that he was a contributor to the communications difficulties and was told to "fix the problem." Hall suggested that claimant meet with the maintenance department supervisor every morning to discuss and resolve any problems that might arise. Hall also counseled claimant to adopt a different demeanor and become more cooperative. Although Hall drafted a letter informing claimant that he would be placed on probation, Hall testified that he decided against such action and that no disciplinary action was taken. Hall also testified that the letter was temporarily placed in claimant's personnel file for future reference should problems reoccur. (Tr. 206).

Hall left Portland believing that the difficulties in Portland were largely resolved. However, claimant subsequently wrote Hall's supervisor (Suggs), stating that he had been unjustly accused of being difficult to work with and that he still required assistance in dealing with future problems. Claimant was flown to Atlanta, where he met with Hall and Suggs. Suggs informed claimant that he was a contributor to the problems in Portland and that the lack of communication between claimant's department and maintenance needed to be "fixed." At the meeting, claimant was given a written response to his previous letter and allowed to respond to its contents. Claimant had difficulty accepting any responsibility for the situation in Portland and testified at hearing that he felt that the maintenance department was entirely at fault. (Trs. 158, 159).

Subsequent to the meeting in Atlanta, claimant took vacation and, upon return to work, was unable to work more than two hours before having to leave. Claimant's family physician referred claimant to a psychologist, who later referred claimant to a psychiatrist, Dr. Bellville. Dr. Bellville diagnosed an adjustment reaction with anxious and depressive features related in major part to claimant's employment.

The Referee concluded that it was not unreasonable for the employer to expect an intelligent and conscientious supervisor to resolve a communication problem between himself and maintenance workers, no matter who was at fault. Finding the employer's corrective or job performance evaluation actions were reasonable, the Referee concluded that claimant's mental disorder was not compensable because it was the result of employment conditions excluded from consideration under ORS 656.802(3)(b).

To establish a compensable psychological condition claim, claimant must prove that the employment conditions producing his mental disorder were 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. ORS 656.802(3)(b); Robert A. Jarvil, 47 Van Natta 221 (1995). Claimant contends that the employer engaged in unreasonable corrective actions and, therefore, that such actions may be considered in evaluating the compensability of his psychological condition. We disagree.

On this record, we are unable to conclude that the employer's corrective actions, as a whole, were unreasonable. Our review of the evidence convinces us that, while the employer might have done more to facilitate communication between claimant and maintenance personnel, the employer's actions were designed to correct a specific deficiency in claimant's performance, i. e., his inability to resolve communication problems with the maintenance department. We do not find that goal, or the actions selected to achieve it, were unreasonable.[1] Robert A. Jarvil, supra.

Therefore, we agree with the Referee's finding that claimant's psychological condition was the result of reasonable corrective actions. Inasmuch as ORS 656.802(3)(b) requires that stressors resulting from such actions be excluded from consideration in determining whether employment conditions were the major contributing cause of claimant's mental condition, the Referee properly upheld the insurer's denial of claimant's psychological claim. See Karen M. Colerick, 46 Van Natta 930 (1994).

ORDER

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

[1] Given the consistent references in claimant's performance evaluations to his need to improve communications with the maintenance department, as well as the instances where supervisory personnel deemed it necessary to fly from Atlanta to Portland to investigate the problem, we conclude that there was indeed a legitimate deficiency in claimant's job performance. (Exs. 7A, 9-2, 11-2, 11A-5, 11B, 13-2). While it is unclear why more was not done at the local level to correct the apparent communication problem, we, nevertheless, cannot conclude that the employer's attempts to resolve the problem through supervisors in Atlanta were unreasonable. Nor do we find that the employer was unreasonable in demanding that claimant, a supervisor, take immediate action in resolving the communication problem. Although the employer did not provide a great deal of guidance as to how claimant should proceed, claimant is an experienced supervisor. Thus, we do not find that the employer acted unreasonably in leaving the precise method of dealing with the dispute to claimant's discretion.

In the Matter of the Compensation of
JEAN F. HAMILTON, Claimant
WCB Case No. 93-10008
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

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

Claimant requests review of that portion of Referee Menashe's order that declined to assess a penalty for the insurer's allegedly unreasonable denial. On review, the issue is penalties.

We adopt and affirm the Referee's order.

ORDER

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

Board Member Gunn dissenting.

Finding that it was not unreasonable for the insurer to deny claimant's low back injury claim and "put claimant's credibility under oath to the test," the Referee declined to assess a penalty. On review, my colleagues have adopted and affirmed the Referee's order. Inasmuch as I do not believe the mere suspicion that claimant might not be credible constitutes "legitimate doubt," I dissent.

Penalties may be assessed when a carrier unreasonably delays or unreasonably refuses to pay compensation. ORS 656.262(10). In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt about its liability at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Further, the insurer must continually reevaluate its denial and rescind a denial which is or becomes unreasonable prior to the issuance of an order setting the denial aside. Id. at 592.

At the time of the denial, the insurer had received a report from attending physician English which indicated that claimant, an intensive care and flight nurse, had the onset of low back pain while unloading heavy equipment from a medical helicopter. Dr. English noted degenerative disc disease; he did not specifically attribute causation to work.

The absence of any medical evidence attributing claimant's low back condition to work activity provides the insurer some measure of legitimate doubt. However, prior to hearing, that doubt was resolved in claimant's favor. Specifically, on May 17, 1994, the insurer deposed Dr. English. Dr. English explained that claimant's injury was caused by loading and unloading the helicopter while in a "mechanically disadvantaged position," viz., bent over to avoid the "hot" helicopter blades.

Therefore, the insurer's denial of claimant's low back condition was no longer reasonable after Dr. English testified. Yet, the insurer continued to fight the claim through the hearing process. On these facts, I would reverse the Referee and assess a penalty for the insurer's unreasonable denial. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
DEWEY W. KENNEDY, Claimant
WCB Case No. 93-14332
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Referee Hazelett's order that: (1) denied its motion to dismiss claimant's request for hearing concerning a proposed medical treatment dispute arising from a Managed Care Organization (MCO) for lack of jurisdiction; and (2) found that the proposed treatment was appropriate. The parties submit "post-hearing" Director and Referee orders, as well as a motion to deny a subpoena in another case. We treat such submissions as a motion for administrative notice. On review, the issues are jurisdiction, administrative notice, and medical services.

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

Evidence

On review, claimant submits a copy of a "post-hearing" September 19, 1994 Proposed and Final Order Concerning a Bona Fide Medical Services Dispute. In that order, the Director found the proposed treatment appropriate. SAIF objects to this submission, contending that it is not germane to the jurisdiction issue. In addition, with his brief, claimant submits a copy of a motion to deny a subpoena in another case. SAIF requests that we strike the motion and any argument claimant makes that relies on the motion. Finally, SAIF submits with its brief copies of two orders issued by Referee Menashe which deal with the issue of jurisdiction over MCO disputes in other cases.

We have no authority to consider evidence not in the record. However, the Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." This has been held to include agency orders and stipulations by the parties. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Mark A. Crawford, 46 Van Natta 725 (1994); Jenetta L. Gans, 41 Van Natta 1791 (1989).

Inasmuch as Referee Menashe's orders and the Director's order constitute agency orders, we may take administrative notice of these orders. However, we note that the Director's order is not particularly relevant, given the fact that it is based on a different record from that before us. More importantly, in view of our conclusion that the Director was without jurisdiction to address the issue of the appropriateness of the proposed treatment, the Director's order is null and void. Therefore, we perform our review without regard to it. Furthermore, given our subsequent decision in Job G. Lopez, 47 Van Natta 193 (1995)[1], Referee Menashe's orders are not persuasive evidence regarding the jurisdiction issue.

As for claimant's submission of a copy of a motion to deny a subpoena in another case, that is not a document of which we may take administrative notice. In any event, in light of our Lopez holding, it is unnecessary to resolve this administrative notice question.

Jurisdiction

Claimant compensably injured his low back in 1968 and subsequently underwent five low back surgeries, with the last surgery being performed on November 1, 1991. Claimant's hip and leg pain returned after the surgery. In April 1993, Dr. Rosenbaum recommended surgical implantation of a spinal infusion pump to dispense pain relieving medication. Dr. Misko, attending physician, referred claimant to Dr. Grewe, neurosurgeon, who also recommended the surgery based on claimant's response to testing. Dr. Misko and Dr. Fleming, consulting M.D., concurred with the surgical recommendation.

Dr. Grewe requested approval for the proposed surgery from CareMark Comp, an MCO with whom SAIF had contracted. In July 1994, CareMark Comp disapproved Dr. Grewe's proposed surgery request. (Ex. 23A). Dr. Grewe appealed this decision to the next level within the CareMark Comp system. (Ex. 38). At the time of hearing, CareMark Comp had not yet issued its final decision.[2]

In the meantime, claimant requested a hearing regarding, among other issues, SAIF's alleged "de facto" denial of his claim for low back surgery. Arguing that exclusive jurisdiction over the dispute rested with the Director, SAIF moved for dismissal of the hearing request. By his order, the Referee denied the motion and set aside SAIF's "de facto" denial. SAIF requested Board review.

Subsequent to the Referee's order, the Board issued its decision in Job G. Lopez, supra. There, after the Director upheld an MCO's disapproval of the claimant's physician's surgery request, the claimant requested a hearing. The carrier moved for dismissal of the hearing request, arguing that the Director had exclusive jurisdiction over the dispute. The referee denied the motion, and the carrier requested Board review.

On review, the Board rejected the carrier's contentions that, under ORS 656.260(4)(d) and (6), and 656.704(3), the Director had exclusive jurisdiction over the dispute. Rather, the Board concluded that, in the MCO context, determining where jurisdiction lies depends on the nature of the medical services issue in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994), and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Board decided that, because the particular disputed medical treatment involved a proposed surgery, jurisdiction to review the dispute vested solely in the Hearings Division. Id. at 201. On the merits, the Board relied on the opinion of one of the claimant's treating physicians to find that the proposed surgery was appropriate. Id. at 201-202.

SAIF presses essentially the same jurisdictional arguments that we rejected in Lopez. We adhere to our rejection of those arguments. Rather, in light of Lopez, we determine the nature of the disputed medical services issue in this case to ascertain who had jurisdiction to resolve the medical services issue presented by this case.

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[1] Although a signatory to this order, Board Member Haynes directs the parties' attention to her dissent in Job G. Lopez, supra.

[2] CareMark Comp eventually issued a final decision disapproving the proposed surgery. In June 1994, Dr. Misko requested Director's review of the dispute. This resulted in the September 19, 1994 Director's order discussed in the "Evidence" section of our opinion.

Here, as in Lopez, the dispute involves claimant's attending physician's request to perform spinal surgery. Because the request involves proposed medical services, under Martin v. City of Albany, supra, and Jefferson v. Sam's Cafe, supra, we conclude that jurisdiction to review the request is vested solely in the Hearings Divisions pursuant to ORS 656.283. Accordingly, we affirm the Referee's decision.

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 436-15-010(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 $1,200, 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 March 29, 1994 is affirmed. For services on Board review, claimant's counsel is awarded $1,200, to be paid by the SAIF Corporation.

March 9, 1995 Cite as 47 Van Natta 401 (1995)

In the Matter of the Compensation of
JEFFERY M. MOURLAS, Claimant
WCB Case No. 92-14216
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Schultz's order which: (1) found that claimant's aggravation claim was barred by *res judicata*; and (2) upheld the insurer's denial of claimant's aggravation claim for a low back condition. On review, the issues are *res judicata* and aggravation.

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

Claimant compensably injured his low back in August 1988 resulting in a L4-5 laminectomy. The claim was closed with an award of 15 percent unscheduled permanent disability.

In November 1991, claimant sought treatment for a gradual worsening of low back pain. His then treating physician, Dr. Waldram, recommended an MRI to rule out a herniated disc. The December 11, 1991 MRI revealed multilevel degenerative disc disease, scarring at L4-5, and a small disc prominence at L4-5. Based on the MRI, Dr. Waldram advised against surgery, but recommended an exercise program.

Based on his treatment in November and December 1991, claimant filed a claim for aggravation. The parties resolved the November 1991 aggravation claim pursuant to a July 30, 1992 stipulated settlement, which awarded additional unscheduled permanent disability. In addition to resolving the aggravation issue, the July 1992 settlement provided that "all issues raised or raisable thereby on the date of this Order are dismissed with prejudice."

In September 1992, claimant sought emergency room treatment, reporting that he experienced increased low back pain after moving a piece of furniture. (Ex. 21). Claimant then sought treatment from Dr. Misko, who examined him on December 11, 1992. Dr. Misko diagnosed a recurrent disc and recommended a myelogram and post-myelogram CT scan. (Ex. 24).

On December 17, 1992, claimant filed a claim for aggravation based on Dr. Misko's December 11, 1992 report. The insurer denied the claim on April 9, 1993.

The Referee found that the July 30, 1992 stipulated settlement, which had resolved a November 1991 claim for aggravation, was the last award or arrangement of compensation. The Referee determined that, since the current claim for aggravation was based on medical evidence (a December 11, 1991 MRI) that existed prior to the July 1992 settlement, claimant was precluded from relitigating whether that evidence established an aggravation.

Claimant asserts that his aggravation claim is not based on the December 1991 MRI but rather on his increased symptoms in September 1992, which he asserts constitutes a worsening. We understand claimant to argue that his claim is not precluded by the July 1992 stipulation because it is based on a worsening, or changed condition, from that resolved by the agreement. We disagree.

Dr. Misko's December 11, 1992 report states that claimant's symptoms worsened in December 1991; there is no reference to a September 1992 worsening. Furthermore, Dr. Misko relies on the December 1991 MRI to diagnose claimant, interpreting it as showing a massive disc recurrence at L4-5. Thus, we find that Dr. Misko's report was based on the same claim resolved by the July 1992 agreement.

Furthermore, evidence from other treating physicians show that claimant's condition did not change. Based on an August 1993 MRI, Dr. Smith, a consulting neurosurgeon, interpreted the study as showing only postoperative scarring at L4-5. (Ex. 35). Based on a myelogram and CT scan, Dr. Brett, another consulting neurosurgeon, found a disc protrusion at L4-5 with no significant neural impingement. (Ex. 41). Such opinions are consistent with that of claimant's former neurosurgeon, Dr. Waldram, who found that the December 1991 MRI showed scarring at L4-5 and a small disc protrusion. (Ex. 29).

Thus, we find that claimant's current aggravation claim is based on the same condition which was settled by the July 1992 settlement. Hence, we conclude that claimant's current aggravation claim is barred by the stipulated settlement. Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73 (1994).

ORDER

The Referee's order dated February 8, 1994 is affirmed.

March 9, 1995 Cite as 47 Van Natta 402 (1995)

In the Matter of the Compensation of
OXY OD, Claimant
WCB Case No. 94-05921
ORDER ON REVIEW
Swanson, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Menashe's order that: (1) found claimant entitled to temporary disability for a specific period; and (2) assessed a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties.

We adopt and affirm the Referee's order with the following supplementation. On review, the insurer acknowledges that claimant is entitled to temporary partial disability (TPD). However, it contends that claimant's TPD award should be "offset" by wages he would have received from his employer had he accepted his employer's offer to return to work after a Christmas lay-off (rather than continue to work for another employer).

In essence, the insurer's contention pertains to a calculation of claimant's TPD. Inasmuch as the issue presented at hearing concerned claimant's entitlement to TPD, the insurer's request is not properly before us.

In any event, in calculating claimant's TPD, the insurer's will be required to follow the formula set forth in OAR 436-60-030. In doing so, we note that neither the aforementioned rule nor any applicable statute provides for an "offset" for potential wages that a claimant did not actually receive.

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 areasonable fee for claimant's attorney's services on review concerning the temporary disability issue is $500, to be paid by the insurer. In reaching this conclusion, we have

particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Inasmuch as penalties are not considered compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to an attorney fee for services devoted to the penalty issue. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The Referee's order dated August 26, 1994 is affirmed. For services on review, claimant's counsel is awarded a $500 attorney fee, payable by the insurer.

March 9, 1995 Cite as 47 Van Natta 403 (1995)

In the Matter of the Compensation of
SALOME ORENDAY, Claimant
WCB Case No. 94-05757
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Herman's order that: (1) found that claimant was not entitled to additional temporary disability; and (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

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

Claimant was initially treated by Dr. Huston. On March 14, 1994, Dr. Huston released claimant to light duty work with certain physical restrictions. (Exs. 5, 6). Within these limitations, Dr. Huston released claimant to work eight hours per day, 40 hours per week. (Ex. 6).

On April 6, 1994, claimant changed his attending physician to Dr. Stringham. (Ex. 8). On April 11, 1994, Dr. Stringham concurred with Dr. Huston's March 14, 1994 work release. (Ex. 7).

CONCLUSIONS OF LAW AND OPINION

The Referee initially concluded that, because claimant earned his regular wage for the modified work he performed, his temporary partial disability (TPD) rate was zero and, therefore, he was not entitled to any additional sums. On reconsideration, citing Stone v. Whittier Wood Products, 116 Or App 427 (1992), on recon 124 Or App 117 (1993), the Referee acknowledged that TPD must be determined by measuring the proportionate loss of "earning power at any kind of work," rather than proportionate loss of "pre-injury" [sic, should be "post-injury"] wages. Furthermore, the Referee acknowledged that, in response to the Stone decision, the Department promulgated temporary rule OAR 436-60-030. (WCD Admin. Order 94-050). However, since claimant was paid his regular wage for his modified work and because there was no evidence regarding claimant's earning power at any type of work, the Referee reasoned that claimant had failed to prove entitlement to any additional temporary disability. In addition, finding no entitlement to additional TPD, the Referee found that SAIF's claims processing was not unreasonable and declined to assess any penalties. We disagree and reverse.

Here, claimant was compensably injured on October 13, 1993. Claimant received temporary total disability (TTD) from January 26, 1994 to April 18, 1994. (Ex. 14). On April 6, 1994, Dr. Stringham, claimant's attending physician, released claimant to restricted light work for eight hours per day, 40 hours per week. (Exs. 6, 7). The employer offered claimant modified work at his regular wage and claimant began that modified work on April 18, 1994. We agree with the Referee's reasoning and conclusions that SAIF properly terminated claimant's TTD when he returned to modified work on April 18, 1994. ORS 656.268(3)(a); Viking Industries v. Gilliam, 118 Or App 183 (1993).

Claimant worked three and a half hours on April 18, 1994. He worked four hours on April 19, 1994. He left work on both days due to pain. On April 19, 1994, claimant saw Dr. Matthey for cervical and shoulder pain. (Ex. 10). Dr. Matthey did not further restrict claimant's release to work. On May 3, 1994, claimant returned to Dr. Stringham, who released claimant to restricted light duty work for four hours per day. (Exs. 11-2, 12). Claimant returned to modified work on May 4, 1994. SAIF did not pay any temporary disability for the period from April 18, 1994 to May 3, 1994. SAIF began paying TPD on May 4, 1994. The issue here is claimant's entitlement to TPD during the period from April 18, 1994 to May 3, 1994.

Claimant's claim is in open status; therefore, the issue is claimant's procedural entitlement to temporary disability. A claimant's procedural entitlement to temporary disability for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician. OAR 436-30-035(1); Mary A. Lockwood-Pascoe, 45 Van Natta 355 (1993).

Here, although Dr. Stringham released claimant to work eight hours a day for the period in question, he did not release claimant to his regular job. Instead, claimant was released to restricted, light work. Therefore, we find that Dr. Stringham authorized temporary disability during the period in question. OAR 436-30-035(1).

SAIF has a duty to process a claim. See OAR 436-60-010(1) (insurer shall process claim in accordance with Chapter 656, WCD administrative orders and bulletins); Dennis R. Lewis, 46 Van Natta 2408, on recon 46 Van Natta 2501 (1994). At the time of Dr. Stringham's authorization for temporary disability, temporary OAR 436-60-030 was in effect. SAIF was required by this rule to compute TPD in reference to claimant's "earning power at any kind of work." See Stone v. Whittier Wood Products, supra. Such a directive involves evaluating all relevant circumstances that affect a worker's ability to earn wages.

SAIF argues that the amount of TPD due during the relevant time period would be zero, based on an eight hour day at the modified job, which paid claimant's regular wage. However, under both temporary OAR 436-60-030(2) and the reasoning in Stone , post-injury wages do not, in and of themselves, establish whether a worker has a "diminished earning power at any kind of work," nor are they dispositive of the rate of temporary partial disability. Therefore, SAIF's argument is not persuasive. SAIF must apply the temporary rule and calculate claimant's TPD based on claimant's "earning power at any kind of work." Dennis R. Lewis, supra.

There is no evidence that SAIF computed claimant's temporary disability in accordance with the administrative rule. Furthermore, the claims processing burden falls on SAIF, not claimant. OAR 436-60-010(1). Therefore, the fact that SAIF failed to properly compute claimant's temporary disability does not result in a finding that claimant failed to meet his burden of proving entitlement to additional TPD. Rather, this claim must be returned to SAIF, who is directed to make the proper calculation of claimant's temporary disability in light of the temporary rule and SAIF's general claims processing responsibilities.

In addition, we find that SAIF's conduct in failing to compute claimant's TPD in accordance with temporary OAR 436-60-030 was unreasonable. Consequently, claimant is entitled to recover a penalty for SAIF's unreasonable claims processing, to the extent that such unreasonable claims processing has resulted in any amounts "then due." Dennis R. Lewis, supra. A penalty of 25 percent is appropriate. The amount will be determined when SAIF calculates the TPD in accordance with the "post-Stone" administrative rule and will be based on amounts "then due" from April 18, 1994 to May 3, 1994, the period at issue.

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); former OAR 438-15-055(1).

ORDER

The Referee's order dated June 20, 1994, as reconsidered on July 1, 1994, is reversed. The claim is remanded to the SAIF Corporation for calculation of temporary partial disability for the period from

April 18, 1994 to May 3, 1994, in accordance with the law. Claimant is awarded a 25 percent penalty for SAIF's unreasonable failure to properly calculate claimant's temporary partial disability based on the temporary partial disability due from April 18, 1994 to May 3, 1994. Claimant's attorney shall receive one-half of this penalty under ORS 656.262(10). Claimant's attorney is awarded 25 percent of the increased compensation, if any, created by this order, not to exceed $3,800.

March 9, 1995 Cite as 47 Van Natta 405 (1995)

In the Matter of the Compensation of
MARGIE STEPHENSON, Claimant
WCB Case No. 94-05149
ORDER ON REVIEW
Stephen V. Piucci, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Hoguet's order that set aside its denial of claimant's claim for bilateral elbow, bilateral knee and sternum injuries. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, we do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is employed by American Building Maintenance, a self-insured employer as a janitor. She works for the employer at the Portland International Airport which is operated by the Port of Portland (Port). Claimant's employer contracts with the Port to provide janitorial services at the airport. On March 29, 1994, claimant completed her work shift at approximately 11:30 p.m. She punched out and, with her supervisor and a co-worker, left the terminal building through a main door on the baggage claim level. While running along a public walkway on her way to catch a shuttle bus to the employee parking lot, claimant fell and was injured.

The Referee found that claimant's injuries arose out of and in the course and scope of her employment. The employer argues that the "going and coming rule" applies and that, under that rule, claimant's injuries are not compensable since they do not arise out of the course and scope of her employment. We agree.

As a general rule, injuries which occur while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210, 216 (1987). The "parking lot rule" is an exception to the going and coming rule. Under the "parking lot rule," injuries sustained on the employer's premises while the employee is proceeding to or coming from work have a sufficient work-connection to be considered to have occurred "in the course of employment." Norpac Foods, Inc., v. Gilmore, 318 Or 363, 366-67 (1994). In addition to the "in the course of employment" element, a claimant must also establish that the injury "arose out of" employment in order for the claim to be compensable. Id.

Injuries are not considered to be within the course and scope of employment unless the employer exercises some control over the area where the injury occurred. Such control is established either by employer ownership or maintenance, or the presence of employer-created special hazards. Cope v. West American Ins. Co., 309 Or 232, 239 (1990).

Here, claimant was injured on a public walkway. In addition, there were no employer-created special hazards on the walkway. After punching out, claimant was free to do what she wished after work, although the employer encouraged employees to catch the shuttle bus and go home. Shuttle buses to the employee lot ran every 10 to 15 minutes. Claimant was not required to take the first shuttle bus after she finished her shift. In addition, claimant was not required to park in the employee lot and could also take the city bus to work, although she would have to walk over the same walkway

on which she was injured to reach the city bus. Claimant testified that when she fell, she was in a hurry to go home because she was tired after a long day at work.

We find this case to be similar to Cope v. West American Ins. Co., supra, 309 Or at 420. There, the worker was injured on her way to work after she left a parking lot leased by the employer. As the worker left the lot on foot, she was struck by a vehicle driven by a co-worker. The Cope Court held that when an employee is injured on a public sidewalk over which the employer has no control, and on which there are no employer-created hazards, the connection between the injury and the employment is insufficient to make the injury compensable.

We also find the present case analogous to Janet V. Dollens, 42 Van Natta 2004 (1990) aff'd mem 107 Or App 531 (1991). There, the claimant was a food service cashier/dishwasher for the self-insured employer which had a contract with Boeing Company. The claimant fell and injured herself on the way from a Boeing parking lot on her way to clock in at her place of employment, which was located within property owned by Boeing. The parking lot where the claimant fell was owned and maintained by Boeing. The employer did not control the area where the claimant was injured. We concluded that the claimant had shown none of the manifestations of employer control that would allow her to avoid the general rule that injuries incurred while coming to and going from work are not compensable. Accordingly, we upheld the employer's denial.

We find no material distinction between the facts of Dollens and the facts in the present case. Here, as in Dollens, claimant was injured in an area over which the employer had no control. Although claimant was hurrying to catch a shuttle bus to the employer's parking lot after punching out, we do not see a distinction between this case and Dollens where the claimant was injured leaving the employer's parking lot to clock in, rather than proceeding to the lot after punching out.

Because claimant has not shown that the employer exercised control over the public walkway on which she was injured, we are not persuaded that claimant's injury arose within the course and scope of her employment. Accordingly, the employer's denial of claimant's injury claim will be upheld.

ORDER

The Referee's order dated August 4, 1994 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's award of a $2,200 attorney fee is also reversed.

March 9, 1995 Cite as 47 Van Natta 406 (1995)

In the Matter of the Compensation of
JACK S. VOGEL, Claimant
WCB Case No. TP-94005
THIRD PARTY DISTRIBUTION ORDER
Schneider, et al., Claimant Attorneys
Scott Terrall & Associates, 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. ORS 656.593(3). Specifically, claimant contests the paying agency's (Johnston & Culbertson, hereafter "J & C") entitlement to receive reimbursement from the remaining balance of settlement proceeds for claim costs attributable to an independent medical examination, a medical arbiter examination, and an "overpaid" permanent disability award. We hold that a distribution in which J & C receives the remaining balance of settlement proceeds is "just and proper."

FINDINGS OF FACT

In April 1993, while working as a security officer, claimant was involved in a motor vehicle accident. The accident occurred when the vehicle claimant was operating was struck by another car.

Claimant filed an "801" claim for a strained neck, shoulder, and back. J & C, as claims administrator for the self-insured employer, accepted the claim and has provided benefits.

In June 1993, Dr. McAnulty, claimant's attending physician, submitted a supplemental medical report. Noting that claimant was stationary without permanent impairment on April 21, 1993, Dr. McAnulty released claimant to regular work as of June 16, 1993.

In August 1993, Dr. McKillop, orthopedist, examined claimant at J & C's request. Referring to questions apparently posed by J & C's claims examiner, Dr. McKillop found claimant medically stationary on August 10, 1993, and evaluated claimant's ranges of motion, motor/reflex changes, as well as his physical limitations. This evaluation pertained to claimant's cervical spine, left shoulder, right hip, and lower extremities. Despite claimant's subjective complaints, Dr. McKillop did not observe sufficient findings to impose work restrictions on claimant. Consequently, Dr. McKillop concluded that claimant was probably able to return to his regular work. In September 1993, Dr. McAnulty concurred with Dr. McKillop's report.

In October 1993, a Determination Order (DO) issued. Claimant was found medically stationary as of August 10, 1993. The DO also awarded 16 percent unscheduled permanent disability. According to an evaluator's worksheet accompanying the DO, the award was for claimant's "neck" (based on claimant's reduced cervical range of motion), while his reduced lumbar range of motion findings were "offset."

In December 1993, claimant requested reconsideration of the DO. Disagreeing with his impairment findings, claimant asked for a medical arbiter examination.

Dr. Martens, orthopedist, performed a medical arbiter examination. After evaluating claimant's physical limitations and medical history, Dr. Martens concluded that claimant had no permanent impairment resulting from his accepted condition/sequelae. Noting that claimant had returned to his regular work without restriction, Dr. Martens found no chronic or permanent medical condition attributable to claimants accepted condition/sequelae.

A May 13, 1994 Order on Reconsideration modified the DO. Claimant's permanent disability award was reduced to "none." The Order on Reconsideration was accompanied by "Explanatory Notes" from the Department's Appellate Unit. Notwithstanding claimant's denials to the examining physicians of prior neck, shoulder, or back problems/complaints, the Department noted that claimant had previously filed 1987 and 1990 low back injury claims and had received awards totalling 38 percent unscheduled permanent disability. Noting that claimant's attending physician (Dr. McAnulty) had found no permanent impairment and that Dr. Martens (medical arbiter) had found very little objective findings, the Department determined that claimant had not suffered permanent impairment as a result of the compensable injury.

In June 1994, claimant requested a hearing. He raised the following issues: permanent disability (unscheduled/scheduled); temporary disability; premature closure; and penalties.

Meanwhile, claimant had retained legal representation to pursue a third party action against the driver of the vehicle involved in his April 1993 motor vehicle accident. With J & C's approval, claimant and the third party reached a $12,000 settlement.

Prior to claimant's scheduled hearing, J & C notified him of its asserted lien. J & C claimed $9,581.16, comprised of $954.18 in temporary disability, $5,449.37 in permanent disability, and $3,177.60 in medical bills (including charges from Dr. McKillop and Dr. Martens, $500 and $200 respectively).

On September 14, 1994, a Referee dismissed claimant's hearing request. The Referee found that claimant had withdrawn his request for hearing. That order was not appealed.

Thereafter, claimant petitioned the Board for resolution of a dispute regarding a just and proper distribution of the settlement proceeds. Claimant opposes J & C's request for reimbursement of its permanent disability payments. Noting that the Order on Reconsideration had reduced claimant's permanent disability award to zero, claimant contends that J & C was not entitled to recover its "overpayment" through the lien reimbursement process.

Finally, claimant objects to J & C's reimbursement request for the "IME" and "Medical Arbiter" reports. ($500 and $250 respectively). Asserting that those services were rendered for claims processing purposes, claimant argues that such costs are not recoverable.

CONCLUSIONS OF LAW AND OPINION

If the worker settles a third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

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.

Here, after deduction of claimant's attorney fee and 1/3 statutory share under ORS 656.593(1) and (2), a balance of $5,600 remains. Claimant does not challenge J & C's entitlement to reimbursement for its temporary disability payments ($954.18) and $2,427.60 in medical bills. When that sum ($3,381.78) is deducted from the $5,600 remaining balance, the amount left in dispute is $2,218.22.

J & C contends that it is entitled to the remainder of the funds. It relies on its $5,449.37 in permanent disability payments, as well as its payments for Dr. McKillop's "IME" bill and Dr. Martens' "medical arbiter" bill.

In resolving this dispute, we are mindful of the court's admonishment that we must refrain from automatically applying the third party judgment scheme when determining a "just and proper" distribution for third party settlement proceeds. Urness v. Liberty Northwest, supra. 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. In other words, in exercising our statutory authority under ORS 656.593(3), we do not arbitrarily adhere to the specific distribution scheme set forth in ORS 656.593(1). Rather, 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 J & C to receive in partial satisfaction of its lien.

Pursuant to ORS 656.593(1)(c), the paying agency shall be paid and retain the balance of a third party recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service. "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8). Where a paying agency has incurred expenditures for compensation attributable to an accepted injury claim and the claimant has not challenged the payment of those benefits, we have found it "just and proper" for a paying agency to receive reimbursement for such claim costs. Mark S. Randolph, 43 Van Natta 1770 (1991).

With those general principles in mind, we turn to resolution of the parties' dispute. We begin with the conflict regarding J & C's entitlement to reimbursement for expenses relating to the IME and medical arbiter reports.

It is well settled that claim evaluation reports are analogous to litigation reports and, as such, are not properly includable in a paying agency's lien against a third party recovery. See David G. Payne, 43 Van Natta 918 (1991). J & C acknowledges this longstanding principle. However, it seeks to distinguish this case on the basis that claimant's attending physician concurred with the "IME" findings. Because of this concurrence, J & C reasons that the IME was simply a substitute for a closing examination by the attending physician.

Had the record indicated a reluctance on the part of claimant's attending physician (Dr. McAnulty) to perform a closing examination, we might have been willing to entertain J & C's "Payne" distinction. However, the record merely suggests that claimant was referred to Dr. McKillop for "an independent medical examination" to address questions posed by J & C's claim examiner regarding claimant's medically stationary status, impairment findings, and physical limitations. In light of such circumstances, Dr. McAnulty's subsequent concurrence with Dr. McKillop's report does not transform the report from its original status as a claim evaluation report. Consequently, consistent with the Payne rationale, we do not consider it "just and proper" for J & C to receive reimbursement for its claim costs attributable to Dr. McKillop's report.

J & C's reimbursement request for expenses related to the medical arbiter report presents a much closer and novel question. On first blush, since a medical arbiter examination resembles a claim evaluation procedure, our inclination would be to apply the Payne rationale and reject a paying agency's reimbursement claim for such expenses. However, as detailed in the legislative history which accompanied the adoption of ORS 656.268(7), the medical arbiter process was expressly designed to avoid or reduce litigation. See Daniel L. Bourgo, 46 Van Natta 2505 (1994). Thus, unlike an "IME" report, a medical arbiter report is not intended for litigation purposes. Moreover, in this particular case, again unlike an "IME" situation, the medical arbiter report was obtained at the request of claimant, not the paying agency.

Under such circumstances, we are inclined to conclude that it is "just and proper" for J & C to receive reimbursement for its costs attributable to the medical arbiter examination. However, we need not resolve this question because we conclude that it is "just and proper" for J & C to recover its expenses related to claimant's permanent disability award. In other words, inasmuch as the permanent disability expenses exceed the remaining balance of settlement proceeds, the question of whether the medical arbiter costs are reimbursable is moot.

Claimant does not challenge J & C's representation that he has received $5,449.37 in permanent disability payments. Likewise, claimant does not contest the fact that these payments were made pursuant to a Determination Order award granted under his accepted April 1993 injury claim. Nevertheless, reasoning that this award was erroneously based on preexisting disability (which the Order on Reconsideration subsequently recognized when it reduced claimant's award to zero), claimant contends that the permanent disability payments should not be reimbursed from his third party recovery. Instead, claimant recommends that J & C be required to recover its overpayment under ORS 656.268(13) from his future permanent disability awards under the accepted April 1993 injury claim.

Claimant misunderstands the statutory scheme. A carrier may recover overpayments of benefits paid to a worker in accordance with ORS 656.268(13) or pursuant to a referee's or Board order. See OAR 436-60-170; Harris v. Ireland Trucking, 115 Or App 692 (1992). Such a recovery process is not contingent on a paying agency's failure to obtain a share of third party settlement proceeds. In other words, regardless of the eventual outcome concerning a third party settlement distribution dispute, a paying agency may seek authorization to offset overpaid benefits against future permanent disability awards. Consequently, J & C's success or failure in recovering partial or complete satisfaction of its "overpaid" permanent disability award from the third party settlement will not affect its future claim processing rights or obligations.

Claimant argues that any permanent disability award paid by J & C was for a condition that was not a subject of the third party settlement. Thus, he asserts that such an award is not reimbursable from the settlement proceeds. In support of his contention, claimant relies on Donna L. Johnson, 45 Van Natta 1586 (1993).

In Johnson, the claimant challenged a paying agency's claim for full reimbursement for medical bills paid under a compensable injury claim. Relying on a third party judgment (which had expressly determined that a portion of the bills were not related to the third party injury), the Board limited the paying agency's lien to claim costs attributable to expenses for which claimant had received a third party recovery.

The present dispute is distinguishable. To begin, unlike Johnson, since this dispute pertains to a settlement, rather than a judgment, the "just and proper" distribution of standard of ORS 656.593(3) is

applicable. Furthermore, there is no contention that the settlement proceeds were limited to a specific body part or excluded a particular body part, medical bill, or award. Rather, it is undisputed that the settlement resolved claimant's third party claim arising from his compensable injury. Inasmuch as Johnson involved a third party judgment which expressly excluded a particular body part and medical bill from claimant's recovery, we consider its holding to be of little assistance to us in resolving this current distribution dispute.

As previously noted, in reducing claimant's permanent disability to zero, the Department found that there was no permanent impairment as a result of claimant's injury. Based on this finding, as well as considering claimant's prior receipt of awards for previous low back injuries, the Department concluded that he was not entitled to a permanent disability award as a result of this compensable injury.

In light of the Department's ultimate findings, claimant reasons that the DO award was attributable to a condition for which J & C was not responsible and which was not subject to the third party settlement. We disagree.

As noted in our findings, the DO award was based on claimant's reduced range of motion findings in his "neck," not for "offset" findings in the low back. Inasmuch as the prior awards were attributable to low back injuries, the record does not support claimant's contention that the DO award was due to the preexisting low back injuries. To the contrary, the record establishes that the DO award was based on claimant's "neck" impairment findings, which were subsequently discounted during the reconsideration proceeding which followed a medical arbiter examination.

The subsequent elimination of the DO award does not mean that the permanent disability payments lawfully paid in accordance with that order are not "compensation" paid for a compensable injury. If anything, the reconsideration order's reduction of claimant's permanent disability award may call into question the basis for claimant's $12,000 third party settlement. However, such a question is not before us.

In any event, the extinguishing of claimant's permanent disability award does not change the undeniable fact that the permanent disability benefits were paid pursuant to a Department order under claimant's accepted April 1993 injury claim. As such, those benefits constitute compensation for which we consider it "just and proper" for J & C to receive reimbursement from the remaining balance of third party settlement proceeds. ORS 656.593(3); Mark S. Randolph, supra.[1]

Accordingly, we hold that it is "just and proper" for J & C to receive the remaining balance of settlement proceeds ($5,600). Claimant's attorney is directed to forward the aforementioned sum to J & C.

IT IS SO ORDERED.

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[1] We recognize that, in Randolph, we automatically applied the statutory distribution scheme in ORS 656.593(1) in determining a "just and proper" distribution under ORS 656.593(3). For the reasons discussed by the Urness court and this order, such strict adherence to the third party judgment recovery scheme of ORS 656.593(1) is inappropriate. Nonetheless, even without such an automatic application of ORS 656.593(1), the general reasoning expressed in Randolph regarding the justness and propriety for a paying agency to recover reimbursement for actually incurred claim costs remains persuasive. Therefore, we apply that general concept expressed in Randolph in determining a "just and proper" distribution based on the merits of this case and without strict adherence to ORS 656.593(1).

In the Matter of the Compensation of
KAREN A. FALETTI, Claimant
WCB Case No. 93-09664
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of those portions of Referee Spangler's order which: (1) denied its motion to dismiss claimant's request for hearing for lack of jurisdiction over a medical services claim; (2) awarded claimant's counsel an assessed attorney fee under ORS 656.386(1) for his services in setting aside an alleged "de facto" denial of a medical services claim; and (3) awarded an assessed fee for SAIF's allegedly unreasonable claim processing. On review, the issues are jurisdiction 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's attending physician, Dr. Randle, requested authorization from SAIF for physical therapy for claimant. Caremark, SAIF's Managed Care Organization (MCO), disapproved the request. After the MCO denied reconsideration, claimant filed a request for hearing. Claimant also requested Director review, but subsequently withdrew the request for review. SAIF moved to dismiss the hearing request on the grounds that jurisdiction to review the medical services issue did not lie with the Hearings Division, but rather with the Director under ORS 656.260(6).

The Referee denied SAIF's motion for dismissal, reasoning that the MCO provisions of ORS 656.260 did not abolish claimant's right to request a hearing concerning the reasonableness and necessity of her medical treatment. We agree.

Subsequent to the Referee's order, the Board issued its decision in Job G. Lopez, 47 Van Natta 193 (1995). There, after the Director upheld an MCO's disapproval of the claimant's physician's surgery request, the claimant requested a hearing. The carrier moved for dismissal of the hearing request, arguing that the Director had exclusive jurisdiction over the dispute. The referee denied the motion, and the carrier requested Board review.

On review, the Board rejected the carrier's contentions that, under ORS 656.260(4)(d) and (6), and 656.704(3), the Director had exclusive jurisdiction over the dispute. 47 Van Natta at 194-200. Rather, the Board concluded that, in the MCO context, determining where jurisdiction lies depends on the nature of the medical services issue in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994) and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Board decided that, because the particular disputed medical treatment involved a proposed surgery, jurisdiction to review the dispute vested solely in the Hearings Division. Id. at 201-202.

Here, SAIF presses essentially the same jurisdictional arguments that we rejected in Lopez. We adhere to our rejection of those arguments.[1] In light of Lopez, we determine the nature of the disputed medical services issue in this case to ascertain who had jurisdiction to resolve that issue.

Here, as in Lopez, the dispute involves a request for proposed medical services. Under Martin and Jefferson, jurisdiction to review the request is vested solely in the Hearings Division pursuant to ORS 656.283. Accordingly, we affirm the Referee's decision denying SAIF's motion to dismiss.

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[1] Although a signatory to this order, Board Chair Neidig refers the parties to her dissent in Job G. Lopez, 47 Van Natta 193 (1995).

SAIF also contests the Referee's award of an assessed attorney fee pursuant to ORS 656.386(1) for claimant's counsel's services in setting aside SAIF's "de facto" denial of her medical services claim. SAIF contends that, since it had no authority to deny a request for treatment under its MCO contract, it could not have "denied" claimant's medical treatment.

ORS 656.262(1) states that "[p]rocessing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer. All employers shall assist their insurers in processing claims as required by this chapter." Because the statute requires all employers to assist in processing injured workers' claims, and because it makes no distinction between carriers that contract with MCOs and those that do not, we conclude that all carriers, whether or not they contract with MCOs, remain subject to the usual statutory claims processing duties. Therefore, since SAIF remained subject to its usual claims processing duties, and since it did not accept, deny or pay for claimant's medical services within 90 days of claimant's request for authorization of physical therapy, it "de facto" denied claimant's medical services claim. Therefore, SAIF's conduct amounted to a denial of a claim for compensation not limited to the amount of compensation or extent of disability. See SAIF v. Allen, 320 Or 192 (1994); Snowden A. Geving, 46 Van Natta 2355, 2356 (1994). Thus, the Referee correctly determined that claimant is entitled to an assessed attorney fee under ORS 656.386(1).

Finally, the Referee awarded an assessed attorney fee pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable refusal to accept or deny claimant's medical services claim. In reaching this conclusion, the Referee reasoned that nothing in ORS 656.260 could reasonably be read to place claim processing responsibilities on the MCO rather than SAIF. Thus, the Referee found SAIF's claim processing to have been unreasonable. We disagree.

Given the complexity of the jurisdictional issues involved in claims concerning MCO's, we do not find that SAIF's refusal to accept or deny the medical services claim was unreasonable. As our decision in Lopez demonstrates, resolution of the jurisdictional issues concerning the Hearings Division and MCO's was a complex procedural matter, with persuasive arguments both for and against our holding in that case. Thus, we find that SAIF had a legitimate basis for interpreting the statutory scheme as providing that resolution of the MCO dispute was subject to the procedures set forth in ORS 656.260, as well as the applicable Director's rules. We cannot, under these circumstances, find that SAIF acted unreasonably. Therefore, we reverse the Referee's decision assessing an attorney fee for SAIF's allegedly unreasonable failure to accept or deny claimant's medical services claim.

Claimant's counsel is entitled to an attorney fee for services on review concerning the jurisdictional/medical services 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 attorney fee for claimant's attorney's services on review regarding the jurisdictional/medical services issues is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services devoted to the attorney fee issues. See Dotson v, Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 18, 1994 is affirmed in part and reversed in part. That portion which assessed a $500 attorney fee for SAIF's allegedly unreasonable claim processing is reversed. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by SAIF.

In the Matter of the Compensation of
FRED W. HODGEN, Claimant
WCB Case No. 93-08500
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Jeffrey Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a positive PPD skin test for tuberculosis. In his brief, claimant contends that the Referee erred in declining to admit several post-hearing reports. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except we replace the last sentence in the second paragraph with: "None of these residents has been shown to have an active case of TB."

CONCLUSIONS OF LAW AND OPINION

Evidence

The hearing in this matter was heard on March 24, 1994. Claimant testified that co-worker Hamm had a positive PPD skin test in early 1993. Dr. Brandt, the chief medical officer for the insured, testified that Mr. Hamm subsequently had two negative chest x-rays and a negative PPD test.

The Referee continued the hearing to receive the parties' written closing arguments. SAIF submitted its closing argument on May 17, 1994. On May 19, 1994, claimant filed a motion to admit Mr. Hamm's 1993 medical records (proposed Exhibits OAA and 7AA), and a May 13, 1994 letter from Dr. Dworkin concerning those medical records (proposed Exhibit 9). SAIF objected to the motion. Finding that the post-hearing reports were neither newly discovered evidence that could not have been obtained with due diligence prior to hearing, nor documents that represented evidence "material" to claimant's case, the Referee declined to admit the proposed exhibits into evidence.

Claimant challenges the Referee's evidentiary ruling, contending that the Referee excluded material evidence. We disagree.

After reviewing the proffered evidence, we agree that it is not material to establish whether claimant was exposed to tuberculosis at work. Moreover, even if we were to consider the proposed exhibits, the outcome would be the same. That is, the excluded evidence concerning co-worker Hamm does not rise to the level necessary to refute the evidence presented by SAIF that there are no active cases of tuberculosis among either the staff or the resident population at work. Therefore, we need not consider whether the Referee abused his discretion by excluding the post-hearing reports. See Larry D. Poor, 46 Van Natta 2451 (1994).

Compensability

We adopt the Referee's reasoning and conclusion as it pertains to this issue with the following comment.

On review, claimant urges the Board to find his positive PPD skin test compensable based on Dr. Dworkin's opinion that claimant "most likely" acquired a tuberculosis infection at work. ORS 656.266 requires a claimant to affirmatively prove that his condition is, in fact, related to the work environment. See Ruben G. Rothe, 45 Van Natta 369, 372 (1993). Here, claimant has not affirmatively proven any exposure to tuberculosis at work. Thus, Dr. Dworkin's opinion is insufficient to prove that claimant's exposure, in fact, occurred at work. Accordingly, we agree with the Referee that claimant

has not established that his employment caused exposure to tuberculosis or resulted in a positive PPD test.[1]

ORDER

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

[1] Board Member Gunn acknowledges that he is required by the doctrine of stare decisis to follow the Board's holding in Ruben G. Rothe, supra. However, for the reasons expressed in his dissenting opinion in Lynne D. Gibbons, 46 Van Natta 1698, 1699 (1994), he continues to disagree with the Rothe holding and the underlying analysis, and to find that where a claimant who works in a "high risk" occupation shows that the working environment has a hazardous substance, establishes that he was exposed to such substance, and there is evidence that exposure was the major contributing cause of the occupational disease, the condition should be considered compensable.

In the Matter of the Compensation of
CLIFTON EDWARDS, Deceased, Claimant
WCB Case No. 94-04160
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Jeffrey R. Gerner (Saif), Defense Attorney

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

The SAIF Corporation requests review of Referee Lipton's order that denied SAIF's request to set aside an Order on Reconsideration that had awarded the decedent 17 percent (54.40 degrees) unscheduled permanent disability. On review, the issue is the propriety of the Order on Reconsideration. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last paragraph of "Additional Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The decedent had an accepted workers' compensation claim for a September 20, 1991 injury. He died on August 29, 1993 from causes unrelated to his compensable injury. A Determination Order issued on October 19, 1993, which did not award permanent disability. (Ex. 8).

On January 21, 1994, the decedent's former attorney requested reconsideration of the October 19, 1993 Determination Order, raising issues of permanent disability. (Ex. 8a). The decedent's former attorney explained to the Department that, although the decedent had not left any statutory beneficiaries, he was pursuing the matter on behalf of the decedent's estate. (Ex. 8b). The attorney requested that review of the claim be continued in light of the fact that SAIF could be required to pay a burial allowance pursuant to ORS 656.218(5).

The March 29, 1994 Order on Reconsideration awarded 17 percent (54.40 degrees) unscheduled permanent disability. (Ex. 9). SAIF requested a hearing, contending that the Order on Reconsideration was void because there were no beneficiaries of the permanent disability award.

At hearing, the parties stipulated that, among other things, the decedent left no statutory heirs and the funeral expenses were in excess of $3,000. The Referee concluded that the issue of burial benefits was premature because there was no evidence that a demand had been made for SAIF to pay a burial allowance under ORS 656.218(5). The Referee also rejected SAIF's contention that the Order on Reconsideration was void.

On review, SAIF contends that the Order on Reconsideration is void because the decedent was not survived by statutory beneficiaries and his personal representative lacked authority to initiate the reconsideration process. We agree.

Survival of actions in workers' compensation cases is governed strictly by statute. See Majors v. SAIF, 3 Or App 505 (1970); Velma L. Vetternack, 46 Van Natta 929 (1994). Because the decedent died before the Determination Order had issued, ORS 656.218(2) applies. That statute provides:

> "If the worker's death occurs prior to issuance of a notice of closure or making of a determination under ORS 656.268, the insurer or the self-insured employer shall proceed under ORS 656.268 and determine compensation for permanent partial disability, if any."

Pursuant to ORS 656.218(2), SAIF was required to proceed under ORS 656.268 and determine whether the decedent was entitled to compensation for permanent partial disability. SAIF fulfilled this obligation by submitting the claim to the Department for evaluation and closure. On October 19, 1993, a Determination Order issued that awarded no permanent disability.

Although ORS 656.218(2) refers to "a notice of closure or making of a determination under ORS 656.268," there is no express provision in the statute that refers to the reconsideration process in ORS 656.268. Moreover, ORS 656.218(2) refers to the duties of the insurer or employer, not to the rights of a worker's personal representative to pursue the claim.

ORS 656.218(4) provides that if the worker dies before filing a request for hearing, "the persons described in subsection (5) of this section shall be entitled to file a request for hearing and to pursue the matter to final determination as to all issues presented by the request for hearing." As in ORS 656.218(2), there is no express provision in ORS 656.218(4) that refers to the reconsideration process in ORS 656.268. We note that the amendments to ORS 656.268 concerning the "reconsideration process" were adopted subsequent to ORS 656.218. ORS 656.218 was last amended in 1987 (Or Laws, ch. 887, section 16) and not thereafter amended to incorporate or refer to the 1990 enactments, including the reconsideration process.

Consequently, ORS 656.218 does not refer to the reconsideration process. Although that may be an anomalous result, we are not at liberty to "insert what has been omitted, or to omit what has been inserted" in construing a statutory provision. ORS 174.010. See Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) (curious result was compelled by the statutes). Since there is no statutory provision that allows a personal representative to request reconsideration of a determination order, the decedent's personal representative was not statutorily authorized to request reconsideration of the Determination Order that did not award permanent partial disability. Therefore, the March 29, 1994 Order on Reconsideration that awarded decedent 17 percent (54.40 degrees) unscheduled permanent disability is void.

In any event, even if we were to construe ORS 656.218(4) to include the reconsideration process, we conclude that the personal representative is not, pursuant to ORS 656.218(4), one of "the persons described in subsection (5)" who may pursue the claim. ORS 656.218(5) provides:

> "The payments provided in this section shall be made to the persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal. In the absence of persons so entitled, a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204."

Thus, the phrase in ORS 656.218(4) "persons described in subsection (5)" who are entitled to pursue the matter to final determination refers to "persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal." ORS 656.218(5). In general, death benefits are payable to the worker's surviving spouse, children under the age of 18 years or "dependents." See ORS 656.204.

In Trice v. Tektronix, Inc., 104 Or App 461 (1990), the claimant died after she had filed a request for hearing on the issue of temporary total disability benefits for her compensable stress claim. At the time of her death, she was unmarried and was not survived by any minor children. The employer filed a motion to dismiss on the ground that the claimant had left no statutory beneficiaries to pursue her request for hearing. The claimant's 28-year-old daughter, as the personal representative of her estate, moved for an order substituting her for the claimant.

The Trice court held that the right to pursue a deceased claimant's hearing request is limited under ORS 656.218 to those who are entitled to death benefits under ORS 656.204. Id. at 465. The court concluded that the personal representative was not a statutory beneficiary entitled to pursue the hearing request.

Likewise, in the present case, the decedent's personal representative is not a statutory beneficiary. Therefore, even if we were to construe ORS 656.218(4) to include the reconsideration process, the decedent's personal representative was not, pursuant to ORS 656.218(4), one of "the persons described in subsection (5)" of ORS 656.218 and was not entitled to request reconsideration of the Determination Order that did not award permanent disability. See Trice v. Tektronix, Inc., supra. Consequently, we conclude that the March 29, 1994 Order on Reconsideration that awarded the decedent 17 percent (54.40 degrees) unscheduled permanent disability is void because it was issued in response to a request from an entity which lacked standing under the Workers' Compensation law.

Moreover, since the March 29, 1994 Order on Reconsideration is void, the decedent's personal representative may not collect a burial allowance pursuant to ORS 656.218(5). ORS 656.218(5) provides, in part: "In the absence of persons so entitled, a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204." ORS 656.204(1) provides that "[t]he costs of burial, including transportation of the body, shall be paid, not to exceed $3,000 in any case." Since we have concluded that the March 29, 1994 Order on Reconsideration is void, there is no unpaid award of permanent disability benefits. Thus, the "unpaid award" is zero. The lesser of the unpaid award (zero) and the burial costs (which exceed $3,000) is zero. See ORS 656.218(5); Wilma F. Macaitis (Deceased), 42 Van Natta 2449 (1990).

ORDER

The Referee's order dated July 15, 1994 is reversed. The March 29, 1994 Order on Reconsideration that awarded the deceased claimant 17 percent (54.40 degrees) unscheduled permanent disability is vacated.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that the Order on Reconsideration was void because the personal representative lacked statutory authority to initiate the reconsideration process. Therefore, I respectfully dissent.

Although decedent's Determination Order did not award permanent disability, the March 29, 1994 Order on Reconsideration awarded 17 percent unscheduled permanent disability. In this proceeding, the decedent's personal representative is attempting to collect a portion of those benefits on behalf of the estate for burial expenses under ORS 656.218(5). Despite the fact that there is no statute or rule that specifically precludes a personal representative from initiating a reconsideration proceeding, the majority concludes that the Order on Reconsideration was void because ORS 656.218 does not refer to the reconsideration process. The result of the majority's decision is to give SAIF a windfall and render ORS 656.218(5) meaningless.

This body is required to construe the Workers' Compensation Law liberally in favor of the injured worker. Reynaga v. Northwest Farm Bureau, 300 Or 255, 262 (1985). This is a well-established principle applicable to the Workers' Compensation Law by virtue of its character as a remedial statute. Nevertheless, the majority construes the statutes at issue in this case in a hypertechnical manner to deny decedent's estate benefits to which decedent would otherwise have been entitled.

Because I would conclude that the Order on Reconsideration was valid, I would allow decedent's personal representative to collect a burial allowance pursuant to ORS 656.218(5). I respectfully dissent.

In the Matter of the Compensation of
MICHAEL A. GIANCOLA, Claimant
WCB Case No. 94-04028
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

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

The insurer requests review of Referee Livesley's order which increased claimant's scheduled permanent disability award for loss of use or function of the left wrist from none, as awarded by Order on Reconsideration, to 10 percent (15 degrees). On review, the issue is scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Surgery

Claimant suffered a compensable left scaphoid fracture on December 28, 1990, which progressed to a fibrous nonunion. On August 8, 1992, claimant underwent a right anterior iliac crest bone graft to the left scaphoid nonunion. The surgery involved removing the nonunion bone defect and packing a cancellous bone graft into the defect in the scaphoid. No internal fixation was utilized since the scaphoid was stable. A subsequent tomogram confirmed a complete healing of the fracture. Claimant's treating physician declared claimant medically stationary on August 26, 1993 with no permanent impairment of the wrist.

The Referee found that claimant's surgery constituted a carpal bone fusion and, applying former OAR 436-35-110(4), awarded 5 percent impairment for the surgery. In reaching his conclusion, the Referee relied on the Manual of Orthopedic Terminology, 4th Ed., 1990 which defines fusion as "the uniting of two bony segments, whether a fracture or a vertebral joint."

The insurer argues that the graft surgery does not qualify as fusion surgery because a fusion implies loss of use or function of a joint, or of one or the other of adjacent parts. The insurer, therefore, contends that graft surgery and fusion surgery are distinct, such that the standards allow an impairment award only for the latter. We agree.

The standards do not define fusion, but do define ankylosis to mean "a bony fusion or arthrodesis. Ankylosis does not include pseudarthrosis or articular arthropathies or fibrous unions." Former OAR 436-35-005(2). A bony fusion is defined as "the union of the bones of a joint by proliferation of bone cells, resulting in complete immobility." Dorland's Illustrated Medical Dictionary, 25th Ed., 1974. Inclusion of the term "bony fusion" in the definition of ankylosis implies an intent to award permanent disability where the fusion has resulted in complete immobility of the joint. See, e.g., OAR 436-35-080 (wrist joint ankylosed). Thus, the surgery resulting in a fusion results in immobility of the joint.

Here, the medical evidence does not establish that claimant's wrist joint is ankylosed as a result of the graft surgery. Thus, to accept the Referee's definition would convert all graft surgeries into fusion surgeries for purposes of applying the standards. Such an application is overbroad, particularly when, as here, the medical evidence establishes that the scaphoid fracture has healed without any permanent impairment.[1] Accordingly, we conclude that claimant's graft surgery is not ratable under the standards. See also John M. Ames, 44 Van Natta 684 (1992) (not every surgical procedure is ratable); James A. Rouse, 43 Van Natta 2405 (1991) (bone graft surgery to repair fractured toe not ratable). Consequently, claimant is not entitled to a permanent disability award for the graft surgery.

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[1] The surgical procedure did not result in any loss of use or function of claimant's wrist. Thus, there is no disability to be addressed under the existing standards. Therefore, we need not remand to the Director to adopt a temporary rule. See Susan D. Wells, 46 Van Natta 1127 (1994).

Chronic Condition Impairment

Claimant is entitled to an award for chronic condition impairment when the admissible medical opinion establishes that claimant is unable to repetitively use a body part "due to a chronic and permanent medical condition." Former OAR 436-35-010(6); Weckesser v. SAIF Corporation, 132 Or App 325 (1995).

On August 26, 1993, Dr. Wilson, claimant's treating physician, opined that claimant had no permanent impairment of the wrist and released him to regular work without restrictions. Dr. Stanford, medical arbiter, examined claimant on March 12, 1994. In addition to finding a normal examination, Dr. Stanford reported that:

> "there is no evidence that [claimant] is unable to repetitively use his hand or wrist due to a diagnosed chronic and permanent medical condition arising out of his accepted condition. *** The only limitation I would put on him would be that with very heavy work in a repetitive manner, but otherwise he appears to examine normally today."

Dr. Stanford noted that claimant experienced discomfort with pushups an that type of activity, but given his normal examination findings, Dr. Stanford expressly stated that claimant did not have a chronic condition or that he was unable to repetitively use his wrist. In addition, Dr. Stanford's recommendation that claimant avoid repetitive heavy work does not mean that claimant has lost his ability to use his wrist repetitively. Mark A. Roberts, 46 Van Natta 1168 (1994).

In light of Dr. Wilson's opinion that claimant has no permanent impairment and Dr. Stanford's specific finding of no chronic condition, we find that claimant is not entitled to an award for chronic condition impairment. See Rae L. Holzapfel, 45 Van Natta 1748 (1993), aff'd mem Holzapel v. M. Duane Rawlins, Inc., 127 Or App 208 (1994).

Based on this record, we conclude that claimant has failed to prove that he is entitled to an award of scheduled permanent disability for his graft surgery and for a chronic wrist condition.

ORDER

The Referee's order dated September 30, 1994 is reversed. The March 23, 1994 Order on Reconsideration, which awarded no permanent disability, is reinstated and affirmed.

Board Member Gunn dissenting.

The majority holds that claimant's graft surgery is distinct from fusion surgery and, therefore, because the standards do not address impairment for graft surgery, claimant is not entitled to a permanent disability award for the surgery. I see little difference between a fusion and a graft and, therefore, would find claimant entitled to a permanent disability award for the surgery.

Under ORS 656.295(5), our role is to apply the standards for the evaluation of disability as adopted by the Director. We do not measure the amount of disability, that is defined by the standards. Accordingly, our review is limited to determining whether the standards were correctly applied. ORS 656.295(5); see Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993).

The standards award disability for surgery involving carpal bone fusion. OAR 436-33335-110(4). Thus, as I see it, the question is whether the standards compensate for a carpal bone fusion if the procedure performed is called a graft. My only experience with grafting is the grafting which results in the fusion of two varieties of trees or repair of a tree by fusing it back together. Thus, I agree with the Referee's reliance of the definition of fusion provided in the Manual of Orthopedic Terminology. As in my tree grafting example, in this case, there has been a uniting of a bone graft with the scaphoid bone to repair the fractured scaphoid.

The majority declined to equate the graft surgery to fusion surgery on the basis that, as a result of the surgery, claimant's fracture healed without permanent impairment. I do not think that whether the surgery was a success is relevant to whether the surgery is ratable under the standards. As I interpret the applicable standard, it awards disability for the surgical procedure itself, not for its outcome.

I would hold either that graft and fusion surgery are the same or that the standards fail to address claimant's impairment. If the former, then the standards were incorrectly applied and claimant is entitled to a 5 percent award for the surgery. If the latter, then the Board should remand the case to the Director of the Department of Consumer and Business Services to adopt a temporary rule. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538, 542 (1993).

The majority also wrongly denied claimant a 5 percent award for chronic condition impairment. Again, I would agree with the Referee that the medical arbiter's limitation that claimant not perform very heavy work in a repetitive manner is sufficient to establish that claimant has a chronic condition for which he should be awarded permanent disability.

Because I disagree with the majority on both counts, I would affirm the Referee's order. Therefore, I respectfully dissent.

March 14, 1995 Cite as 47 Van Natta 419 (1995)

In the Matter of the Compensation of
RICHARD E. LESTER, Claimant
WCB Case No. 94-00524
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

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

The SAIF Corporation requests review of that portion of Referee Neal's order which awarded claimant an attorney fee under ORS 656.386(1) for his counsel's efforts in obtaining rescission of a "de facto" denial prior to hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

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

On January 12, 1994, claimant's counsel filed a request for hearing, raising issues of temporary disability, penalties and attorney fees. A hearing was scheduled for April 8, 1994.

On March 23, 1994, SAIF rescinded its denial and accepted claimant's left carpal tunnel syndrome (CTS). (Ex. 19).

Claimant's counsel did not file a request for hearing from SAIF's January 21, 1994 "new injury" denial. (Ex. 17B, Record). Claimant's counsel did not file a request for hearing from SAIF's "de facto" denial of claimant's left carpal tunnel syndrome (CTS) claim.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's counsel had been instrumental in obtaining compensation for claimant without a hearing by securing acceptance of claimant's left CTS claim. Therefore, the Referee awarded an attorney fee in the amount of $2,000 for claimant's counsel's efforts, under ORS 656.386(1). SAIF requested Board review of the Referee's attorney fee award, contending that an attorney fee of $150 would be more appropriate for claimant's counsel's efforts.

The relevant portion of ORS 656.386(1) 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."

We agree with the Referee that claimant's counsel was instrumental in obtaining compensation for claimant. However, the record reveals only limited involvement by claimant's attorney. We find that claimant did file a claim for his left hand condition in December 1993. (Ex. 11B). We accept claimant's counsel's representation that she counseled claimant to file the claim due to the continuing problems with his left hand. (Respondent's Brief at 2). The record also contains a letter by claimant's counsel dated January 12, 1994, requesting updated discovery, including current medical records. (Ex. 17A). There is no question of claimant's counsel's involvement in this case. However, we note that that involvement, with respect to the left CTS condition, was limited to counseling claimant and requesting discovery.

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). As set forth above, claimant's counsel's efforts which resulted in acceptance of the CTS claim were minimal. In particular, we note that claimant's counsel did not request a hearing from any claim denials, and his counsel's other efforts were minimal. Under these circumstances, we conclude that a $750 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.

In addition, we have not considered any of counsel's services rendered subsequent to the rescission regarding the CTS issue. Amador Mendez, 44 Van Natta 736, 737 (1992). Likewise, because attorney fees are not compensation, we do not consider claimant's counsel's services on review regarding the attorney fee issue. Id.

ORDER

The Referee's order dated April 15, 1994, as reconsidered May 27, 1994, is modified in part. In lieu of the award of $2,000 in attorney fees, we award $750 in attorney fees under ORS 656.386(1).

Board Member Gunn dissenting.

The majority has modified the Referee's attorney fee award, even though it agreed with the Referee that claimant's attorney was instrumental in setting aside the SAIF Corporation's "defacto" denial without a hearing. The majority failed to identify what factors, if any, it applied in deciding to reduce the amount of claimant's counsel's fee awarded by the Referee.

The Referee, who reviewed the record and considered the relevant attorney fee factors, awarded a fee of $2,000. The majority reduced that amount with little or no rationale. Although the majority cites the factors in OAR 438-15-010(4), it fails to indicate how it could differ by $1,250 from the Referee's application of these same factors.

The one reason the majority does cite as a rationale for its decision is that it considered claimant's attorney's efforts to be "minimal." Having never been a lawyer, but only a client, I tend to evaluate the result rather than the performance. In this case, claimant's attorney "was instrumental " in obtaining the acceptance of claimant's left CTS claim. Under current law, this was a difficult task of substantial benefit to claimant.

The majority's second-guessing of the Referee is not supported by the record or the result obtained for claimant. In addition, this revisionist approach to attorney fee disputes only spawns more of them, clogging the system with disputes that are not better decided at this level.

For these reasons, I must respectfully dissent.

March 14, 1995 Cite as 47 Van Natta 420 (1995)

In the Matter of the Compensation of
JACK C. McANINCH, Claimant
WCB Case N0. 92-12593
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Foss, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Referee Daughtry's order that set aside its denial of claimant's aggravation claim for a left knee condition. On review, the issue is aggravation.

We adopt and affirm the Referee's order, except that we do not address the scope of the employer's acceptance. In addition, we offer the following supplementation.

This case is controlled by Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994). In Messmer, the claimant injured his neck and shoulder at work. The claim was subsequently closed by a Determination Order which awarded permanent disability based in part on the effects of surgery for the claimant's degenerative disease. The employer did not appeal the Determination Order. The claimant later filed an aggravation claim for a worsening of his degenerative condition, which the employer denied. The claimant argued that the employer was barred from denying the compensability of his degenerative condition because the employer had failed to appeal the Determination Order's award of permanent disability for his degenerative condition.

We concluded that the carrier was not precluded from denying the compensability of claimant's aggravation claim, on the ground that neither the carrier's approval of surgery nor its failure to challenge the Determination Order constituted an acceptance of the claimant's degenerative neck condition. Richard J. Messmer, 45 Van Natta 874 (1993). The court disagreed, reasoning that the scope of the compensable claim was inseparable from the determination of extent of disability. 130 Or App at 258. Inasmuch as the employer did not challenge the Determination Order's permanent disability award, the court determined that the employer was barred from later arguing that the condition for which the award was made was not part of the compensable claim. The Messmer court emphasized that the result was not that the degenerative condition was accepted, but that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id.

The circumstances of this claim are similar. The employer accepted claimant's May 12, 1988 injury claim for a left knee ("strain?") condition. The claim was closed by a February 10, 1989 Determination Order that awarded 16 percent scheduled permanent disability for claimant's left knee, including a 3 percent rating for his June 1988 surgery. (Exs. 11, 12). This surgery had revealed a fresh complex tear of the posterior horn of the left medial meniscus and lateral femoral condylar degenerative changes. (Ex. 4).

In January 1992, claimant filed an aggravation claim. The employer denied the claim on the basis that claimant's current left knee problems result from preexisting degenerative joint disease, rather than the accepted injury.

Like the claimant in Messmer, claimant in this case received an award of permanent disability based on the effects of surgery necessitated (in part) by preexisting degeneration, as well as the (unaccepted) torn left meniscus. Nonetheless, since the employer did not challenge the award of permanent disability granted in the February 1989 Determination Order, it may not now deny the compensability of claimant's torn meniscus and left knee degeneration. In other words, the employer must treat claimant's current left knee condition (including the torn meniscus and the degeneration) as a compensable condition under the 1988 claim. Messmer v. Deluxe Cabinet Works, supra; see John C. Beaver, 47 Van Natta 165 (1995); Roger L. Wolff, 46 Van Natta 2302, 2304 (1994); compare Olson v. Safeway Stores, Inc., 132 Or App 424 (1995) (Where it was not obvious from the Determination Order and Evaluator's worksheet that the unappealed determination orders awarded permanent disability for the claimant's preexisting degenerative condition, the court declined to address whether the employer could be barred from denying the degenerative condition by its failure to appeal the determination orders).

Finally, ev3n if the employer was not precluded from denying claimant's aggravation claim, we would agree with the Referee that claimant's May 1988 work injury (which directly caused the torn left meniscus condition) and its compensable sequelae (including the June 1988 surgery and degeneration resulting from that surgery) constitute the major contributing cause of claimant's current left knee problems. We would base this conclusion on the opinions of Dr. Boughal, attending physician, and Dr. Smith, orthopedist, as did the Referee. See Somers v. SAIF, 77 Or App 259 (1986) (We rely on medical opinions which are well-reasoned and based on an accurate and complete history). Accordingly, we also agree with the Referee that claimant has proven a compensable worsening under ORS 656.273.[1]

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[1] In Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), the court held that ORS 656.005(7)(a)(B) does not apply in aggravation cases and a compensable worsening is established if the compensable injury is a material contributing cause of the worsening, even if the claimant had a noncompensable condition that preexisted the compensable injury. Here, unlike Jocelyn, supra, claimant's current condition result largely from indirect consequences of the compensable injury. Under these circumstances, ORS 656.005(7)(a)(A) may apply in this aggravation context. See Judy L. Magill, 47 Van Natta 169 (1995). However, we need not answer that question, because claimant prevails regardless of the standard of proof in this case.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, 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 to claimant of the interest involved.

ORDER

The Referee's order date June 7, 1993 is affirmed. For services on review, claimant is awarded a $1,750 attorney fee, payable by the self-insured employer.

March 14, 1995 Cite as 47 Van Natta 422 (1995)

In the Matter of the Compensation of
EWELL McCRAE, Claimant
WCB Case No. C403204
SECOND ORDER DENYING RECONSIDERATION
Gatti, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Claimant's former attorney has submitted a letter in response to our February 16, 1995 Order Denying Reconsideration which adhered to our February 2, 1995 order that: (1) approved a Claim Disposition Agreement (CDA) between claimant and the insurer; and (2) declined to grant claimant's former attorney's request that we direct the insurer to distribute a portion of the CDA proceeds to the former attorney. Asserting that our decision leaves him "no other recourse but to file a lawsuit directly against his prior client," claimant's former attorney suggests that we "find some type of administrative recourse" to resolve these attorney fee disputes.

For all the reasons expressed in our February 16, 1995 order, we decline to reconsider our February 2, 1995 order approving the CDA. Nevertheless, in doing so, we must take issue with claimant's former attorney's inference that no administrative remedy existed for resolution of his attorney fee dispute with his former client. Such an inference is inaccurate.

As represented by our holdings in Billy Lemons, 46 Van Natta 2428 (1994), and Michael J. Galbraith, 46 Van Natta 910, on recon 46 Van Natta 1144 (1994), such disputes have been settled within the confines of our CDA decision. However, there are some significant distinctions between those rulings and the present case.

First, and foremost, the former attorneys in those cases timely and completely filed their lien notices. In the present case, claimant's former attorney neglected to submit either a copy of an executed retainer agreement or an affidavit supporting his claim. Secondly, in both of the previous cases, the record supported the claimant's attorney's entitlement to a portion of the settlement proceeds. Here, as explained in our prior order, the record as developed did not support claimant's former attorney's assertion that he was entitled to a portion of the CDA proceeds.

In conclusion, it is apparent that claimant's former attorney is dissatisfied with our decision. Nonetheless, such dissatisfaction does not support claimant's former attorney's conclusion that no administrative recourse existed for resolution of the attorney fee dispute. As detailed above, such an administrative remedy was fully available to him had he chosen to develop a proper record which supported his claim. Inasmuch as claimant's former attorney failed to timely and properly avail himself of that remedy, he must suffer the consequences of that inaction.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBIN L. SMITH, Claimant
WCB Case No. 93-07304
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of Referee Baker's order which declined to award penalties and attorney fees for the insurer's allegedly unreasonable failure to approve her choice of attending physician and to reimburse claimant for medical treatment, mileage and prescriptions. In its brief, the insurer contends that litigation of these issues is barred by res judicata. On review, the issues are medical services, res judicata, penalties and attorney fees. We vacate in part and reverse in part.

FINDINGS OF FACT

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

Claimant sustained a compensable left hip and left sacroiliac injury on August 4, 1984, for which she has received 15 percent unscheduled permanent partial disability. Claimant's aggravation rights expired in March 1991.

Claimant (a Bend-area resident) began treating with Dr. Belza, a Bend neurosurgeon, in February 1993, at which time she was reporting low back and left hip and leg symptoms. Dr. Belza could detect little objectively wrong with claimant both on examination and after diagnostic testing.

The insurer wrote claimant on March 19, 1993, advising her that she had treated with a total of four doctors since her compensable injury, including Dr. Belza. Claimant was further advised that OAR 436-10-060(3) allowed her to change treating physicians only twice after her initial choice. The balance of the letter informed claimant of the rest of the provisions of the administrative rule and stated in closing that "The purpose of this letter is to notify you of these rules. Should you disagree with our inventory of physicians, please contact us at your earliest convenience." (Ex. 19).

The insurer subsequently informed claimant by letter of March 22, 1993 that it had contracted with a Managed Care Organization (MCO) and that further treatment should be administered through a physician in the MCO. Claimant was also told that she might be allowed treatment with a physician outside the MCO, but that she must contact the insurer prior to receiving treatment. Failure to do so, wrote the insurer, could result in nonpayment of medical services. Finally, the insurer stated that claimant was not entitled to palliative treatment except under limited circumstances, which it listed in the letter. See ORS 656.245(1)(b).

Claimant continued to receive medical treatment from Dr. Belza. She also underwent examinations by a consulting physician, Dr. Mahoney, and by a panel of Western Medical Consultants. These examinations resulted in few objective findings. The insurer paid for Dr. Belza's treatment.

Dr. Belza wrote the insurer on June 1, 1993, in response to inquiries regarding the status of claimant's current condition and need for treatment. Although conceding that claimant's low back and left hip and leg pain was of "unclear etiology," Dr. Belza still considered claimant's condition to be related to her compensable injury. Dr. Belza acknowledged that there were no strong objective findings, but he emphasized that claimant's symptoms and complaints were very consistent. Dr. Belza admitted that his treatment was palliative. However, he wrote that he was attempting to provide curative treatment. (Ex. 35).

On July 14, 1993, Dr. Belza again wrote the insurer and expressed his belief in the merit of claimant's pain complaints. (Ex. 41). Claimant later that month moved from her home in the Bend area to Sweet Home. On July 27, 1993, claimant's attorney requested permission for claimant to treat with a doctor closer to Sweet Home. The insurer refused permission by letter of July 30, 1993, noting its March 1993 correspondence with claimant. The insurer also stated that the panel of Western Medical Consultants had indicated that claimant's treatment was neither palliative nor curative and that Dr. Belza had concurred with the panel's findings.

On August 4, 1993, claimant's counsel sought assistance from the Medical Director in obtaining approval of the request for a change of attending physician. (Ex. 45). By Proposed and Final Order of September 24, 1993, the Department concluded that claimant was subject to the insurer's MCO contract and that it was inappropriate for the Director to consider the request for a change of attending physician until the MCO dispute resolution process had been completed. (Ex. 48).

On October 18, 1993, the Department wrote the insurer, stating that it had informed claimant's counsel that the MCO did not process change of attending physician requests and that the insurer had approved of a physician in the Sweet Home area, Dr. Becker, to treat claimant. Based on this information, the Department's letter concluded that the issue of the change of attending physician had been resolved. (Ex. 49).

Also on October 18, 1993, claimant returned to Dr. Belza because she had not yet received authorization to see a physician in Sweet Home. (Ex. 51). Dr. Belza completed a palliative care request form, requesting authorization of physical therapy. (Ex. 52). Claimant then requested reimbursement for mileage from her Sweet Home residence to Dr. Belza's Bend office in connection with her treatment on October 18th.

Claimant subsequently received the insurer's permission to treat with Dr. Becker, which she did on November 2, 1993. On November 8, 1993, consistent with his October 1993 examination, Dr. Belza performed facet blocks at L5-S1. A nuclear bone scan recommended by Dr. Belza was also performed.

On November 24, 1993, the insurer denied claimant's mileage request relative to her October 18, 1993 visit to Dr. Belza. (Ex. 58). That same day, the insurer wrote Dr. Belza to inform him that it was disapproving his request for palliative treatment, along with his bills for treatment provided on October 18 and November 8, 1993. The reason given was that he was not a member of the insurer's MCO. (Ex. 59).

Dr. Belza has continued to treat claimant. The insurer has not paid for claimant's bone scan, nor has it paid for Dr. Belza's treatment on and after October 18, 1993, as well as related mileage and medication.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought penalties and attorney fees for the insurer's allegedly unreasonable failure to pay for claimant's medical services, including billings, mileage and medication. Claimant also contended that there was an improper denial of medical services by reason of the insurer's refusal to approve claimant's choice of Dr. Belza as her attending physician.

Reasoning that the current MCO regulations, as well as other medical rules severely restrict a claimant's choice of attending physician, the Referee found that the insurer's claim processing was not unreasonable. Thus, the Referee denied all relief requested by claimant.

On review, claimant contends that she is entitled to continue her treatment with Dr. Belza. She also alleges that the Referee erred in failing to award penalties and/or attorney fees for the insurer's allegedly unreasonable resistance to the payment of compensation. The insurer responds by asserting that litigation of the medical services and penalty and attorney fee issues is barred by res judicata as a result of the Director's prior order.

Res Judicata

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

We disagree with the insurer's contention that the Department's decision bars her from litigating the issues raised at the Hearings Division. The Director's order only addressed the issue of claimant's request for a change of attending physicians. The Director held that the attending physician dispute was to be resolved through the MCO's dispute resolution process. In contrast, the issues being litigated before the Board concern reimbursement of medical expenses and mileage related to claimant's treatment with Dr. Belza, as well as penalties and attorney fees.

Inasmuch as the Director's order did not address these issues and held (erroneously, as subsequently acknowledged in the Director's October 18, 1993 letter) that the attending physician dispute must be resolved through the MCO dispute resolution process, we find that there was no final determination of the issues presented by claimant's request for hearing. Therefore, we conclude that litigation of the reimbursement, penalty and attorney fee issues was not barred by the Director's Proposed and Final Order.

Change of Attending Physician

Claimant initially contends that she is entitled to treat with Dr. Belza because he is her attending physician. Inasmuch as the insurer had approved Dr. Becker as claimant's attending physician, we construe claimant's request to treat with Dr. Belza as a request for change of attending physician. However, we do not have jurisdiction to resolve the continuing dispute regarding Dr. Belza's status as attending physician.

In Tracy Johnson, 43 Van Natta 2546 (1991), and in Ronald D. Robinson, 44 Van Natta 1657 (1992), we held that disputes involving change of attending physician are not a "matter concerning a claim" over which the Hearings Division has jurisdiction. Rather, we concluded that such disputes are solely within the province of the Director and must be resolved under the applicable procedures for administrative review set forth in OAR 436-10-008(2). ORS 656.704(3); ORS 656.245(3).

Accordingly, we find the statute provides a "proceeding for resolving a dispute regarding medical treatment," within the meaning of ORS 656.704(3). Thus, we conclude that original jurisdiction over this matter rests with the Director, rather than the Hearings Division.[1]

Penalty and Attorney Fee Issues

While we do not address the attending physician dispute, we do have jurisdiction to decide whether penalties and attorney fees should be assessed for the insurer's failure to reimburse claimant for prescriptions, mileage and medical treatment. Inasmuch as no party "wished" Director review of claimant's medical treatment pursuant to ORS 656.327(1), the Board has jurisdiction to resolve the issues related to claimant's medical treatment. See Meyers v. Darigold, Inc., 123 Or App 217 (1993).

Moreover, inasmuch as claimant's right to receive compensation (reimbursement for medical treatment, medication and mileage) is directly in dispute, claimant's request for hearing involves a "matter concerning a claim." See ORS 656.704(3). Therefore, we have jurisdiction to decide the issues raised by claimant's hearing request, including the compensability of claimant's medical bills.

Although we do not decide the issue of whether Dr. Belza can remain claimant's attending physician, we agree with claimant's contention that the insurer unreasonably refused to reimburse claimant for mileage, prescriptions and medical bills related to Dr. Belza's treatment. Claimant asserts that the insurer failed to give claimant proper notice under OAR 436-10-060(22) & (23) of eligible medical providers and the manner in which she was to be provided compensable medical services under the MCO. We agree.

OAR 436-10-060(22) provides that, when a medical provider, such as Dr. Belza, is not a member of a MCO, and does not qualify as a primary care physician, the insurer must notify the medical service provider that medical services after the date of the notification shall not be compensable. Although the insurer advised Dr. Belza of its MCO contract via a copy of the March 22, 1993 letter to claimant, that letter did not provide Dr. Belza with the requisite notice that his medical services would no longer be paid after the date of the letter. In fact, the letter stated that claimant might be allowed to treat with a physician who is not a member of the MCO and that failure to contact the insurer prior to treating with a non-MCO physician "may" result in nonpayment of services.

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[1] We note that while the Director was requested to resolve the attending physician dispute, the Proposed and Final Order did not decide the issue of whether claimant could change attending physicians. Thus, it would appear that the issue remains viable.

Inasmuch as the insurer's letter did not clearly reject Dr. Belza as claimant's attending physician or expressly provide that any further bills from Dr. Belza would not be reimbursed, we conclude that the March 22, 1993 letter did not comply with the requirements of OAR 436-10-060(22). Further, the insurer did not inform claimant of the manner in which she could receive medical services as required by OAR 436-10-060(23).

Because the insurer did not comply with the notice requirements of the aforementioned administrative rules, the insurer improperly refused to reimburse claimant for her medical and related expenses. See Sandra L. Masters, 44 Van Natta 1870, 1872 (1992) (Where the employer failed to comply with the Department's notification process regarding how changes in workers' compensation law would affect the claimant's right to receive temporary disability, the employer could not unilaterally terminate temporary disability benefits because the claimant had not complied with the new law). Thus, since the insurer did not contest the causal relationship between claimant's compensable injury and her treatment, we find that claimant was entitled to reimbursement of her medical expenses, including mileage and prescriptions, until the insurer's notices of November 24, 1993, at which time the insurer notified claimant and Dr. Belza that reimbursement of her October 18 and November 8, 1993 office visits would not be approved.

Finally, given the clear requirements of the applicable administrative rules, we also conclude that the insurer's failure to reimburse claimant for medical and related expenses resulting from Dr. Belza's treatment was unreasonable. Accordingly, we assess a 25 percent penalty on "amounts then due" (as a result of this order) at the time of the insurer's November 24, 1993 letters. Such penalty is to be shared equally by claimant and her attorney. See ORS 656.262(10).

The insurer's conduct was also 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).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review regarding the medical treatment and related services issues is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the 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. We further note that claimant's counsel is also receiving a portion of claimant's penalty for unreasonable claim processing.

ORDER

The Referee's order dated April 8, 1994 is vacated in part and reversed in part. The Referee's order is vacated insofar as it pertained to claimant's request for a change of attending physician. The insurer's "de facto" denial is set aside and the claim is remanded to it for processing in accordance with law. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the insurer. Finally, claimant is entitled to a 25 percent penalty on amounts due at the time of the insurer's November 24, 1993 letter (as a result of this order), to be shared equally by claimant and her counsel.

In the Matter of the Compensation of
WILLIAM W. SWINT, Claimant
WCB Case No. 91-14261
ORDER ON REMAND
Emmons, Kropp, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Swint v. Guerdon Industries, 125 Or App 285 (1993). The court reversed our prior order which affirmed a Referee's order that dismissed, for lack of jurisdiction, claimant's request for hearing concerning the insurer's refusal to pay for medical services. Citing its decision in Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court remanded for reconsideration.

FINDINGS OF FACT

Claimant compensably injured his low back in September 1985. His claim was closed by an August 1986 Determination Order with an award of 20 percent unscheduled permanent disability. Although he continued to have occasional pain in the low back and legs, he did not seek treatment until April 1990.

In April 1990 claimant sought chiropractic treatment with Dr. Smith for increased pain in the low back, hips and legs. Dr. Smith filed an aggravation claim with the insurer, on claimant's behalf. (Ex. 3A). By letter dated June 19, 1990, the insurer denied the aggravation claim, stating in pertinent part: "[The insurer] denies responsibility and compensability for your current disability and/or medical treatment." (Ex. 4). Claimant requested a hearing on that denial.

At the December 7, 1990 hearing before Referee Spangler, the issues were framed as: (1) whether claimant sustained an aggravation of the accepted 1985 injury; and (2) whether his then-current medical services were causally related to the 1985 injury. By Opinion and Order dated December 10, 1990, Referee Spangler set aside the insurer's June 19, 1990 denial "in its entirety" and ordered the insurer to "accept and process claimant's aggravation claim according to law." In the order, Referee Spangler stated that the medical services issue was rendered moot by the aggravation issue, explaining:

> "That is, claimant has prevailed in proving an aggravation, which will require the insurer to reopen his claim and to pay all benefits--including medical services--according to law. Furthermore, I have found above that the September, 1985, compensable injury was the major contributing cause of claimant's April, 1990, worsened low back condition and resulting need for medical services." (Ex. 5-5).

The insurer requested Board review. By Order on Review dated September 6, 1991, the Board reversed Referee Spangler's order, and reinstated and upheld the insurer's aggravation denial. (Ex. 7). William W. Swint, 43 Van Natta 1848 (1991).

Dr. Smith submitted to the insurer billings for low back treatment dating from April 1990. The last billing was made on October 3, 1991. None of those billings were paid, nor did the insurer issue a written denial of treatment. Instead, the insurer requested the Director to review the reasonableness and necessity (i.e., appropriateness) of the chiropractic treatment.

Claimant requested a hearing concerning the insurer's non-payment of billings for chiropractic treatment rendered before July 1, 1990.

CONCLUSIONS OF LAW AND OPINION

Referee Daughtry dismissed claimant's hearing request for lack of jurisdiction. Relying on the Board's decision in Stanley Meyers, 43 Van Natta 2643 (1991), Referee Daughtry held that the 1990 statutory amendments vested the Director with exclusive jurisdiction to review the reasonableness and necessity of medical treatment. On review, we affirmed the Referee's order.

The Court of Appeals reversed, citing to its decision in Meyers v. Darigold, Inc., supra, which issued subsequent to the Referee's and Board's orders. In Meyers, the court held that, absent a "wish" for Director review of medical treatment pursuant to ORS 656.327, the Board (and Hearings Division) retains jurisdiction to review the appropriateness of treatment. Id. at 222. Based on Meyers, the court remanded this case for reconsideration. On reconsideration, we reach the following conclusions.

In his original appellant's brief filed on Board review, claimant contended that the compensability of the disputed chiropractic treatment was previously litigated before Referee Spangler, and that "[t]he effect of the Board's ruling [in September 1991] was to find that the medical services were provided for a compensable injury." (App. Br. at p. 1).

The compensability of chiropractic treatment for claimant's low back condition was expressly denied by the insurer. See Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993) (carriers are bound by the express language of their denials). The denial, including the issue of the compensability of treatment, was actually litigated before Referee Spangler. Finding that claimant's worsened back condition and resultant need for treatment were compensably related to the accepted injury, Referee Spangler set aside the insurer's June 19, 1990 denial in its entirety.

However, Referee Spangler's order was appealed, and reversed by the Board's September 6, 1991 order. William W. Swint, supra. Finding that claimant's compensable condition had not sufficiently worsened to support a compensable aggravation claim, the Board "reinstated and upheld" the insurer's denial. The Board did not adopt the Referee's finding that claimant's need for treatment was compensably related to the accepted injury,[1] nor did the Board's order set aside any portion of the insurer's denial. Hence, we find that the denial of claimant's then-current disability and medical treatment was upheld.[2] The Board's order apparently was not appealed and was therefore a valid and final judgment. In addition, the determination of the compensability of chiropractic treatment was essential to the Board's final judgment upholding the denial.

Because the compensability of the chiropractic treatment was expressly denied by the insurer's June 19, 1990 denial and actually litigated before Referee Spangler, and since the denial was finally reinstated and upheld in its entirety by the Board's September 1991 order, we conclude that issue preclusion applied to bar claimant from litigating the compensability of the same treatment or of subsequent treatment for the same, unchanged back condition. See North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Therefore, the insurer shall not be ordered to pay for chiropractic treatment rendered prior to July 1, 1990.[3]

Our conclusion in this case is consistent with the Court of Appeals' analysis in 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 letter which denied, not only the heart attack claim, but also the claimant's preexisting coronary artery disease. At hearing, the referee found that the heart attack was compensable, set aside the carrier's denial "in its entirety," and remanded the case to the carrier for processing. The referee's order was not appealed. Later, the carrier issued a denial of the coronary artery disease. The court held that the carrier was precluded by the prior referee's order from contesting the compensability of the coronary artery disease. While noting that no claim had been previously made for the coronary artery disease, 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 not been overturned 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 decision had the effect of ordering the acceptance of the coronary artery disease. Id.

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[1] Whereas a worker must prove that his compensable condition has worsened in order to establish his entitlement to additional disability compensation under the aggravation statute, ORS 656.273, he is entitled to medical services under ORS 656.245 if the need for services resulted from the compensable injury, without a showing of a worsened condition. See Smith v. SAIF, 302 Or 396, 401-02 (1986); Meyers v. Darigold, Inc., supra, 123 Or App at 223-24. Therefore, claimant could have proven his entitlement to medical services, despite the absence of a worsened condition.

[2] It may well have been the Board's intent not to uphold the portion of the insurer's denial which denied medical treatment. However, the Board's order unambiguously, and without exception, reinstated and upheld the insurer's denial. Under the circumstances, the appropriate course of action would have been for claimant to request reconsideration of the Board's order or to appeal the order to the courts. Because claimant did neither, he is now precluded from relitigating the issues finally determined by that order.

[3] According to Referee Daughtry's statement of issues, which is not disputed by the parties, the only medical services in dispute were those rendered before July 1, 1990. Therefore, our holding applies to those chiropractic services pertaining to the insurer's previously litigated and upheld June 19, 1990 denial and later services which were provided prior to July 1, 1990.

Just as the carrier's denial in King framed the issue for litigation in that case, the insurer's June 19, 1990 denial also framed the issues before Referee Spangler. In that denial, the insurer specifically denied claimant's low back treatment, thus the compensability of that treatment was at issue before Referee Spangler. The Board's subsequent reversal of Referee Spangler's order and upholding of the denial had the effect of establishing that the low back treatment was not compensable. Because the Board's order has become final, claimant is precluded from relitigating the compensability of that treatment.

Accordingly, on reconsideration, we reverse the Referee's January 24, 1992 order. Claimant's hearing request is reinstated. Claimant's request for payment of pre-July 1, 1990 medical treatment and associated attorney fees is denied.

IT IS SO ORDERED.

March 15, 1995 Cite as 47 Van Natta 429 (1995)

In the Matter of the Compensation of
CONNIE M. JOHNSON, Claimant
WCB Case Nos. 93-14319 & 93-10916
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Bostwick, et al., Defense Attorneys
John Snarskis, Defense Attorney

Reviewed by Board Members Haynes and Hall.

St. Paul Fire & Marine requests review of Referee Bethlahmy's order that: (1) set aside its denial of claimant's proposed left knee anterior cruciate ligament stabilization surgery; and (2) upheld Industrial Indemnity's denial of claimant's "new injury" claim for her left knee condition. On review, the issues are res judicata, compensability, and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a carpenter for St. Paul's insured, Wright-Schuchart. In 1990, she suffered a left knee injury which St. Paul accepted. On July 2, 1990, Dr. North performed a left knee arthroscopic partial medial menisectomy and an ACL tag excision. Claimant's claim was closed by a January 10, 1991 Notice of Closure.

Claimant's left knee problems continued. On April 3, 1992, St. Paul denied claimant's aggravation claim, which arose out of claimant's request for authorization for left knee anterior cruciate ligament stabilization surgery. Claimant requested a hearing. A referee upheld the denial. On review, the Board set aside the denial to the extent that it denied claimant's anterior cruciate ligament repair surgery. Connie M. Johnson, 46 Van Natta 495 (1994). St. Paul appealed and that case is pending before the Court of Appeals.

In July 1993, claimant began working for David A. Mowat Company, insured by Industrial Indemnity. She sought treatment for her left knee on July 27, 1993 and Dr. Baldwin recommended left knee anterior ligament stabilization surgery. Claimant filed a "new injury" claim against Industrial Indemnity and requested authorization for surgery from St. Paul. Both claims were denied and claimant requested a hearing.

The Referee set aside St. Paul's denial. The Referee reasoned that St. Paul's general acceptance of claimant's left knee injury claim encompassed the torn medial meniscus and anterior cruciate deficit, the cause of claimant's current need for treatment. We agree and adopt her reasoning and conclusions, with the following supplementation concerning the status of the case.

We note at the outset that neither claimant nor St. Paul contend on review that Industrial Indemnity is responsible for claimant's current need for left knee surgery. Instead, St. Paul argues that the present claim for left knee surgery is barred by the prior litigation. See Connie M. Johnson, supra.

The Referee found, and we agree, that res judicata does not apply to the present claim, because the prior litigation is not final (the case is pending before the Court of Appeals). See Drews v. EBI Companies, 310 Or 134 (1990). Moreover, because we agree with the Referee that St. Paul's acceptance encompassed claimant's current left knee condition, we further agree with the Referee that St. Paul remains responsible for claimant's proposed left knee surgery.

Claimant is entitled to an assessed attorney fee for prevailing over St. Paul'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 $800, to be paid by St. Paul. 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 May 18, 1994 is affirmed. For services on review, claimant's counsel is awarded an $800 attorney fee, payable by St. Paul Fire & Marine.

March 15, 1995 Cite as 47 Van Natta 430 (1995)

In the Matter of the Compensation of
CYNTHIA L. NICHOLS, Claimant
WCB Case No. 94-05837
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

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

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

The Referee found that the insurer had properly calculated claimant's rate of temporary disability without considering claimant's two-week vacation as an "extended gap" in her employment. See OAR 436-60-025(5)(a).[1] On review, claimant contends that the Referee erred in concluding that her vacation was not an "extended gap." Thus, she asserts that this period should not be considered in calculating her average weekly wage.

As the Referee noted, the determination of whether an "extended gap" in employment exists is made on a case-by-case basis. Dena L. Barnett, 43 Van Natta 1776, 1777 (1991). This determination depends not only on the length of the "gap," but also on whether the gap caused a change in the working relationship between the worker and the employer. See Adam J. Delfel, 44 Van Natta 524, 525 (1992).

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[1] OAR 436-60-025(5)(a) provides as follows:

"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 exists within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker;..."

Inasmuch as there is no evidence in the record that claimant's vacation caused a change in the working relationship between claimant and the employer, nor any evidence that claimant's vacation was anything other than an expected period of time off work, we agree with the Referee that the insurer correctly calculated claimant's temporary disability. See ORS 656.266; Craig E. Hobbs, 39 Van Natta 690 (1987). Accordingly, we affirm the Referee's decision on this issue.

ORDER

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

March 16, 1995 Cite as 47 Van Natta 431 (1995)

In the Matter of the Compensation of
JOSE CAMPUZANO, Claimant
WCB Case No. 94-01244
ORDER ON REVIEW
Angelo Gomez, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

The SAIF Corporation requests review of that portion of Referee Mills' order which directed it to calculate claimant's rate of temporary disability benefits. On review, the issue is rate of temporary disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer as a seasonal farm worker since 1977. The farm season usually starts in late February or early March and usually ends around Thanksgiving. Claimant goes to Mexico during the seasonal lay-off. Although the work is seasonal, the record establishes that claimant is a permanent year-round employee who is subject to seasonal lay-offs.

At the start of the 1992 season, claimant delayed his return to work until March 18, 1992 because of the birth of a grandchild. Claimant sustained a compensable injury on May 26, 1992.

The Referee found that claimant's 15 1/2 week lay off was particularly and abnormally lengthy so as to be considered an "extended gap" under OAR 436-60-025(5)(a). The Referee, therefore, concluded that claimant's average weekly rate be calculated based on the ten to ten and one-half weeks that claimant worked prior to his injury. We find that claimant's seasonal lay-off does not constitute an "extended gap."

The parties agree that claimant's temporary disability rate should be determined under OAR 436-60-025(5)(a), which 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."

Whether extended gaps in a claimant's employment exist is determined on a case-by-case basis. Sally M. Turpin, 37 Van Natta 924, 926 (1985). Determining what is an "extended gap" is not based solely on the length of the gap in work, but is also based on whether the gap has caused a change in the work relationship between employer and employee. Adam J. Delfel, 44 Van Natta 524, 525 (1992). If the work is seasonal, periods of layoff are to be expected, and unless they are abnormally lengthy or occur during an irregular time of year, periods of layoff are not considered "extended gaps." Id.

The Referee found that applying the rule would result in a wage rate that would not approximate claimant's actual loss of income. We rejected similar reasoning in Turpin, supra. There, the referee found that in order to fairly compensate the claimant, her benefits should be calculated to approximate her historical earnings, by applying the exception to the rule, although there had been no extended gaps in claimant's employment. We disagreed, stating that since the claimant's layoffs were not "extended," the rule required that her temporary disability rate be computed using the entire 26-week period preceding her claim.

In Delfel, supra, we found that the breaks in the claimant's employment, including a seven week layoff, did not constitute "extended gaps" because the breaks were within the reasonable expectations of the claimant and the employer and because the employment relationship between the claimant and the employer did not change as a result of the break.

Here, claimant's employment relationship with the employer did not change during the gap in employment. While he was in lay-off status, claimant's employer continued to provide medical and other benefits and to maintain claimant's apartment. Long lay-offs at the end of the farming season were expected. Except for one year, claimant has not worked for the employer during the winter months. The employer had no specified time in which claimant was to return to work in the Spring. In 1992, claimant chose to delay his return to work until late March. In light of the above, we conclude that the rate of temporary disability should be based on claimant's average weekly earnings for the previous 26 weeks before the date of injury.

ORDER

The Referee's order dated April 4, 1994 is reversed in part and affirmed in part. In lieu of the temporary total disability (TTD) rate found by the Referee, claimant's TTD rate shall be based on his average weekly earnings for the 26 weeks prior to the date of injury. Claimant's attorney's "out-of-compensation" fee is reversed. The remainder of the order is affirmed.

March 16, 1995 Cite as 47 Van Natta 432 (1995)

In the Matter of the Compensation of
NORA M. DARNER, Claimant
WCB Case No. 94-03265
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Mongrain's order that affirmed an Order on Reconsideration that awarded, bilaterally, 9 percent (17.28 degrees) scheduled permanent disability for loss of use or function of the right and left arms. On review, the issue is extent of scheduled permanent disability.

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

In reaching our conclusion, we do not consider the "post-reconsideration order" medical report of Dr. Davies, a non-attending psychologist. In Daniel L. Bourgo, 46 Van Natta 2505 (1994), we concluded that a "post-reconsideration order" supplemental medical arbiter report was inadmissible under ORS 656.268(7), as such a report constituted "subsequent medical evidence of the worker's impairment" which is prohibited by the statute. In Bourgo, we reasoned that such an interpretation of the statute was consistent with the legislature's intent to avoid "dueling doctors" and a litigious reconsideration process. Applying that rationale in the present case, therefore, we find that a medical arbiter was appointed, and therefore, Dr. Davies' post-reconsideration order report consisting of subsequent medical evidence of claimant's impairment, is inadmissible. ORS 656.268(7); Bourgo, supra.

ORDER

The Referee's order dated August 15, 1994 is affirmed.

In the Matter of the Compensation of
CHRISTOPHER J. KAUFMAN, Claimant
WCB Case No. 94-03382
ORDER ON REVIEW (REMANDING)
Floyd H. Shebley, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Bethlahmy's order that: (1) found that claimant's "new injury" claim for a low back condition was barred by a Claim Disposition Agreement (CDA) regarding a prior accepted low back claim; and (2) dismissed claimant's request for hearing. On review, the issue is whether the CDA barred claimant's new injury claim. We vacate the Referee's order and remand.

FINDINGS OF FACT

Claimant was compensably injured on April 3, 1992, when he strained his mid and low back in an automobile accident. His claim, numbered 3W-L4-0699, with an injury date of April 3, 1992, was accepted as disabling on May 6, 1992. A July 1992 Notice of Closure closed the claim with an award of temporary disability, but no permanent disability.

On August 12, 1992, claimant lifted a water cooler at work and experienced back pain. Thereafter, claimant was treated by Dr. Long and Nurse Practitioner Kathleen Hobbs.

On August 27, 1992, claimant was treated by Dr. Hickman, M.D. Dr. Hickman diagnosed a low back strain and found that claimant was medically stationary from the August 12, 1992 injury. Claimant continued to receive physical therapy for his low back condition.

On December 22, 1992, claimant signed a CDA in which claimant released his rights to permanent disability, vocational rehabilitation, survivor benefits, and all other rights (with the exception of medical services) under his April 3, 1992 injury claim. The CDA provided that the claim number was 3W-L4-0699, with an injury date of April 3, 1992. The total consideration for the CDA was $5,000, and the accepted conditions were listed as "mid and low back strain." The CDA was approved by the Board on February 1, 1993.

On January 28, 1993, the insurer sent claimant notice that his aggravation claim was being accepted. The following day, the insurer prepared a Form 1502, notifying the Workers' Compensation Division that claimant's aggravation claim had been accepted.

On November 17, 1993, claimant was seen by Dr. Long. Dr. Long reported that claimant had increased symptoms and diminished physical capacities, which would make it difficult for claimant to obtain employment. Dr. Long recommended that claimant resume formal treatment, and stated that claimant's claim would need to be reopened.

The insurer refused to reopen or process claimant's aggravation or "new injury" claim for the August 12, 1992 work incident. On March 16, 1994, claimant filed a request for hearing from the insurer's "de facto" denial of his August 12, 1992 injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant could not relitigate entitlement to additional benefits by characterizing the August 1992 injury as a new injury, rather than an aggravation claim. The Referee relied on Safeway Stores Inc. v. Seney, 124 Or App 450 (1993), and concluded that claimant's claim was barred by the prior CDA. As a result of this conclusion, the Referee dismissed claimant's request for hearing. We disagree.

Subsequent to the Referee's order, we issued our decision in Jeffrey B. Trevitts, 46 Van Natta 1767 (1994). In Trevitts, the claimant was attempting to obtain nonmedical benefits for a condition that arose from the underlying accepted condition. Persuaded that the CDA provided for a full release of benefits under the accepted injury, we concluded that all of the claimant's nonmedical service rights related to the entire claim had been settled by the CDA. Jeffrey B. Trevitts, supra.

We find Trevitts to be distinguishable from the present case. In Trevitts, we determined the effect of a CDA on a claimant's rights to "non-medical services" benefits resulting from a condition which had not been expressly listed as an accepted condition under the CDA. In determining that the claimant had released his rights to such benefits, we reasoned that, had the parties intended that the claimant retain such rights, the CDA would have specifically provided that the claimant's release of rights and benefits was partial. Noting that the CDA contained no such exclusionary language, we further concluded that other sections of the disposition indicated that no such exclusion was intended. Specifically, we highlighted the following sections of the CDA: (1) the first or "summary" page listed the disposition as a "full release" of all temporary and permanent disability benefits, as well as vocational assistance; (2) a provision in which the claimant released "all other benefits except for medical services"; and (3) an express provision that "claimant retains his right to medical services for the compensable injury."

In reaching our conclusion in Trevitts, we emphasized that we are not holding that parties may never dispose of only one condition (and its benefits) in a CDA if they so desire. However, in order to do so, we declared that the CDA should clearly state the parties' intent to effect a partial release of the claim and benefits, including a provision clearly stating the intent to preserve and retain "non-medical service" benefits. Jeffrey B. Trevitts, supra.

Claimant in the present case, however, has brought a claim for a new injury, i.e., an injury which is contended to be separate and distinct from his April 1992 accepted injury claim. Accordingly, unlike the facts in Trevitts, this case involves a new injury claim which has never been accepted and, therefore, could not have been the subject of a CDA. See ORS 656.236; OAR 436-60-005(9); Randi E. Morris, 43 Van Natta 2265 (1991) (Purpose of a CDA is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA). Thus, even if a "new injury" claim was in existence at the time the CDA was drafted, executed, and approved, the CDA could not pertain to that claim.

Similarly, the CDA could not settle any compensability dispute concerning an "aggravation" claim. However, the CDA could, and did, resolve claimant's rights to nonmedical benefits under any current or future aggravation claims. In other words, claimant's rights to benefits resulting from any "aggravation" claim under the April 1992 claim would be limited to medical services.

Additionally, we find this case to be distinguishable from Seney. In Seney, the court reversed a Board order which had held that the claimant's "new injury" claim for a shoulder condition was not precluded by a prior stipulation concerning the claimant's appeal from a Determination Order. At the time of the stipulation, the claimant's doctor had diagnosed a temporary aggravation of the claimant's right shoulder injury. Based on that diagnosis, the claimant's counsel had requested temporary disability benefits, and the carrier had provided notice that the claimant's aggravation rights had expired and it was opposed to reopening the claim. The stipulation entered into by the parties provided that all issues which were raised or could have been raised on or before the date of approval were resolved. Safeway Stores, Inc. v. Seney, supra.

Following approval of the stipulation, the claimant's doctor concluded that the claimant's condition was, in fact, a new injury, and the Board concluded that the stipulation did not bar the claim. The court disagreed, reasoning that, regardless of whether the claimant's condition was characterized as an aggravation or a new injury, the condition and compensability of a potential claim were at issue during the negotiations and before approval of the stipulation. Consequently, the court held that the claimant could not escape his bargain by recharacterizing his claim after the fact. Safeway Stores, Inc. v. Seney, supra.

For the following reasons, we find this case to be distinguishable from Seney. First, Seney involved the effect of a stipulation which purported to resolve the parties' pending disputes (including compensability of a new injury claim). Here, in contrast, the CDA did not, and could not, resolve compensability disputes. See e.g., Debbie K. Ziebert, 44 Van Natta 51 (1992); Debra L. Smith-Finucane, 43 Van Natta 2634 (1991). Furthermore, the settlement in Seney had a provision that resolved all issues "raised or raisable." The CDA in this case contained no such provision.

Under the circumstances, we conclude that, because claimant's claim involves a new injury, it is not barred from litigation by the prior CDA. Consequently, claimant is entitled to a hearing on the issue of a "de facto" denial of his new injury claim. We further note that, although claimant released his "aggravation" benefits in the prior CDA, he did not (and could not) release his rights to medical services for the accepted claim. ORS 656.236(1); Donald Rhuman, 45 Van Natta 1493 (1993)(CDA disposes of an accepted claim, with the exception of medical services). Therefore, the resolution of this matter may arguably involve claimant's right to benefits under his prior accepted claim (which are now limited to medical services as a result of the CDA) versus his right to benefits under a "new" injury claim, which would include all benefits under Chapter 656.

As a result of our conclusion that claimant is entitled to a hearing on his "new injury" claim, and a hearing on his entitlement to medical services under the prior, accepted claim, we conclude that dismissal of claimant's request for hearing was improper. Moreover, since the hearing request was dismissed without a hearing, we find that the record is not adequately developed for purposes of review, and a compelling reason exists for remand. ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 741 (1986). Therefore, we remand this matter to the Referee for further proceedings.

Accordingly, the Referee's order dated July 7, 1994 is vacated. This matter is remanded to Referee Bethlahmy for further proceedings to be conducted in any manner which, in the Referee's discretion, achieves substantial justice. Following these proceedings, the Referee shall issue a final appealable order.

IT IS SO ORDERED.

March 16, 1995 Cite as 47 Van Natta 435 (1995)

In the Matter of the Compensation of
BELINDA V. KINYON-BECK, Claimant
WCB Case No. 94-04048, 94-01359 & 94-02008
ORDER ON RECONSIDERATION
Whitehead & Klosterman, Claimant Attorneys
Raymond Myers (Saif), Defense Attorney
Mitchell, Lang & Smith, Defense Attorneys
Bostwick, et al., Defense Attorneys

The SAIF Corporation requests reconsideration of our February 21, 1995 Order on Review that: (1) affirmed those portions of the Referee's order that upheld Kemper Insurance's (Kemper's) compensability and responsibility denial on behalf of J.M. Smucker Co. of claimant's current bilateral wrist condition, and Tokio Fire & Marine Insurance Company's responsibility denial on behalf of Ushio; and (2) reversed that portion of the Referee's order that upheld the SAIF Corporation's compensability and responsibility denials on behalf of Ushio Oregon Industries (Ushio).

In its request for reconsideration, SAIF refers us to that portion of our order that states, "That portion of the Referee's order upholding the SAIF Corporation's denials is reversed." (Order on Review at 7). SAIF asserts that portion of our order does not follow from our finding that claimant's current wrist condition is overuse/tendonitis, not carpal tunnel syndrome (CTS), which condition had been accepted earlier by Kemper. SAIF asserts that, because we specifically found that claimant's current condition is not CTS, but rather, is a new condition, we should have upheld its CTS denial. Kemper has filed a response, agreeing with SAIF's position. Claimant has also filed a response, indicating that she has no objection to SAIF's reconsideration request.

We agree with SAIF's position. For SAIF to be responsible for claimant's accepted CTS, Kemper would be required to establish that, while SAIF was on the risk, claimant sustained a new compensable injury involving the accepted CTS. ORS 656.308; see SAIF v. Yokum, 132 Or App 18, 23 (1994). Our finding that claimant's current condition is other than CTS undercuts that theory.

Accordingly, our February 21, 1995 order is withdrawn. On reconsideration, we modify the following sentences, "That portion of the Referee's order upholding the SAIF Corporation's denials is

reversed. SAIF's denials are set aside and the claim is remanded to SAIF for processing according to law.", to read: "That portion of the Referee's order upholding the SAIF Corporation's denials insofar as they pertained to claimant's current bilateral wrist overuse/tendonitis condition is reversed. The aforementioned portions of SAIF's denials are set aside and the bilateral wrist overuse/tendonitis condition claim is remanded to SAIF for processing according to law.

On reconsideration, as supplemented herein, we republish our February 21, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 16, 1995 Cite as 47 Van Natta 436 (1995)

In the Matter of the Compensation of
KAREN D. MALONEY, Claimant
WCB Case Nos. 93-07480 & 93-08324
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Hazelett's order that dismissed, for lack of jurisdiction, its cross-request for hearing on an Order on Reconsideration award of scheduled permanent disability benefits. On review, the issue is dismissal.

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

Claimant timely requested reconsideration of two October 21, 1992 Notices of Closure relating to two separate injuries. On July 1, 1993, two separate Orders on Reconsideration were issued regarding these injuries. On July 6, 1993, claimant timely filed a request for hearing regarding those orders. (WCB Case No. 93-07480). On July 15, 1993, the employer filed a request for hearing regarding one of the orders. (WCB Case No. 93-08324). There is no dispute that the employer's request for hearing was untimely.

Earlier, claimant had requested a hearing on an aggravation denial issued by the employer. (WCB Case No. 93-01807). The hearings were consolidated regarding the issues involving the Orders on Reconsideration and the aggravation denial. This consolidated hearing convened on September 20, 1993. (WCB Case Nos. 93-01807, 93-07480, 93-08324). The parties agreed to postpone the hearing contingent upon certain conditions, which were listed in the prior Referee's Stipulation and Order of Postponement. That Stipulation stated, in pertinent part:

> "[a]t the designated time for hearing in this matter, September 20, 1993, claimant moved for postponement in order to join additional issues anticipated. The self-insured employer was agreeable to postponement only if the claimant stipulated that she is not claiming entitlement to, and waives any claim for, temporary disability benefits from November 10, 1992 through a date not earlier than six weeks prior to September 20, 1993 (August 9, 1993). The claimant so stipulates, and, based upon this Stipulation, the referee grants the Motion for Postponement."

On July 22, 1994, claimant withdrew her July 6, 1993 hearing request regarding the two Orders on Reconsideration in its entirety and moved to dismiss the employer's cross-request for hearing as untimely. On July 25, 1994, the postponed hearing was reconvened and the Referee granted claimant's motion. Because there remained no valid request for hearing regarding the Orders on Reconsideration, the Referee concluded that the Hearings Division was without jurisdiction to consider the employer's request to reduce claimant's scheduled permanent disability award. The Referee relied on ORS 656.319(4) and Zigurds Laurins, 46 Van Natta 1238 (1994), in reaching his conclusion. (The parties agreed that WCB Case No. 93-01807 would be consolidated with a recent request for hearing filed by claimant on a separate matter).

On review, the employer argues that Zigurds Laurins, supra, is distinguishable. Specifically, the employer relies on the fact that the hearing had convened and a Stipulation and Order had been entered on another issue to argue that the Referee retained jurisdiction over its request to reduce claimant's permanent disability. We disagree that these facts give the Referee jurisdiction where there remained no valid request for hearing regarding an Order on Reconsideration.

ORS 656.319(4) requires a timely request for hearing on a reconsideration order (within 180 days after a Determination Order or Notice of Closure is mailed) before a hearing can be granted on issues relating to the reconsideration order. A party's timely request for hearing places a permanent disability award at issue, and the referee may affirm, increase or decrease the award, even though the other party has not formally cross-appealed the award. See Pacific Trucking Co. v. Yeager, 64 Or App 28 (1983); Kristy R. Schultz, 46 Van Natta 294, 295 (1994); Judith L. Duncan, 45 Van Natta 1457, 1458 (1993). Thus, claimant's timely request for hearing regarding the Orders on Reconsideration placed permanent disability at issue, even though the employer's request for hearing was untimely.

However, here, as in Laurins, the only party to timely request a hearing in regard to the reconsideration orders withdrew that request in its entirety. After that withdrawal, there remained no timely request for hearing that would vest jurisdiction in the Hearings Division. Therefore, the Referee did not have jurisdiction over any issues regarding the reconsideration orders.

The employer argues that the Referee retained jurisdiction because claimant did not withdraw her requests for hearing on all issues, noting that the issues in WCB Case No. 93-01807 remained. The employer cites James S. Franklin, 43 Van Natta 2323 (1991), and Judith L. Duncan, supra, in support of its position. These cases do not support the employer's argument. There, the claimants (the parties with valid hearing requests) withdrew only part of the issues relating to the Determination Order/Order on Reconsideration. Because the claimants still asserted some issues relating to the Determination Order/Order on Reconsideration, the Board found that this partial withdrawal of issues did not preclude the referees from considering the carriers' challenges to the Determination Order/Order on Reconsideration.

Here, claimant withdrew her entire hearing request relating to the reconsideration orders. It does not matter that other issues remained viable, the determinative fact is that claimant withdrew all issues relating to the reconsideration orders. Therefore, there remained no valid hearing request regarding the reconsideration orders that would vest jurisdiction in the Hearings Division. ORS 656.319(4); Zigurds Laurins, supra.

Finally, the fact that the hearing had previously been convened and postponed or that a Stipulation was entered does not change the result. In this regard, the Stipulation did not address the merits of any issues concerning the reconsideration orders; instead, it addressed only the parties' agreement regarding the postponement. As explained above, once claimant withdrew her hearing request relating to the reconsideration orders in its entirety, there remained no valid hearing request to give the Hearings Division jurisdiction over any issues regarding the reconsideration orders.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, to be paid by the 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 5, 1994 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,200, to be paid by the self-insured employer.

In the Matter of the Compensation of
TIMOTHY D. McCUNE, Claimant
WCB Case No. 93-12124
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

The insurer requests review of Referee Black's order that set aside its denial of claimant's occupational disease claim for bilateral hand and arm overuse condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for the employer from April 1993 through late July 1993. He was an assembly worker, doing a combination of roofing and skirting work. On July 9, 1993, claimant filed a claim for "sore forearms." (Ex. 1). Claimant told the lead person and a supervisor about his pain and the employer made an appointment for him with Dr. Fletchall on July 9, 1993.

Dr. Fletchall diagnosed bilateral carpal tunnel syndrome. (Ex. 2). Claimant was given a wrist brace on the right side and Dr. Fletchall recommended a light duty work assignment. Claimant was referred for nerve conduction studies, which were normal. (Ex. 3). Claimant was discharged by the employer approximately at the end of July for reasons unrelated to the claim.

On August 24, 1993, claimant was examined by Dr. Davis, who diagnosed chronic overload syndrome for the right hand and wrist and referred claimant to occupational therapy. (Ex. 5). Some therapy was undertaken without apparent relief. (Exs. 6B, 13).

The insurer denied claimant's claim on September 17, 1993, because of a lack of objective medical evidence to support his contention that his condition was work-related. (Ex. 8).

CONCLUSIONS OF LAW AND OPINION

The Referee found that this was a "credibility" case and concluded that claimant's work activities were the major contributing cause of his hand and arm overuse condition. On review, the insurer argues that claimant was not a credible witness and that claimant gave an erroneous history to the physicians concerning the onset of his condition.

Although the Referee accepted claimant's testimony, he made no express credibility findings based upon claimant's demeanor. Although we generally defer to the Referee's determination of credibility when that finding is based on the Referee's opportunity to observe claimant's demeanor, 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. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Even minor inconsistencies can be a sufficient basis to disagree with the Referee's credibility determination, particularly where factual inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. David A. Peper, 46 Van Natta 1656 (1994); Angelo L. Radich, 45 Van Natta 45 (1993).

After our review of the record, we find material inconsistencies and unexplained discrepancies that cast doubt on claimant's reliability. Claimant told the physicians that he had a gradual onset of pain after he began working for the employer. (Exs. 2, 5, 7). Claimant testified that he experienced tingling and numbness in his forearms approximately a month and a half before he sought medical attention on July 9, 1993. (Tr. 8). On the other hand, claimant testified that he had an injury at work and "felt bad one day." (Id. at 26, 27). Claimant also said that he had no wrist pain before he reported such pain to his supervisors on July 9, 1993. (Id. at 29).

Although claimant testified that he reported his injury to his supervisor and a lead person during the initial month and a half that he had pain, claimant's supervisor testified that the first he

heard of any problem was on July 9, 1993. (Id. at 42). According to claimant's supervisor, claimant told him that his wrists hurt and that he wanted to see a lawyer. (Id. at 38). Claimant explained that his friend had filed a carpal tunnel claim for $40,000 and got some good money out of it. (Id).

Claimant testified that he returned to the same job after he saw Dr. Fletchall. (Id. at 23). In contrast, claimant's supervisor testified that claimant worked only light duty after July 9, 1993. (Id. at 40).

In light of the material inconsistencies in claimant's testimony, we do not find the substance of claimant's testimony credible. Moreover, we conclude that the remainder of the record does not support the compensability of claimant's condition. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

Claimant relies on the opinion of Dr. Davis to support compensability. Dr. Davis reported that claimant "progressively developed pain and disability in his right hand, and to some degree, in his left." (Ex. 5). In a "check-the-box" letter, Dr. Davis agreed that the major contributing cause of claimant's bilateral upper extremity condition was work activities at the employer. (Ex. 15). In light of claimant's inconsistent testimony concerning the onset of his condition, we are not persuaded that Dr. Davis had an accurate history of the work events which led up to claimant's claim. See Miller v. Granite Construction Co., 28 Or App 473 (1977). Moreover, we find Dr. Davis' opinion to be conclusory in that he failed to explain why claimant's symptoms did not resolve after his job ended. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Dr. Nathan, who examined claimant on behalf of the insurer, reported that the continuation of claimant's discomfort for more than a month after his job ended indicated that the basis of the symptoms was not due to work. (Ex. 7).

In sum, we conclude that claimant has failed to prove that his work activities were the major contributing cause of his bilateral hand and arm overuse condition. Accordingly, claimant has failed to establish a compensable occupational disease claim. See ORS 656.802(2).

ORDER

The Referee's order dated August 11, 1994 is reversed. The insurer's denial is reinstated and upheld. The Referee's assessed attorney fee award is also reversed.

March 16, 1995 Cite as 47 Van Natta 439 (1995)

In the Matter of the Compensation of
KENNY J. MILLER, Claimant
WCB Case No. 93-11730
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Lundeen, et al., Defense Attorneys

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

Claimant requests review of Referee Davis' order that affirmed an Order on Reconsideration awarding claimant 2 percent (6.4 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

Adaptability

We adopt and affirm the Referee's conclusions regarding claimant's adaptability value.

Consideration of Prior Award

The Referee concluded that, although claimant's current disability rating due to his March 1992 low back injury was 15 percent, in view of claimant's prior 20 percent permanent disability award for an earlier injury to his low back, the September 1993 Order on Reconsideration correctly awarded claimant 2 percent unscheduled permanent disability (a March 1993 Determination Order had awarded 6 percent). Claimant argues that the Referee erroneously considered his prior disability award for his low back in evaluating his current disability. We disagree, but nevertheless conclude that claimant is entitled to additional permanent disability compensation.

A worker is not entitled to be doubly compensated for a permanent loss in earning capacity that would have resulted from the current injury, but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, 42 Van Natta 2846 (1990). Under ORS 656.214(5), if a claimant suffers from disability due to preexisting injuries and has received unscheduled permanent disability benefits for such disability, the prior award is considered in arriving at the appropriate permanent disability award for the current injury. Vogelaar, supra; see OAR 436-35-007(3)(b).

This determination requires a two-step process. First, we determine the current extent of disability under the applicable standards. Then, we compare that value with the prior award of unscheduled permanent disability to determine if the current disability rating reflects any preexisting disability for which the claimant has already received benefits. See Philip A. Sterle, 46 Van Natta 506, 510 (1994).

This is not a mathematically precise process. Instead, we consider to what extent a prior loss of earning capacity resulted from the same permanent limitations and vocational factors as that relied on in the current evaluation of permanent disability. Every Mendenhall, 45 Van Natta 567, 570 (1993). We will reduce the award by the amount that represents previously compensated loss of earning capacity. Id.

Here, we agree with the Referee that the Order on Reconsideration correctly determined that the extent of claimant's current unscheduled permanent disability is 15 percent. Prior to the March 1992 injury, claimant was awarded 20 percent unscheduled permanent disability for the low back under an earlier claim. (Exs. 10, 16). After taking into account whether and to what extent the prior unscheduled permanent disability award resulted from the same impairment and social/vocational factors, we find that a portion of claimant's current disability as related to his low back condition was not considered and compensated by the previous 20 percent award.

The prior award was based, in part, on a finding that claimant returned to his regular work as a truck driver, which required medium strength. (See Ex. 16-2). Currently, claimant is capable of medium/light work only. (Exs. 30-3, 31-3).

Because of his medium/light work restriction, claimant is no longer able to load and unload his own trucks; rather, he must pay approximately $100 per week for other persons to perform those services. (See Exs. 28E, 29A, Tr. 18, 25). In view of that evidence, we conclude that 6 percent of claimant's unscheduled permanent disability was not present prior to claimant's most recent low back injury. Therefore, we conclude that claimant is entitled to an award of 6 percent unscheduled permanent disability due to the March 1992 injury.

Because our order results in increased compensation, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation (4 percent unscheduled permanent disability) created by this order. ORS 656.386(2); OAR 438-15-055(1). In the event that this substantively increased permanent disability award has already been paid to claimant pursuant to the March 1993 Determination Order (that had awarded 6 percent), claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994).

ORDER

The Referee's order dated April 28, 1994 is modified. In addition to the Order on Reconsideration award of 2 percent (6.4 degrees), claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability for a total unscheduled permanent disability award of 6 percent (19.2 degrees). Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event the unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk, supra.

Board Member Hall dissenting.

The majority finds that claimant currently has 15 percent unscheduled permanent disability, but concludes that all but 6 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 1992 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, the record shows that claimant fully recovered from the disabling effects of the 1986 injury and was performing his regular job when he was injured in 1992. Thus, all of claimant's current permanent partial disability resulted from the 1992 compensable injury. Under the express terms of ORS 656.214(5), therefore, claimant is entitled to receive, without any offset, the full 15 percent unscheduled permanent disability award for the 1992 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 1992 injury, the majority is penalizing him for recovering from his 1986 injury and returning to his regular job. I believe this result is harsh and inconsistent with the objectives of the Workers' Compensation Law. Therefore, I dissent.

In the Matter of the Compensation of
MICHELE S. THOMAS-FINNEY, Claimant
WCB Case No. 93-13163
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al., Claimant Attorneys
Moscato, Byerly, et al., Defense Attorneys

The self-insured employer requested abatement and reconsideration of our February 1, 1995 Order on Review. On March 2, 1995, we abated our order to allow claimant an opportunity to respond. Having received that response, we proceed with our reconsideration.

Our original order found claimant medically stationary on August 19, 1993 and entitled to substantive temporary disability benefits through August 19, 1993; we also denied the employer's request to offset any portion of temporary disability benefits it paid between November 6, 1992 and September 3, 1993. Finally, we affirmed the Referee's increased award of scheduled permanent disability. In its request, the employer asserts that, inasmuch as we found claimant medically stationary and entitled to temporary disability through August 19, 1993, we improperly denied its request to offset temporary disability benefits it paid from August 20, 1993 to September 3, 1993. The employer asks that we modify our order to allow the offset "against permanent disability and/or additional temporary partial disability benefits resulting from the order."

Claimant objects to the request on the basis that the employer already paid claimant's increased permanent disability award. According to claimant, the employer is not entitled to an offset "since there is nothing to recover it from."

We first agree with the employer that, because we found claimant medically stationary and substantively entitled to temporary disability through August 19, 1993, the employer's payment of temporary disability after that date constitutes an overpayment. Therefore, the employer is entitled to an offset.

We have authority to offset overpayments of temporary disability. See ORS 656.268(13). However, for policy reasons, we have restricted this authority to offsetting such overpayments against permanent disability awards and not temporary disability. E.g., Steven E. Maywood, 44 Van Natta 1199 (1992), aff'd mem 119 Or App 511 (1993). Thus, we deny the employer's request to offset the overpayment against the increased temporary disability awarded by our initial order. However, an offset is granted against the increased permanent disability awarded by the Referee and affirmed on review. If, as alleged by claimant, this award already has been paid, the employer may offset the overpayment against any future permanent disability award.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our February 1, 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
WILLIAM V. WARREN, Claimant
WCB Case No. 94-04434
ORDER ON REVIEW
John C. Moore & Associates, Claimant Attorneys
Montgomery W. Cobb, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Neal's order that dismissed his request for hearing for lack of jurisdiction. On review, the issues are jurisdiction, medical services, penalties and attorney fees.

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

Claimant expressly withdrew the issue of a "de facto" denial of medical services. (Tr. 10-11). Accordingly, the only issue before the Referee was claimant's entitlement to penalties and attorney fees under ORS 656.262(10)(a) and ORS 656.382(1). See generally, Francis A. Sims III, 46 Van Natta 1594, 1596 (1994).

When an insurer's misconduct is such that a penalty may be assessed under ORS 656.262(10)(a), no attorney fees are available under ORS 656.382(1). See Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992). Furthermore, the Director has exclusive jurisdiction when the only issue in dispute is entitlement to penalties under ORS 656.262(10)(a). Corona v. Pacific Resource Recycling, 125 Or App 47 (1993).

Here, the only misconduct at issue was the insurer's allegedly unreasonable delay in processing claimant's request for surgery. Consequently, the only remedy available to claimant was a penalty under ORS 656.262(10)(a) (i.e., "in lieu of" an assessed attorney fee award). Martinez v. Dallas Nursing Home, supra. The Director has sole jurisdiction where the only issue in dispute is entitlement to this sort of penalty. Corona v. Pacific Resource Recycling, supra. Accordingly, we agree with the Referee's finding that she lacked concurrent jurisdiction to decide this matter.

ORDER

The Referee's order dated August 12, 1994 is affirmed.

In the Matter of the Compensation of
CALVIN L. WILLIAMS, Claimant
WCB Case No. 91-16987
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Podnar's order which increased claimant's unscheduled permanent disability for a low back injury from 27 percent (86.4 degrees), as awarded by a November 1992 Order on Reconsideration, to 51 percent (163.2 degrees). In his brief, claimant requests that his award of unscheduled permanent disability be increased to 57 percent. On review, the sole 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

Claimant compensably injured his low back on September 11, 1989. A May 7, 1991 Notice of Closure closed the claim with an award of 29 percent unscheduled permanent disability. Claimant requested reconsideration. Prior to reconsideration, the claim was reopened for surgery. On November 18, 1991, an Order on Reconsideration was issued which reduced claimant's unscheduled award to 27 percent. Claimant appealed this reconsideration order, but the hearing was postponed pending claim closure.

On June 5, 1992, a Notice of Closure was issued which awarded no additional permanent disability. Claimant requested reconsideration, which resulted in a December 17, 1992 medical arbiter's examination performed by Dr. Watson. Another reconsideration order was issued on January 13, 1993, which did not award any additional permanent disability on the grounds that claimant's condition had not worsened since the last arrangement of compensation in 1991. Claimant's appeal of that reconsideration order was consolidated for hearing with his appeal of the earlier reconsideration order.

Reasoning that claimant was not required to demonstrate a permanent worsening of his low back condition since the first claim closure in 1991, the Referee rated claimant's disability as of the June 1992 closure. Considering the findings of the December 1992 medical arbiter's examination, the Referee determined claimant's unscheduled permanent disability to be 51 percent.

On review, the employer contends that the Referee erred in redetermining claimant's unscheduled permanent disability because claimant failed to prove a permanent worsening of his low back condition since the first Notice of Closure in 1991. See Stepp v. SAIF, 304 Or 375 (1987). The employer asserts that claimant's permanent disability should be rated at the time of the first closure and that the November 18, 1991 Order on Reconsideration correctly evaluated claimant's unscheduled permanent disability. We disagree with the employer's contentions.

Claimant initially requested a hearing regarding the November 18, 1991 Order on Reconsideration, but the hearing was postponed pending closure of claimant's compensable aggravation claim. The claim was reclosed by Notice of Closure in June 1992, which was affirmed by the January 1993 reconsideration order. Claimant's hearing request on that Order on Reconsideration was consolidated with the earlier hearing request. Inasmuch as neither the May 1991 Notice of Closure nor the November 1991 Order on Reconsideration was a final award or arrangement of compensation, claimant is not required to prove a permanent worsening of his low back condition since the 1991 claim closure. See Every Mendenhall, 45 Van Natta 567, 569 (1993); Susannah Rateau, 43 Van Natta 135, 136 (1991).

In Mendenhall, the claimant initially requested a hearing on a July 13, 1989 Determination Order. However, the claim was reopened prior to hearing and subsequently reclosed by a May 17, 1991 Determination Order. The Determination Order was affirmed by a September 4, 1991 Order on

Reconsideration. Claimant's hearing request on the reconsideration order was consolidated with the earlier hearing request concerning the July 1989 Determination Order. In that case, we applied the standards in effect at the time of the May 1991 Determination Order, citing Wade A. Webster, 42 Van Natta 1707 (1990). In addition, we did not require a comparison of claimant's condition at the time of the May 1991 closure with claimant's condition at the time of the first closure in July 1989 in order to determine whether a permanent worsening had occurred. Every Mendenhall, supra, at 569. We cited Susannah Rateau, supra, as authority.

Rateau was another case in which a Determination order was appealed, but the claim was reopened prior to hearing. Following reclosure of the claim by a subsequent Determination Order and another timely hearing request, the hearing requests were consolidated for hearing. We reasoned that, because the first Determination Order was not a final award or arrangement of compensation, a determination of whether claimant's condition had permanently worsened was premature. Susannah Rateau, supra, at 135.

We recently cited Mendenhall and Rateau in Keith W. Miles, 46 Van Natta 1524, 1526 (1994). There, the claimant appealed Determination Orders issued in May 1990 and July 1992. We held that, when two Determination Orders are consolidated for hearing, the standards in effect on the date of the latest claim closure are applied. Although Miles did not involve the issue of a permanent worsening after closure of an aggravation claim, it does provide support for the Referee's decision to rate claimant's permanent disability at the time of the June 1992 claim closure.

In light of the above cases, we conclude that claimant is not required to prove a permanent worsening as a result of the compensable October 1991 aggravation claim in order to have his permanent disability redetermined at the time of the June 1992 closure. Therefore, the Referee correctly applied the standards in effect on the date of the June 1992 closure. Wade A. Webster, supra. Claimant's permanent disability should be rated as of the time of the January 1993 Order on Reconsideration. ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

Stepp v. SAIF, supra, does not require a different result. There, the claimant received an award of unscheduled permanent disability via a final stipulated order. The claimant subsequently filed an aggravation claim that a referee ordered accepted. The claimant contended after the claim was closed that he was entitled to additional permanent disability. The referee awarded claimant permanent total disability.

We reversed the Referee's award of permanent total disability, reasoning that, although the claimant suffered an aggravation, the worsening was only temporary and claimant had returned to his pre-aggravation status. Thus, the claimant was not entitled to an additional award of permanent disability. Johnnie Stepp, 36 Van Natta 1721, 1724 (1984). The Court of Appeals affirmed our decision. Stepp v. SAIF, 78 Or App 438 (1986). In doing so, the court commented:

> "Claimant appears to argue, however, that, once he proves a temporary worsening, he is entitled to a redetermination of the extent of his permanent disability, even though his compensable condition has not permanently worsened. He cites no authority for that proposition, and we have found none. The effect of that argument would allow him to relitigate the April, 1979, stipulated order for permanent partial disability. That is not permissible. The stipulated order is conclusive as to the extent of the disability on that date. Waldroup v. J.C. Penney Co., 30 Or App 443, 448, 567 P2d 576 (1977). That determination cannot be relitigated in an aggravation claim. Deaton v. SAIF, 33 Or App 261, 263, 576 P2d 35 (1978). Without a permanent worsening of the compensable condition, there is no justification for redetermining the extent of permanent disability." 78 Or App at 441-42 (footnotes omitted)

The Supreme Court affirmed the Board and the Court of Appeals. Stepp v. SAIF, supra. It agreed that the claimant was attempting to relitigate extent of permanent disability without proving a permanently worsened condition. Id. at 381.

The lesson from Stepp is clear. A claimant cannot relitigate extent of disability in the guise of an aggravation claim when there has been no permanent worsening of the claimant's condition.

However, in Stepp, there was a final determination of permanent disability prior to the aggravation claim; whereas in this case, claimant has never received a "final" award of permanent disability. Claimant is not relitigating permanent disability in the guise of an aggravation claim when there has been no final determination of his permanent disability. Thus, we conclude that the Stepp rationale is not applicable to the facts of this claim. Because of this, we further conclude that claimant was not required to prove a permanent worsening as a result of his October 1991 aggravation claim.[1]

Claimant contends that he is entitled to an increase in permanent disability. We agree with the Referee's calculation of claimant's unscheduled permanent disability with the exception of the skills value.[2] As claimant notes, the Referee incorrectly assigned a skills value of 2 for his time-of-injury employment of tractor mechanic helper (DOT 620-684.030), which has an SVP of 4. The skills value should be 3. See OAR 436-35-300(4)(e). Thus, claimant's age and education total is 4, instead of 3 as found by the Referee. When the age/education total (4) is multiplied by the adaptability value of 6, the product is 24. When this product is added to claimant's impairment value of 33, the result is 57 percent. We modify the Referee's award accordingly.

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 regarding the extent of unscheduled permanent disability issue is $1,000, to be paid by the employer. 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 issues and the value of the interest involved.

Finally, because we have increased the unscheduled award made by the Referee, our order results in increased compensation. Therefore, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, provided that the total "out-of-compensation" attorney fee awarded by the Referee's order and this order does not exceed $3,800. ORS 656.386(2); OAR 438-15-055(1)

ORDER

The Referee's order dated February 17, 1994 is modified. In addition to the Referee's and Order on Reconsideration's awards of 51 percent (163.2 degrees) unscheduled permanent disability, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, giving him a total of 57 percent (182.4 degrees) unscheduled permanent disability. Claimant's attorney is awarded an out-of-compensation attorney fee in the amount of 25 percent of the increased unscheduled permanent disability created by this order, provided that the total of fees approved by the Referee and this order shall not exceed $3,800. In addition, claimant's attorney is awarded an assessed fee of $1,000 for services on Board review, to be paid by the employer.

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[1] OAR 436-35-005(9) defines a condition as permanently worsened if it is established by a preponderance of medical evidence concerning the worker's current injury-caused health condition compared to the worker's condition as it existed at the "time of the last arrangement of compensation." Although this rule does not refer to a "final" arrangement of compensation, consistent with Stepp, we interpret the rule as requiring a "final" award or arrangement of compensation.

[2] The employer contends that the medical arbiter's findings of reduced range of motion on which the Referee relied are invalid. The employer asserts that there is no indication that the arbiter performed his measurements properly and that claimant's range of motion was so substantially reduced that the measurements could not possibly be accurate. We disagree with the employer's contentions. The medical arbiter gave no indication that his findings were unreliable, nor are we willing to assume, as the employer would have us do, that the medical arbiter did not perform his examination in accordance with the Department's regulations. See Michael D. Walker, 46 Van Natta 1914, 1915 (1994).

In the Matter of the Compensation of
RICHARD L. WHEELER, Claimant
WCB Case No. 94-03725
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Hazelett's order that set aside that portion of the employer's denial that denied reimbursement of chiropractic services for claimant's compensable 1989 low back injury. In his brief, claimant challenges those portions of the Referee's order that: (1) declined to assess a penalty for an allegedly unreasonable denial; and (2) "affirmed" the employer's denial of claimant's aggravation claim for a low back condition. On review, the issues are medical services, aggravation and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a chiropractor, suffered a compensable low back injury in 1989 while working for the employer. On August 10, 1989, Dr. Stock released claimant to regular work. Dr. Stock reported that claimant's paraspinous muscle spasm and sacral contusion had resolved. (Ex. 9). In October 1989, the claim was closed without an award of permanent disability.

In June 1990, claimant felt the sudden onset of low back pain and left leg pain and tingling while moving household furniture. Claimant sought medical services at an emergency room. Dr. Marks prescribed pain medication and recommended follow-up with an orthopedic surgeon.

In October 1992, claimant moved his family to Everett, Washington. The move required three trips with a moving van. Claimant suffered a recurrence of low back pain. (Tr. 17).

In October 1993, claimant began receiving chiropractic treatments from his brother, Dr. Steven Wheeler. On November 19, 1993, Dr. Steven Wheeler wrote to the employer to request a reopening of claimant's claim. On February 24, 1994, the employer denied compensability of claimant's "aggravation claim and any treatment and/or disability in connection with [his] current condition." (Ex. 20).

At hearing, claimant withdrew his request for reopening of the claim pursuant to ORS 656.273. Claimant sought only an award of medical services pursuant to ORS 656.245. The Referee concluded that claimant was entitled to medical services for his low back condition.

Medical treatment for a compensable condition under ORS 656.245(1) is compensable if the treatment bears a material relationship to the compensable injury. Beck v. James River Corp., 124 Or App 484 (1993). The employer argues that claimant failed to meet his burden of proof because the medical evidence supporting compensability comes from claimant and his family members.

Claimant asserts that between claim closure in October 1989 and October 1993, he was treated numerous times by Dr. Steven Wheeler, his brother, Dr. Karolyn Wheeler, his mother, and Drs. Muhr and Dahlstrom, who are claimant's business associates. No bills exist for these services because claimant received those treatments as "professional courtesy." Claimant asserts that he was professionally capable of monitoring his own condition and he contends that his testimony as an expert witness is persuasive.

The Referee was not inclined to grant claimant's testimony any extra weight based on demeanor in light of claimant's apparent failure to provide a complete history of his ongoing problems. (O & O p. 3). Claimant testified that the major contributing cause of his need for treatment was the compensable injury. (Tr. 9). Claimant testified that after the June 1990 mattress incident when he sought emergency medical treatment, he had moderate left sacral pain, dull, achy, sharp into the buttocks pain. (Tr. 14-15). He said that he was not having any symptoms prior to lifting the mattress. (Tr. 15).

Claimant's testimony on the mattress incident was not consistent. Claimant later testified that "moving of the mattress was just another in a long list of daily activities that bothered my low back and caused pain ever since I fell in 1989." (Tr. 26). When claimant was asked if there was a new injury, he responded: "No, I didn't hurt myself moving the mattress. It was the same pain I had the day before and the day before that, although moving the mattress increased the discomfort that day." (Tr. 26). We find that claimant did not adequately explain why the June 1990 incident was not significant, particularly since he sought emergency treatment. In light of claimant's inconsistent opinions and his financial interest in the claim, we do not find his opinion persuasive.

In addition to claimant's opinion, there are six medical opinions on the issue of causation. Dr. Steven Wheeler requested reopening in November 1993 and reported that since claimant's claim closed, he had not been without left low back pain. (Ex. 17). He opined that claimant's symptoms were related to the compensable injury. Dr. Steven Wheeler subsequently reported that "[s]ince [claimant] never had a low back problem before this [compensable] injury, the entire cause/responsibility for the damage to this lumbosacral spine falls onto this 06-26-89 accident." (Ex. 26).

Dr. Duncan, a chiropractor, disagreed with Dr. Steven Wheeler. Dr. Duncan reported that the fact that claimant had made good progress with return to full work duties and was declared medically stationary in October 1989 mitigated against a significant spinal injury resulting in permanent impairment. (Ex. 28). Dr. Duncan believed that the mattress lifting incident in June 1990 and the move in October 1992 were new lumbosacral strain injuries which were separate and distinct from the compensable injury. (Id). Therefore, Dr. Duncan did not agree that claimant's current complaints were causally related to his compensable injury.

Claimant was examined by Dr. Brooks, orthopedic surgeon, and Dr. Calkin, chiropractor, on behalf of the employer. They concluded that heavy physical activities involved in claimant's move in October 1992 resulted in a lumbar strain/sprain, with symptomatic exacerbation that prompted him to seek chiropractic treatment from his brother. (Ex. 19). Drs. Brooks and Calkin concluded that they did not have objective evidence to indicate that the treatment rendered by claimant's brother was related to the industrial injury. In a "check-the-box" letter, Dr. Steven Wheeler disagreed with the report from Drs. Brooks and Calkin. (Ex. 22).

Dr. Muhr reported that he had treated claimant on three occasions in January 1990 for low back pain. Dr. Muhr stated that he treated claimant for continuing problems he had as a result of his compensable injury. (Ex. 22A). Dr. Karolyn Wheeler, claimant's mother, reported that she had treated her son for low back pain on several occasions and she said that he had only had low back pain since his compensable injury. (Ex. 23). Because both opinions are conclusory regarding causation and do not discuss any intervening events, we do not find the opinions of Dr. Muhr or Dr. Karolyn Wheeler persuasive.

In light of the intervening mattress lifting incident in June 1990 and the move in October 1992, we are persuaded by the opinion of Dr. Duncan that claimant's medical treatment is not materially related to his compensable injury. Our conclusion is supported by the reports from Drs. Brooks and Calkin and Dr. Stock's August 1989 report that claimant's paraspinous muscle spasm and sacral contusion had resolved. None of the remaining medical opinions satisfactorily explain why claimant's medical treatment is related to the compensable injury rather than the intervening events. Moreover, those opinions were rendered by claimant himself or by persons having familial or business relationships with claimant, further reducing their persuasiveness. See Mike Sepull, 42 Van Natta 470 (1990) (physician's opinion not persuasive because he had a significant financial interest in the claim). Consequently, we conclude that claimant has not established that his medical services are compensable.

Although claimant did not cross-request review, he argues that the Referee erred in affirming "the remaining portions of the denial." At hearing, claimant said that he was not seeking reopening of the claim; the only issue was medical services. Claimant asserts that the formal denial had become moot and there were no "remaining portions" to be affirmed. We disagree.

If no "claim" for compensation has been made, the issuance of a denial is premature and the Board will set aside a denial issued on that ground as prospective. See Dorothy Jackson-Duncan, 42 Van Natta 1122 (1990). Claimant can establish that the employer's denial was premature if he can show that no claim for aggravation was made. See William H. Waugh, 45 Van Natta 919 (1993).

Here, the record does not support a finding that the employer's denial of claimant's aggravation claim was premature. On November 19, 1993, Dr. Steven Wheeler requested reopening of claimant's low back claim. On February 24, 1994, the employer denied compensability of claimant's "aggravation claim and any treatment and/or disability in connection with [his] current condition." Notwithstanding claimant's attempt to withdraw the aggravation claim at hearing, the report from Dr. Wheeler constituted a claim, which the employer had a legal duty to accept or deny. See William H. Waugh, supra; Michael D. Holt, 44 Van Natta 962 (1992). Claimant requested a hearing on the denial. Under these circumstances, we conclude that the Referee correctly upheld the remaining portions of the denial.

In light of our disposition, we do not address claimant's argument that the employer's denial was unreasonable.

ORDER

The Referee's order dated July 13, 1994 is reversed in part and affirmed in part. That portion finding medical services compensable is reversed. The Referee's attorney fee award is reversed. The self-insured employer's denial of compensation for medical services is reinstated and upheld. The remainder of the order is affirmed.

March 20, 1995 Cite as 47 Van Natta 449 (1995)

In the Matter of the Compensation of
JOSE L. DURAN, Claimant
WCB Case No. 92-10452
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Garaventa's order that upheld the insurer's partial denial of claimant's injury claim for an inner ear condition. In his brief, claimant contends that the Referee erred in declining to admit as rebuttal evidence a post-hearing report from claimant's physician. In its respondent's brief, the insurer moves to strike those portions of claimant's brief that refer to evidence not in the record. On review, the issues are the Referee's evidentiary ruling, motion to strike, and compensability.

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

Finding that claimant had waived any right to present rebuttal evidence, the Referee declined to admit a post-hearing report from Dr. Black as rebuttal evidence. Claimant contends that the Referee should have afforded him the opportunity to present final rebuttal evidence under OAR 438-06-091(3).

We need not address the evidentiary argument because, even if it is well-taken, the proffered report would not effect the outcome of this case. That is, we would still find, for the reasons stated in the Referee's order, that the medical evidence fails to satisfy claimant's burden of proof. Therefore, we need not consider whether the Referee erred by excluding the post-hearing report. See Larry D. Poor, 46 Van Natta 2451 (1994).

Our resolution of the evidentiary and compensability issues renders the insurer's motion to strike moot.

ORDER

The Referee's orders dated July 25, 1994 and July 27, 1994 are affirmed.

Board Member Hall specially concurring.

I agree that consideration of the proposed exhibit would not affect the outcome of this case. I write separately, however, to express my opinion that the proffered evidence should have been admitted.

As the party bearing the burden of proof, claimant has the right of last presentation of evidence, including rebuttal evidence. See OAR 438-07-023; Robert D. Sloan, 46 Van Natta 87 (1994). OAR 438-06-091(3) provides, in relevant part, that a referee may continue a hearing for further proceedings "[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." "Rebuttal evidence" is defined to include evidence "which tends to explain or contradict or disprove evidence offered by the adverse party." Black's Law Dictionary 658 (Abr. 5th ed. 1983).

Here, Dr. Mangham's post-hearing deposition testimony addressed new issues beyond that offered at hearing. Dr. Black's report addressed those same issues, sometimes directly responding to statements made in Dr. Mangham's deposition. Therefore, given claimant's right of rebuttal, the post-hearing report from Dr. Black should have been admitted.

However, because I agree with the Referee's conclusion on the compensability issue, I join in affirming the Referee's decision to uphold the insurer's partial denial.

March 20, 1995 Cite as 47 Van Natta 450 (1995)

In the Matter of the Compensation of
JULIAN SALAZAR, Claimant
WCB Case Nos. 94-09394 & 94-07018
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reveiwed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Referee Menashe's order that awarded claimant's counsel an assessed attorney fee under ORS 656.382(2) in WCB case number 94-09394, when SAIF withdrew its hearing request. 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 was compensably injured in February 1994. A March 1994 Notice of Closure closed the claim. On July 1, 1994, the Apellate Unit issued an Order on Reconsideration that rescinded the Notice of Closure and ordered that the claim remain in open status. SAIF requested a hearing.

One week before the hearing was scheduled to commence, SAIF advised claimant's counsel that it was no longer disputing that the claim was prematurely closed. At hearing, SAIF withdrew its hearing request in WCB Case Number 94-09394, and asked that the case be dismissed. The Referee dismissed SAIF's hearing request and awarded an assessed fee to claimant's counsel.

On review, SAIF asserts that, inasmuch as there was no decision on the merits in WCB case number 94-09394, claimant is not entitled to an assessed attorney fee under ORS 656.382(2). We agree.

The relevant portion of ORS 656.382(2) provides for an attorney fee award if an insurer requests a hearing and a referee subsequently "finds the compensation awarded to a claimant should not be disallowed or reduced."

There are three predicates to attorney fees under this statute: first, that the insurer filed a request or cross-appeal for a hearing to obtain a disallowance or reduction in the claimant's award of compensation; second, that the claimant's attorney performed legal services in defending the compensation award; and third, that the referee found on the merits that the claimant's award of compensation should not be disallowed or reduced. Strazi v. SAIF, 109 Or App 105, 107-08 (1991).

Accordingly, because the Referee's dismissal was not a decision on the merits, the Referee was without authority to award an attorney fee under ORS 656.382(2) in WCB case number 94-09394. See Strazi v. SAIF, supra; Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549, 550 (1990); Timothy L. Williams, 46 Van Natta 2274 (1994); Kenneth J. Short, 45 Van Natta 342 (1993).[1]

ORDER

The Referee's order dated October 3, 1994 is affirmed in part and reversed in part. That portion of the order that awarded claimant's counsel a $250 assessed attorney fee in WCB case number 94-09394 is reversed. The remainder of the order is affirmed.

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[1] Board Member Gunn acknowledges that he is required by the doctrine of stare decisis to follow the appellate courts' holdings and the Board's holding in Kenneth J. Short, supra. However, for the reasons expressed in his specially concurring opinion in Timothy L. Williams, supra at 2276-77, he continues to disagree with the conclusion that ORS 656.382(2) does not authorize attorney fees for services provided in obtaining the dismissal of a carrier's request for review. ORS 656.382(2) makes no distinction between appeals decided on their merits and those dismissed on other grounds. Thus, because SAIF filed a hearing request that put claimant's compensation at risk, by granting SAIF's motion to dismiss, the Referee implicitly found "that the compensation awarded to claimant should not be disallowed or reduced." Member Gunn reiterates: "it seems only fair that, whenever a carrier's appeal is resolved in the claimant's favor, regardless of whether or not the decision is on the merits, the claimant's counsel should be entitled to a fee for the legal services that assured the claimant's victory." Therefore, he would authorize attorney fees in cases such as this.

March 20, 1995 Cite as 47 Van Natta 451 (1995)

In the Matter of the Compensation of
CHERI A. WALSH, Claimant
WCB Case No. 93-14975
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Lundeen, et al., 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 occupational disease claim for a bilateral arm condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of finding (8). We modify the Referee's ultimate finding of fact (1) to read: Ms. Walsh's bilateral (rather than left) upper extremity symptoms started when she was working at the employer. We supplement as follows.

Claimant is five feet, four inches tall and weighs 90 to 95 pounds. She worked for the employer for about seven years doing production work, with the exception of 1991 and 1992, when she was a supervisor. Prior to becoming a supervisor, claimant had noticed occasional mild pain in her right wrist when operating a chop saw, but found no need to seek medical attention. (Tr. 30, 31, 42). When she returned to production line work in January 1993, her work consisted of inspecting, grading and packing relatively small items into boxes. This work required constant manipulation with her hands and fingers and repetitive use of her upper extremities for at least eight hours a day, with some overtime. (Tr. 31-34). Claimant had no off-the-job hobbies that entailed repetitive use of her wrists, nor did she have a history of injury to either of her wrists or forearms. (Tr. 40). Dr. Maurer noted that claimant's symptoms improved by 60 percent between October 20, 1993 and November 17, 1993, after she had been taken off work. (Ex. 22-40).

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she experienced either an injury or an occupational disease at the employer. The Referee analyzed this claim as an injury claim, concluding that, although claimant reported an injury for which she was diagnosed and treated, that injury resolved and another "bizarre"

condition arose as a possible combination of the effects of the injury and a preexisting psychological condition. The Referee concluded that claimant had failed to carry her burden of causation, based on a lack of a definitive diagnosis or objective findings. We disagree .

We begin by summarizing the relevant facts. Claimant, who is five feet, four inches tall and weighs 90 to 95 pounds, worked for the employer for about seven years doing production work, with the exception of 1991 and 1992, when she was a supervisor. Prior to becoming a supervisor, claimant had noticed occasional mild pain in her right wrist when operating a chop saw, but found no need to seek medical attention. In January 1993, claimant returned to production line work. Her work required constant manipulation with her hands and fingers and repetitive use of her upper extremities for at least eight hours a day, with some overtime. During this period, claimant's right wrist would start to get sore. Claimant self-treated with a wrist-brace. (Tr. 33).

On August 30, 1993, while she was squeezing and picking up a stack of louvers and twisting her wrist to put them in a box, she heard a pop on the back of her wrist and felt a sharp pain from her wrist to her elbow. She was unable to grip with her hand and the employer moved her to work she could perform at a slower pace.

On September 1, 1993, claimant sought medical treatment. Dr. Maurer initially diagnosed carpel tunnel syndrome (CTS). (Ex. 3). On September 14, 1993, Maurer concluded that claimant's symptoms presented as an atypical CTS. He ordered electrodiagnostic studies, which were normal. (Exs. 3 and 4). After ruling out CTS, Maurer changed his working diagnosis to reflex sympathetic dystrophy (RSD). His physical examination revealed tenderness on the back of the wrist, pain on passive manipulation of the wrist, equivocal numbness in the fingers, aching in the arm and a loss of grip and pinch strength. (Exs. 5, 6, 7 and 8).

On November 8, 1993, Dr. Ochoa examined claimant for the insurer. He noted coldness of the right hand and found that claimant "fit the descriptive diagnosis of [RSD]." However, as he was unable to find any neuromuscular condition that caused her condition, he opined that her symptoms were probably not work related, hypothesizing that claimant's pain might be of psychological origin. (Ex. 9).

On October 20, 1993, claimant reported a decrease in pain in her right hand, but reported left hand pain and swelling similar to that she had originally experienced in the right hand. She ascribed the left hand involvement to increased use of the left hand at work while she favored her right hand. Dr. Maurer took claimant off the modified production work she had been doing. (Exs. 10 and 13; Tr. 22-22).

By November 17, 1993, Dr. Maurer noted a 60 percent improvement in claimant's hand symptoms. (Ex. 13-2).

On November 19, 1993, Dr. Ochoa performed diagnostic Phentolamine sympathetic block, which indicated that claimant had no dysfunction of the sympathetic nervous system. (Ex. 11).

Subsequently, Dr. Maurer explained that the change in claimant's symptoms made it difficult to formulate a definitive diagnosis, which he now characterized as overuse syndrome. (Tr. 22-41). Nevertheless, he concluded that claimant's repetitive, intensive production work was the major contributing cause of her arm condition.

Our first task is to determine which provisions of the Workers' Compensation Law are applicable. DiBrito v. SAIF, 319 Or 244 (1994). The test for distinguishing between an industrial injury and occupational disease requires a determination whether the claimed medical condition was unexpected or expected, and whether the onset was sudden or gradual. Id.; James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982). Here, claimant made a claim for a bilateral arm condition that arose over an extended period of intensive, repetitive work with her hands and arms. (Exs. 1, 2 and 10). Consequently, we conclude that she has made a claim for an occupational disease pursuant to ORS 656.802.

An occupational disease is any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment and which requires medical services or results in disability or death, including any series of traumatic events or occurrences. ORS 656.802. Moreover, ORS 656.802(2) requires that existence of a disease or the worsening of a preexisting condition be established by medical evidence supported by objective findings.

The parties do not dispute the repetitive nature of claimant's work. Rather, the argument is centered on the cause of claimant's bilateral arm condition, which has not been definitively diagnosed.

In order to carry her burden, claimant must show that a physician has examined her and determined that she suffers from a disability or condition that requires medical services. Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). That determination may be based on purely objective factors, or on the worker's description of the pain that she is experiencing, as long as the physician indicates that the worker in fact experiences symptoms and does not merely recite the worker's complaints of pain. ORS 656.005(19); Georgia-Pacific Corp. v. Ferrer, supra; Suzanne Robertson, supra.

Here, the reports of Dr. Maurer and Dr. Ochoa indicate that claimant, in fact, experienced the symptoms for which she was seeking treatment. In evaluating claimant's arm symptoms, Dr. Maurer recommended treatment for a condition that initially presented with pain, numbness in the fingers and loss of grip strength and which elicited positive responses to Tinel and Phalen's tests. Moreover, Dr. Ochoa found claimant's right hand cooler than the left, which was consistent with a diagnosis of RSD. Consequently, we find that claimant has established the existence of her bilateral arm condition by medical evidence supported by objective findings.

Moreover, the lack of a definitive diagnosis does not per se defeat the claim. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). It is not a necessary predicate to compensability that the medical experts know the exact mechanism of the disease. Robinson v. SAIF, 78 Or App 581 (1986). However, the causation issue, as opposed to the question of diagnosis, must be resolved. Stewart E. Myers, 41 Van Natta 1985 (1989).

Here, we find Dr. Maurer's opinion on causation more persuasive than that of Dr. Ochoa. Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF, 77 Or App 259 (1986). Dr. Ochoa opined that Dr. Maurer's elicitation of pain and tenderness in response to palpation was not evidence of the existence of an organic disease, but was more probably due to psychological factors unrelated to claimant's work exposure, noting that he has seen many patients with changes in an extremity caused by a primary psychological disorder. (Exs. 20-2 and 20-3).

Dr. Maurer, in contrast, concluded that, although there may be a psychogenic component in pain, claimant had no element of psychogenic pain in her presentation. Instead, he concluded that the major cause of claimant's symptoms was claimant's intense, repetitive work. (Tr. 22-45, 22-46). Moreover, Dr. Maurer pointed out that claimant's symptoms had improved by 60 percent between the time he took her off work on October 20 and November 17, 1993. (Tr. 22-40).

Although Dr. Ochoa opined that claimant's symptoms resulted from a psychogenic cause, there is no evidence in the record that claimant suffered from any psychological condition. Rather, in the absence of evidence of a definitive diagnosis of an organic disease, Ochoa relied on anecdotal evidence regarding persons whose pain symptoms improved after psychological counseling to find that unspecified psychological factors were the cause of claimant's condition regardless of her work. Because Ochoa relied on mere anecdotal evidence that does not involve claimant, and because there is no record evidence of claimant being diagnosed with a psychological condition, we find his opinion concerning claimant to be insufficiently explained. As such, it is not persuasive. Somers v. SAIF, supra; Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

For these reasons, we conclude that Dr. Maurer's opinion is sufficient to establish the compensability of claimant's bilateral arm condition. Consequently, we reverse the Referee's decision finding claimant's occupational disease claim not compensable.

Claimant is entitled to an attorney fee for prevailing over the insurer'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 $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 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 July 18, 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 Board review, claimant's counsel is awarded $3,500, to be paid by the insurer.

In the Matter of the Compensation of
DONNA J. CALHOUN, Claimant
WCB Case No. 93-13286
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Menashe's order that set aside its denial of claimant's occupational disease claim for a left knee condition. Claimant moves to dismiss the employer's request for review on the ground that, after it filed the request for review, the employer formally accepted his claim. On review, the issues are motion to dismiss and compensability. We deny the motion and affirm.

FINDINGS OF FACT

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

On April 18, 1994, the Referee issued an Opinion and Order setting aside the employer's denial of claimant's left knee claim. On May 12, 1994, the employer requested Board review of that order.

On July 26, 1994, the employer, through its processing agent, issued a "1502" form stating that it had accepted claimant's claim. Under the "Explanations" section of the form, the employer stated, "Opinion & order of 4/18/94 order claim accepted. We are appealing that order." The form was copied to claimant's counsel. On October 26, 1994, the employer issued a Notice of Closure. The notice indicated that specified portions of claimant's temporary disability had been "stayed pending appeal per ORS 656.313."

Claimant has moved to dismiss the request for review.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Subsequent to the Referee's order, the Court of Appeals issued its decision in SAIF v. Mize, 129 Or App 636 (1994). There, pursuant to a Board order, a carrier accepted the claimant's claim by a Notice of Acceptance; the notice did not specify that the acceptance was contingent on the carrier's right to appeal. Two weeks later, the carrier petitioned for judicial review of the Board's order. The same day, the carrier sent the claimant a letter stating that its earlier Notice of Acceptance "'was made contingent upon [its] right to appeal this case.'" 129 Or App at 638.

The claimant asserted that, in view of the carrier's acceptance, the petition for review should be dismissed. The carrier argued that it issued the acceptance notice so that the claim could be processed and that it did not intend the acceptance to terminate its appellate rights. The carrier did not argue that the Notice of Acceptance was not an acceptance or that it had been issued by mistake.

The Mize court characterized the issue as concerning the legal effect of the carrier's acceptance with regard to its right to contest the compensability of the claim. The court first concluded that a carrier is not required to accept a claim during the processing of the claim while the compensability issue is being litigated. Id. at 639.

Next, the court determined that the carrier's acceptance was clear and unqualified. Therefore, the court concluded, because the carrier had officially notified the claimant of the acceptance, it could not subsequently deny compensability without complying with ORS 656.262(6).

Finally, the court concluded that, once the carrier had accepted the claimant's claim, the parties were no longer adverse to each other; that is, the controversy over compensability had become moot. Because addressing the merits of the carrier's petition under those circumstances would be to issue an advisory opinion, the court dismissed the petition for review. Id. at 640.

In Timothy L. Williams, 46 Van Natta 2274 (1994), we addressed a similar issue. There, the employer accepted the claimant's claim by a Notice of Acceptance that did not, in any way, specify that it was contingent on the employer's right to appeal. Then, several days later, the employer purported to correct or modify the acceptance by issuing a letter explaining that the Notice of Acceptance had been issued in error and that the claim had been appealed by means of the employer's motion for reconsideration of a referee's order.

Analyzing the case under Mize, we concluded that, in light of the employer's initial clear and unqualified acceptance, it could not subsequently deny compensability without complying with ORS 656.262(6). Id. at 2275. Because the employer's "correction" letter did not comply with that provision, we concluded that, once the employer accepted claimant's claim, the parties were no longer adverse to each other, and the controversy over compensability had been rendered moot. Id. Because an opinion issued under those circumstances would have been purely advisory, we dismissed the employer's request for review. Id.

This case is distinguishable from Mize and Williams. Here, unlike those cases, the employer did not issue a Notice of Acceptance clearly and unqualifiedly accepting the claim. Rather, after it filed its request for Board review, the employer issued a "1502" form[1] that explained, "Opinion & order of 4/18/94 order claim accepted. We are appealing that order." (Emphasis added). Such an explanation indicates that the employer's "acceptance" was contingent on its right to appeal. Consequently, we find that the employer's "acceptance" was not clear and unqualified. That finding is supported by the employer's Notice of Closure, which indicates that the employer was appealing the Referee's order.[2] Therefore, we conclude that, unlike Mize and Williams, the employer's acceptance was not governed by ORS 656.262(6). Rather, we conclude that, by issuing a qualified acceptance, the parties continued to be adverse to each other, and the controversy over compensability was not rendered moot.

Claimant argues that, because there is no evidence that the employer mistakenly accepted her claim, Mize compels us to dismiss the employer's request for review. We disagree. Although the Mize court noted that the carrier did not argue that its acceptance was a mistake, the bedrock of the holding in that case was the carrier's clear and unqualified acceptance. Here, as we have stated, the employer's acceptance was not unqualified. Accordingly, we reject claimant's mistake argument and deny the motion to dismiss the employer's request for Board review.

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[1] 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). Therefore, becuse claimant's motion rests primarily on the employer's "1502" form, it is arguable that claimant has failed to establish that the employer accepted his claim. However, in view of the employer's Notice of Closure, which suggests that the claim had been accepted, see ORS 656.268(4)(a) (authorizing closure of accepted conditions), we do not resolve that issue.

We note claimant's argument that, because neither ORS 656.268(4)(a) nor ORS 656.313 required the employer to issue a Notice of Closure while this matter was on appeal, we should dismiss the employer's request for review. That argument misses the mark, because the employer did, in fact, issue of Notice of Closure, indicating that it was preserving its right to appeal the Referee's compensability determination. Under Mize, we consider the Notice of Closure for purposes of determining whether the employer's "acceptance" was clear and unqualified.

[2] We note that the employer's October 26, 1994 Notice of Closure indicates that, pursuant to ORS 656.313, portions of claimant's temporary disability compensation was stayed pending appeal. That notice is consistent with the employer's claim processing obligations under ORS 656.268 and the Referee's order. Moreover, the notice's reference to stayed compensation was in accordance with ORS 656.313, see Felipe A. Rocha, 45 Van Natta 47 (1993); see also SAIF v. Vanlanen, 127 Or App 346, rev den 319 Or 211 (1994); Diamond Fruit Growers v. Goss, 120 Or App 390, rev den 317 Or 583 (1993), and was consistent with the explanation provided in the employer's "1502" form. Furthermore, it confirms that the employer's "acceptance" was not clear and unqualified.

This case is similar to our decision in Janice M. Hunt, 46 Van Natta 1145 (1994). There, while a referee's order was on review, the insurer issued a "Notice of Acceptance," accepting the claimant's claim as disabling. The insurer simultaneously notified the claimant of its intent to continue to challenge the referee's classification determination. In view of those facts, we concluded that the insurer's Notice of Acceptance was not inconsistent with its assertion on appeal that the claimant's condition was not disabling. Accordingly, we denied the claimant's motion to dismiss the request for review.

Similarly, here, the employer issued its "1502" form indicating that it was simultaneously accepting claimant's claim and appealing the Referee's order mandating the acceptance of the claim. Accordingly, we conclude that the employer's "1502" form is not inconsistent with its assertion on appeal that claimant's condition is not compensable. For these reasons, we find Janice M. Hunt additional support for our decision to deny claimant's motion to dismiss.

To reiterate, we conclude that, because the employer's post-Referee order acceptance of claimant's claim was qualified by references in the "1502" form and the Notice of Closure to the employer's appeal of the Referee's order, the controversy between the parties regarding the compensability of the claim remains viable. Accordingly, we deny claimant's motion to dismiss the employer's request for review.

Compensability

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

The Referee relied on the opinion of Dr. Jenkins, claimant's treating physician, in determining that claimant proved compensability. The employer asserts that Dr. Jenkins' opinion is not entitled to any weight because it qualifies as a "check-the-box" opinion and, therefore, is not reliable.

In Marta I. Gomez, 46 Van Natta 1654 (1994), we explained that, regardless of the form, the persuasiveness of a medical opinion is gauged on whether it is both well-reasoned and based on complete information as opposed to conclusory and poorly analyzed. The test is the same whether the opinion is articulated by the physician or someone else on behalf of that doctor. Id.

Here, claimant's attorney drafted a letter summarizing a conversation between counsel and Dr. Jenkins regarding the cause of claimant's left knee condition, to which Dr. Jenkins concurred. (Ex. 16). The document described Dr. Jenkins' findings from his surgery of claimant's knee and explained that claimant's work activities were the major contributing cause of her need for treatment. (Id.) Inasmuch as this medical opinion is based on Dr. Jenkins' observation of claimant's knee during surgery and is sufficiently well-reasoned, we find it reliable. See Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988). We reach this conclusion regardless of the form of the opinion. Marta I. Gomez, supra.

We also find unpersuasive the employer's assertion that the opinions of Dr. Duff, examining orthopedist, Dr. Browning, the initial treating occupational medicine specialist, and Dr. Wilson, consulting occupational health specialist, outweigh Dr. Jenkins' opinion. Each physician based his or her opinion on a diagnosis of loose bodies in claimant's knee. (Exs. 12, 13, 14). During surgery, however, Dr. Jenkins observed no loose bodies, instead finding an osteochondral lesion and some damage to the lateral femoral condyle. (Ex. 16-1). In view of these surgery findings, we conclude that Drs. Duff, Browning, and Wilson all based their opinion on incomplete information and, therefore, are entitled to no deference. See Somers v. SAIF, 77 Or App 259 (1986).

Finally, relying on Ruben G. Rothe, 45 Van Natta 369 (1993), the employer contends that compensability was not proved because claimant showed only that her knee hurt while working and not a causal relationship between her knee condition and work activities. We disagree. As explained above, Dr. Jenkins' opinion established causation under ORS 656.802(2). Therefore, we find Rothe distinguishable from this case.

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

ORDER

The Referee's order dated April 18, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

March 21, 1995 Cite as 47 Van Natta 457 (1995)

In the Matter of the Compensation of
DONNA J. CALHOUN, Claimant
WCB Case No. 93-14793
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of Referee Menashe's order that: (1) found that claimant had not requested a hearing within 60 days of her notice of the self-insured employer's denial of her occupational disease claim for baker's asthma condition; (2) found that claimant lacked good cause for her untimely hearing request; and (3) dismissed her request for hearing. On review, the issues are evidence, timeliness of the request for hearing, and, if timely, compensability.

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

In May 1993, an employee at Constitution State Service Co., the claims processor for the self-insured employer, mailed a certified letter to claimant denying a claim for baker's asthma. The letter was returned to Constitution State. On December 14, 1993, claimant requested a hearing concerning the baker's asthma claim.

Prior to the January 28, 1994 hearing, claimant's attorney served on Robin Wells, a claims representative at Constitution State, a subpoena duces tecum requiring her to testify at the hearing and demanding production of the claims file, including "computer notes prepared by you or anyone else[.]" (Ex. 17). At hearing, following Ms. Wells' testimony, the employer's attorney offered Exhibit 16, a printout of computer notes concerning the claim, including an entry dated July 19, 1993 indicating that claimant called and spoke to Ms. Wells on that date and expressed concern that she had not appealed the denial. The document was not provided to claimant's attorney before the hearing.

Over claimant's attorney's objection, the Referee admitted Exhibit 16. (Tr. 111). Claimant challenges that ruling, asserting that, because the document was not timely produced pursuant to OAR 438-07-015 and the subpoena duces tecum, and such action materially prejudiced claimant, all evidence concerning the computer notes should not have been admitted.

A carrier must furnish all relevant documentary evidence to the claimant within fifteen days of such demand. OAR 438-07-015(1). Subsequently obtained evidence must be provided within seven days of receipt by the disclosing party. OAR 438-07-015(4). The Referee has discretion to admit or exclude evidence that was not disclosed pursuant to the rules. OAR 438-07-018(4). In making such a determination, the Referee must decide whether "material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs any prejudice to the other party or parties." Id. If material prejudice is found, the Referee may exclude the evidence or continue the hearing "for such action as is appropriate to cure the material prejudice[.]" Id.

We agree with claimant that Exhibit 16 was not timely disclosed. Ms. Wells testified that the July 19, 1993 entry was generated contemporaneously with the telephone call and that it was not produced until a recess during the hearing. (Tr. 108, 110). Based on such evidence, we find that Constitution State possessed the evidence before the filing of the request for hearing but did not timely provide it to claimant as required by OAR 438-07-015. Moreover, as computer notes, Exhibit 16 precisely satisfied the description of the document described in claimant's supoena duces tecum.

Furthermore, we find no good cause for the late disclosure. According to Ms. Wells, she did not produce the evidence based on the advice of the employer's attorney.[1] (Tr. 113). We find such an explanation insufficient in the absence of a specific basis for the untimely disclosure.[2]

In support of her argument that she was materially prejudiced by the late disclosure, claimant asserts that such an action prohibited her attorney "from adequately preparing claimant's case on all available information[.]" We have previously found that a party is materially prejudiced when lack of disclosure impairs case preparation. Donald R. Dodgin, 45 Van Natta 1642, 1643 (1993). Therefore, we must determine whether the lack of timely disclosure impaired claimant's case preparation.

Following admission of Exhibit 16, Ms. Wells testified that, during the July 19, 1993 telephone conversation with claimant, claimant expressed concern because she had not appealed the denial. (Tr. 127-28). Claimant then testified that she had no recollection of such a conversation. (Id. at 146). Claimant neither denied nor admitted that the event occurred.

In view of claimant's lack of recall regarding any telephone conversation, we are not persuaded that her attorney's case preparation was impaired. Claimant does not explain what particular actions her counsel was prohibited from performing in preparing for the hearing. Claimant's attorney not only cross-examined Ms. Wells regarding the computer notes and telephone conversation, but recalled claimant to testify in response to Ms. Wells' testimony. At no time did claimant's counsel request a continuance during the hearing or assert that he needed additional time to review and rebut the document. Under such circumstances, we find no material prejudice to claimant from the admission of Exhibit 16. Therefore, the Referee did not abuse his discretion in allowing the evidence into the record.

Alternatively, even if we found that the Referee's ruling was an abuse of discretion and found the computer notes inadmissible, we would not exclude Ms. Wells' testimony regarding the July 19, 1993 conversation. After Ms. Wells reviewed the computer notes, her memory was refreshed concerning the discussion. (Tr. 109). She then testified that claimant had expressed concern that she had not yet appealed the denial. (Id. at 109, 127). This testimony was based on Ms. Wells' recollection of the discussion. (Id. at 127).

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[1] We first note that such testimony was provided in an "offer of proof" by claimant's attorney. An offer of proof is a mechanism for providing to the decisionmaker the substance of excluded evidence. E.g., OEC 103. Inasmuch as the Referee admitted Exhibit 16, we treat claimant's "offer of proof" as being part of the record.

Furthermore, although Ms. Wells testified that she did not provide the document on the advice of counsel, she also stated that she did not receive such advice until the morning of the hearing. (Tr. 117). The employer's attorney apparently also was not aware of the demand by the subpoena for computer notes until the morning of hearing. (Id. at 119-20). Thus, there is no explanation for the failure to disclose Exhibit 16 for the period prior to the morning of hearing.

[2] During his closing argument, the employer's attorney claimed that the document was not provided before hearing because its purpose was to impeach claimant's assertion that she had no knowledge of the denial of her baker's asthma claim until being informed of it by her attorney in December 1993.

Evidence reasonably believed relevant and material only for purposes of impeachment of a witness need not be disclosed in advance of hearing and may be offered and admitted solely for impeachment. Former OAR 438-07-017 (Emphasis added). Inasmuch as one of the issues pertained to the timeliness of claimant's hearing request, a key element in resolving that question would be when claimant received notice of the denial. Since the computer notes indicated that claimant was aware of the denial more than 90 days before the filing of her hearing request, we conclude that the notes had a substantive evidentiary purpose. Consequently, we are not persuaded that the employer had a reasonable belief that the computer notes were relevant and material only for impeachment purposes. Therefore, we find that Exhibit 16 does not qualify as impeachment evidence and there was no good cause for its late disclosure on this basis.

We also find no merit to claimant's argument that the Referee erred in admitting Exhibit 16 as impeachment evidence but considering it as substantive evidence. See former OAR 438-07-017. The employer's attorney at one point during the hearing indicated that he was offering Exhibit 16 for the purpose of impeachment. (Tr. 84). However, when the document was actually received into the record, there was no indication that the exhibit was offered or admitted solely for purposes of impeachment. (Id. at 111). On the contrary, the Referee's order clearly shows that he considered the document as substantive evidence.

The record shows that, although Exhibit 16 refreshed Ms. Wells' memory, her testimony regarding claimant's statements during the conversation was independent of the document. Even assuming that Exhibit 16 is not admissible, we find no authority, and claimant cites none, for excluding such testimony. Furthermore, we find no material prejudice to claimant's preparation of her case from the admission of the testimony. In this regard, as discussed above, claimant's attorney not only cross-examined Ms. Wells, but offered claimant's testimony in rebuttal and at no time requested a continuance.

Inasmuch as Ms. Wells testified with some specificity regarding the telephone conversation, recalling that claimant expressed concern about the denial, and claimant had no recollection regarding the event, we find Ms. Wells' testimony more persuasive. Thus, we agree with the Referee that the record shows that claimant was aware that her baker's asthma claim had been denied at least as of July 19, 1993. Claimant did not establish good cause for her failure to timely file the request for hearing. Therefore, we affirm the Referee's dismissal of claimant's request for hearing. See ORS 656.319(1).

ORDER

The Referee's order dated April 4, 1994 is affirmed.

In the Matter of the Compensation of
DOMINIC R. GORDON, Claimant
Own Motion No. 94-0435M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
Liberty NW Insurance Corp, Insurance Carrier

The insurer initially submitted claimant's request for temporary disability compensation for his compensable multiple body parts and electrocution shock injury. In its own motion recommendation, the insurer contended that claimant's aggravation rights expired on April 7, 1994, and it submitted a Notice of Closure dated April 7, 1989 which noted that "No time loss" was awarded, to support its position. The insurer recommended against reopening on the grounds that surgery or hospitalization is not reasonable and necessary, and claimant has not sustained a worsening of the compensable injury. Claimant requested a hearing with the Hearings Division. (WCB Case No. 94-09427). Claimant requested the Board "hold [its] Own Motion decision in abeyance until the compensability of the medical treatment has been resolved." On September 14, 1994, the Board postponed action on the own motion matter pending outcome of that litigation.

By Opinion and Order dated January 9, 1995, Referee McWilliams set aside the insurer's "de facto" denial. In addition, that order noted that: claimant's claim was accepted by the insurer as disabling on May 18, 1989; claimant's claim has never been closed by Determination Order or Notice of Closure; and claimant entered into a Claim Disposition Agreement (CDA) on April 22, 1991, in which he "compromised" or settled his claim "for compensation and payments of any kind due or claimed for the past, the present, and the future except for compensable medical services."

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b).

The record indicates that claimant's claim was accepted as disabling on May 18, 1989, and was never closed by Determination Order or Notice of Closure. On March 2, 1995, the Board requested the parties' submit their positions regarding the effect of the CDA on claimant's pending own motion claim. By letter dated March 10, 1995, claimant contends that the CDA of April 22, 1991, was the first settlement, or closure, of the claim. By letter dated March 15, 1995, the insurer agreed with claimant that "it appears that his claim was closed by CDA on April 22, 1991." As both parties agree that claimant's claim was first closed on April 22, 1991, it appears that claimant's aggravation rights will expire five years from that first "closure" date, on April 22, 1996.

Therefore, as it appears that claimant's aggravation rights have not yet expired; the Board, in its own motion authority, does not have jurisdication over this claim. On that basis, we were without jurisdiction to issue the September 14, 1994 order postponing action. We hereby withdraw that order and dismiss claimant's request for own motion relief.

IT IS SO ORDERED.

March 21, 1995 Cite as 47 Van Natta 460 (1995)

In the Matter of the Compensation of
HOLLY HAMMON, Claimant
WCB Case No. 94-01126
CORRECTED ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Roberts, et al., Defense Attorneys

It has come to our attention that our March 20, 1995 Order on Review contained a clerical error. Specifically, our order incorrectly stated that the Referee's order had "set aside" the insurer's denial. In order to correct this oversight, we withdraw our prior order. In its place, we issue the following corrected order. The parties' rights of appeal shall begin to run from the date of this order.

Claimant requests review of Referee Thye's order that upheld the insurer's denial of claimant's claim for a back injury. On review, the issue is compensability.

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

The Referee found claimant not credible based on her demeanor while testifying. We defer to the Referee's demeanor based credibility finding. See Bush v. SAIF, 68 Or App 230 (1984). Because claimant's testimony that she injured her back at work on January 7, 1994 is not credible, we do not find Dr. Stewart's medical opinion, based on claimant's history of the injury, to be persuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977). Accordingly, we agree with the Referee that claimant has not established that she sustained a compensable injury at work on January 7, 1994.

ORDER

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

March 22, 1995 Cite as 47 Van Natta 460 (1995)

In the Matter of the Compensation of
JULIE A. RAE, Claimant
WCB Case No. 94-03041
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Mills' order that dismissed her request for hearing as untimely. On review, the issues are timeliness of the hearing request, and, potentially, "validity" of the insurer's denial, compensability and attorney fees.

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

The relevant portion of ORS 656.319 requires a request for hearing be filed within 60 days after

claimant was notified of the insurer's decision to deny her claim for benefits; however, this deadline is extended to 180 days upon a showing of "good cause" to excuse the late filing.[1]

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(1). See Anderson v. Publishers Paper Co., 78 Or App 513, 517 rev den 301 Or 666 (1986). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Claimant filed her request for hearing more than 60 days, but less than 180 days, after the insurer denied the compensability of her injury claim for a low back condition. She asserts that she had "good cause" for her late filing. She claims to suffer from a learning disability which makes it difficult to process auditory information. Claimant argues that this disability led her to misinterpret verbal exchanges between herself and the insurer's claims adjusters, particularly Ms. Meader. She contends that Ms. Meader, "intentionally or unintentionally," led claimant to believe that she did not have to take any action with respect to the insurer's denial of compensability for her low back condition. (App. Br. at 5). However, claimant admitted that Ms. Meader did not tell her that she did not have to appeal the denial letter; and, in fact, Ms. Meader told claimant to look to that letter for information about how to proceed. (Tr. 45).

The Referee found that claimant did not have good cause for her untimely request for hearing. In reaching this conclusion, the Referee explained that claimant's situation was analogous to the circumstances in Debra A. Smith, 42 Van Natta 1531 (1990). In Smith, the claimant argued that she had good cause for her untimely hearing request because she was relying on oral statements from the insurer's employee that additional information was required and the fact that the insurer had set an appointment for an independent medical examination after the 60 day limit for appealing the insurer's denial had expired. There, we held that the claimant did not have good cause for her untimely filing, because the insurer's employee did not mislead the claimant by telling her that her claim would be accepted either upon receipt of the additional information or after the statutory time for requesting a hearing had passed.

Here, claimant concedes that Debra A. Smith would be controlling were it not for her learning disability. (App. Br. at 4). Claimant argues that Debra A. Smith is distinguishable because "where the development of the misunderstanding is based upon factors over which claimant has no control," then good cause is established. (App. Br. at 5).

We have previously held that an incapacitating physical condition can be excusable neglect and, thereby, form the basis for a good cause exception to the 60 day time limitation for filing a request for hearing. See Patricia Mayo, 44 Van Natta 2260 (1992); Jerry M. McClung, 42 Van Natta 400 (1990). However, such is not the case here.

Claimant asserts that her auditory learning disability impaired her ability to communicate effectively over the telephone with the insurer's representatives. However, claimant admits that the insurer's claims adjuster did not tell her that she could take no action with respect to its denial letter. Moreover, the adjuster advised claimant to look to that denial letter for instruction on how to proceed with her claim. That denial letter informed claimant, in bold typeface, that if she did not agree with the denial she was required to file a written request for hearing within 60 days. (Ex. 16).

We find no evidence that the insurer's claims adjuster misled claimant, intentionally or unintentionally, to believe that she did not have to appeal her denial letter within 60 days. Debra A. Smith, supra. Moreover, we discern no medical condition that would have precluded claimant from following the notice of appeal rights set forth by that denial letter.

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[1] ORS 656.319(1) provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

Claimant has not proven that she was unable to timely file her injury claim due to mistake, inadvertence, surprise or excusable neglect. ORCP 71B(1); Anderson v. Publishers Paper Co., supra. Rather, claimant's untimely filing is attributable to a lack of diligence. Consequently, there was no good cause to excuse claimant's untimely filing of her request for hearing and, therefore, the Referee had no jurisdiction to address the merits of her claim. Cogswell v. SAIF, supra. Accordingly, we affirm the Referee's order that dismissed claimant's request for hearing as untimely.

Finally, claimant argues that the insurer's denial was not "valid" and, therefore, the 60 day limit for requesting a hearing did not start to run. Specifically, claimant asserts that the insurer failed to provide a copy of the denial letter to her attending physician, Dr. Ward, as required by ORS 656.313(3).[2] (App. Br. 6). This argument is without merit.

There is no authority for the proposition that failure to deliver a notice of denial to a claimant's treating physician, pursuant to ORS 656.313, extends the 60 day period for claimant to appeal that denial. See ORS 656.262. Moreover, the parties agree that claimant received the denial directly. Under these circumstances, the insurer's denial was procedurally sufficient to trigger the 60 day appeal period.

As we have upheld the dismissal of claimant's request for hearing, we need not address her arguments concerning compensability and attorney fees.

ORDER

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

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[2] ORS 656.313(3) provides:

"If an insurer or self-insured employer denies the compensability of all or any portion of a claim submitted for medical services, the insurer or self-insured employer shall send notice of the denial to each provider of such medical services and to any provider of health insurance for the injured worker."

March 22, 1995 Cite as 47 Van Natta 462 (1995)

In the Matter of the Compensation of
CHERYL A. TRASK, Claimant
WCB Case No. 93-06558
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Claimant has requested reconsideration of our Order on Review dated March 1, 1995. Specifically, claimant's counsel contends that he is entitled to an out-of-compensation attorney fee for his services in having the Determination Order set aside as prematurely issued.

The request is granted. Accordingly, our March 1, 1995 order is withdrawn. On reconsideration, we adhere to and republish our former order, with the following modification and supplementation. The parties' rights of appeal shall begin to run from the date of this order.

In our original order, we found claimant's fibromyalgia condition to be compensable. We also found that the condition was not medically stationary at the time of claim closure. Therefore, we set aside the Determination Order as prematurely issued. Claimant's counsel contends that he is entitled to an out-of-compensation fee for his services in setting aside the Determination Order. We agree.

Because we have found that claimant's claim was prematurely closed, we conclude that claimant's attorney is entitled to an attorney fee payable from any increased compensation that may be created by this order. ORS 656.386(2). Claimant's counsel is entitled to 25 percent of the increased compensation resulting from this order, not to exceed $1,050, payable by the SAIF Corporation directly to claimant's counsel. See OAR 438-15-055; Record (attorney retention agreement). This fee is payable in addition to the assessed fee awarded by our original order, pursuant to ORS 656.386(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK L. HADLEY, Claimant
WCB Case No. 90-18036
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On March 2, 1995, we issued our Order on Remand which affirmed a Referee's order that set aside the self-insured employer's "de facto" denial of claimant's medical services claim for a vehicle equipped with an automatic transmission. Contending that our order neglected to award his counsel an attorney fee for services previously rendered during Board review, claimant seeks reconsideration.

In order to further consider this matter, we withdraw our March 2, 1995 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD J. BIDNEY, Claimant
WCB Case Nos. 91-13048, 91-01028 & 91-01029
ORDER ON REMAND
Richard A. Sly, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. Bidney v. Avison Lumber Company, 123 Or App 468 (1993). Citing Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the court has reversed our prior orders (which were both based on the conclusion that jurisdiction over the parties' dispute regarding claimant's proposed surgery rested with the Director), reinstated orders issued by Referees Knapp and Menashe, and remanded the consolidated cases for reconsideration of SAIF's appeal of Referee Knapp's order (WCB Nos. 91-01028 & 91-01029).

FINDINGS OF FACT

We adopt the Referees' findings of fact as contained in their April 26, 1991 and November 26, 1991 orders.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered compensable injuries to his neck and low back in 1976 and 1985, respectively. On August 17, 1990, Dr. Berkeley requested authorization for cervical surgery. SAIF did not respond. On January 22, 1991, claimant requested a hearing.

On April 26, 1991, Referee Knapp found that the surgery was compensable, reasonable, and necessary. Setting aside SAIF's "de facto" denial, Referee Knapp awarded a $2,750 attorney fee under ORS 656.386(1). SAIF was also required to pay a $500 attorney fee under ORS 656.382(1), based on its failure to timely respond to the claim. SAIF requested Board review.

On March 18, 1992, we vacated Referee Knapp's order. We concluded that the Hearings Division lacked jurisdiction over the dispute involving claimant's proposed surgery. (WCB Nos. 91-01028 & 91-01029). Claimant petitioned for judicial review.

Meanwhile, on April 9, 1991, SAIF had requested Director's review of claimant's proposed surgery. An August 28, 1991 Director's order found that the proposed surgery was not reasonable and necessary. Claimant requested a hearing.

On November 26, 1991, Referee Menashe vacated the Director's order, reasoning that the Director lacked authority to address the proposed medical treatment issue under ORS 656.327 because claimant had previously requested a hearing from SAIF's "de facto" denial. Referee Menashe neither awarded an attorney fee under ORS 656.386(1) nor penalties and attorney fees for allegedly unreasonable claim processing. In light of the unsettled law, Referee Menashe did not consider SAIF's conduct unreasonable. SAIF requested Board review.

On August 27, 1992, we reversed Referee Menashe's order. Reasoning that the Director had exclusive jurisdiction over the dispute regarding the appropriateness of the proposed surgery, we reviewed the Director's order for substantial evidence under ORS 656.327(1)(b). Based on that review standard, we affirmed the Director's order. In addition, we declined to award a penalty or related attorney fee for SAIF's allegedly unreasonable conduct because there had been no resistance to the payment of compensation since the Director's order had been affirmed. Donald J. Bidney, 44 Van Natta 1688 (1992).

On appeal, the court reversed both of our orders, reinstated the Referees' orders, and remanded for reconsideration of SAIF's appeal of Referee Knapp's order in light of Jefferson v. Sam's Cafe, supra. In that case, the court held that ORS 656.327, which provides a procedure for Director review of medical services disputes, does not apply to disputes regarding proposed medical treatment. The Jefferson court concluded that since ORS 656.327 does not apply to future medical treatment, the Board and its Hearings Division have exclusive jurisdiction to resolve disputes concerning proposed medical treatment. See Martin v. City of Albany, 320 Or 175, 188 (1994).

On reconsideration, we agree with Referee Knapp that the opinions of Dr. Nash, treating physician, and Dr. Berkeley, consulting neurosurgeon, are persuasive concerning the appropriateness of the proposed cervical surgery. We further agree with Referee Knapp that SAIF's failure to timely respond to the claim constituted unreasonable conduct supporting an attorney fee award under ORS 656.382(1). Consequently, we adopt Referee Knapp's reasoning and conclusions on these issues, found on page 7 of his Opinion and Order.

In addition, we acknowledge SAIF's motion to remand for admission of the Director's August 28, 1991 order, Proposed and Final Order M91-85, and claimant's objection to that motion. (Record at 103-113). SAIF argues that the record is improperly, incompletely, or otherwise insufficiently developed without the above-referenced Director's order. See ORS 656.295(5). We disagree.

First, we note that the Director lacked authority to address this dispute concerning proposed medical services. Jefferson v. Sam's Cafe, supra. Under these circumstances, we question the relevancy of the Director's conclusions, or the record which was developed before that forum. Second, because SAIF offers no explanation for its failure to seek this subsequently proffered evidence supporting its position prior to hearing, we find that it has not established due diligence in this regard. Third, because we find the opinions of Dr. Nash, treating physician, and Dr. Berkeley to be persuasive, we do not find that the Director's order regarding the reasonableness and necessity of the proposed surgery would likely affect the outcome of this case. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Consequently, it does not merit remand. See ORS 656.295(5).

Accordingly, we affirm Referee Knapp's order that set aside SAIF's "de facto" denial of claimant's claim for proposed low back surgery. In addition, we affirm the Referee's $2,750 attorney fee (for prevailing against the "de facto" denial) and $500 penalty-related attorney fee (for unreasonable failure to timely respond to the claim).

In addition, inasmuch as claimant has finally prevailed before the Board after remand from the court in both cases, he is entitled to a reasonable attorney fee for services before every forum in each case. See ORS 656.388(1). In this regard, we note that the court has reinstated Referee Menashe's order, which vacated a Director's order purporting to find that the proposed surgery is not reasonable and necessary (and declined to award a penalty based on a conclusion that SAIF's referral to the Director was not unreasonable). Thus, because the Director's order and the Board's order reinstating the Director's order represent orders denying the claim for compensation, claimant is also entitled to an attorney fee for finally prevailing in this matter after remand. Id.; see Lois J. Schoch, 47 Van Natta 71 (1995) (An attorney fee awarded where the claimant finally prevailed after remand with respect to an invalid Director's order denying the claim for compensation); Sherry Y. Drobney, 46 Van Natta 964 (1994).

In evaluating claimant's counsel's entitlement to attorney fees, we acknowledge receipt of claimant's counsel's statement of services documenting 134.3 hours of time spent on these cases and a specific request for a fee of $23,502.50. We also acknowledge receipt of SAIF's objection to the request, on the grounds that claimant has not yet prevailed in obtaining his compensation (because the Board has not ruled on the reasonableness and necessity of the proposed surgery) and the amount requested is excessive.[1]

As a result of this decision, we first note that claimant has finally prevailed regarding his claim for proposed medical services. Accordingly, as stated above, claimant is entitled to a reasonable attorney fee for his services before every forum. We turn to consideration of the amount of the fee to be awarded (in addition to Referee Knapp's assessed fees, which we have previously reinstated and affirmed).

In determining a reasonable attorney fee award, 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 consolidated files consist of some 82 exhibits, with at least 8 solicited by claimant's attorney. There are also numerous letters from claimant's counsel concerning pre-hearing and procedural matters. The hearings each involved one witness and transcripts totaling 65 pages. Claimant's counsel submitted extensive briefs to the Board and court, thoroughly analyzing the issues raised in the two cases.

As demonstrated by the Referees', Board, and court decisions, the jurisdiction issue represented a complex legal question. On the other hand, the reasonableness and necessity of the proposed medical treatment presented a medical question which is similar to medical issues which the Board normally confronts. As a general rule, the value of the interest, as well as the benefit secured, in the form of medical services are considered to be rather modest. Melvin L. Martin, 47 Van Natta 107, on recon 47 Van Natta 268 (1995); Dwight E. Fillmore, 40 Van Natta 794 (1988), aff'd Weyerhaeuser Co. v. Fillmore, 98 Or App 567, 571, rev den 308 Or 608 (1989); Derry D. Blouin, 35 Van Natta 570 (1983). The appellate briefs from each of the parties establishes that their respective arguments were presented in an articulate and skillful manner. Finally, there was a substantial risk that claimant's counsel might go uncompensated.

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 before Referee Menashe, the Board and the court is $9,500, to be paid by SAIF. This award is in addition to those previously granted by Referee Knapp's order. In reaching this conclusion, we have particularly considered the nature of the proceedings, the complexity of the issues, the benefit secured for claimant, the time devoted to the case (as represented by the record, claimant's appellate briefs, and claimant's counsel's statements of services), and the risk that claimant's counsel might go uncompensated. We further note that claimant is not entitled to an attorney fee for services pertaining to the penalty and attorney fee issues. See Jay A. Nero, 47 Van Natta 163 (1995); Amador Mendez, 44 Van Natta 766, 737 (1992); Juan A. Garcia, 43 Van Natta 2813, 2815 (1991).

Accordingly, on reconsideration, as supplemented herein, Referee Knapp's order dated April 26, 1991 is affirmed.

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[1] SAIF cites Rita L. Jefferson, 47 Van Natta 255 (1995) in support of its contention that $6,000 would be a reasonable attorney fee in the present case. In this regard, SAIF argues that the issues in the two cases are identical and they were similarly appealed. The cases are distinguishable. First, although both cases involved jurisdictional issues, they involve different services expended by different counsel. Second, unlike Jefferson, the present "case," is actually two cases (which were litigated separately until consolidated at the court level). Under these circumstances, we do not consider the attorney fee award in Jefferson to be controlling.

In the Matter of the Compensation of
JOYCE A. CRUMP, Claimant
WCB Case No. 93-08718
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al., Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Mills' order that set aside its "de facto" denial of claimant's right knee injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with one exception. Claimant took care of five adults at the foster care center, rather than two adults. (Tr. 4).

CONCLUSIONS OF LAW AND OPINION

While employed with the employer (a grocery store), claimant worked for two weeks during August 1991 at a foster care center, where she sustained an injury to her right knee. In October 1991, claimant underwent arthroscopic surgery on the knee. She did not file a workers' compensation claim for this injury.

In January 1992, claimant slipped and fell while working for the employer, injuring her right knee and back. The employer accepted a claim for the back condition, but neither accepted nor denied a claim for the right knee. The employer also did not issue a disclaimer of responsibility pursuant to ORS 656.308(2). Claimant filed a request for hearing, alleging a "de facto" denial of her right knee condition.

The Referee found that, because the employer failed to issue a disclaimer of responsibility, it was precluded from relying on ORS 656.005(7)(a)(B) by arguing that the major contributing cause of claimant's right knee condition was her August 1991 injury. The Referee concluded that claimant proved compensability by showing that the January 1992 injury materially contributed to her condition.

As it did at hearing, the employer asserts on review that claimant must first prove compensability regardless of its failure to comply with ORS 656.308(2). According to the employer, the applicable statute for determining compensability is ORS 656.005(7)(a)(B), based on medical evidence that claimant's August 1991 injury combined with the January 1992 injury. The employer further contends that, because the January 1992 injury was not the major contributing cause of claimant's resultant condition, claimant failed to establish compensability. Finally, because ORS 656.308(2) pertains to the issue of responsibility, the employer reasons that the statute is not applicable.

There is no dispute that, although the employer "de facto" denied claimant's right knee condition, the issue of compensability was raised and litigated at hearing. Thus, the issue in this case is the effect of the employer's failure to comply with ORS 656.308(2) on claimant's burden of proving compensability of her January 1992 right knee injury claim.

Compensability must be proved as a threshold to determining responsibility. E.g., Joseph L. Woodward, 39 Van Natta 1163 (1987). In particular, the worker must first show that the claim, whether for an accidental injury or occupational disease, is causally related to work activities. ORS 656.005(7)(a), 656.802(2).

ORS 656.308(2) provides, in part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer." Any employer or insurer against whom a

> claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection." (Emphasis added).

By its terms, the statute relates only to the issue of responsibility. Specifically, it allows a carrier to assert that responsibility for a claim should be assigned to another employer or insurer if it has correctly followed the procedure for disclaiming responsibility. The statute does not refer to denials of compensability, nor indicate that claimant is relieved of establishing the requisite causal relationship between the claim and work activities if the carrier does not comply with the subsection.

As discussed above, responsibility becomes an issue only if the claim is proved to be compensable. Inasmuch as we find that ORS 656.308(2) is most reasonably construed as being limited to the issue of responsibility, we hold that application of the statute is contingent on the claim being proved compensable.

This approach is consistent with prior Board cases. Leonard C. Hobbs, 46 Van Natta 171 (1994); Michael R. McMahon, 45 Van Natta 2214 (1993); Rachel J. Dressler-Iesalnieks, 45 Van Natta 1792 (1993); Richard F. Howarth, 44 Van Natta 1531 (1992). In each of these cases, the Board upheld the carriers' denials of compensability even though they failed to issue disclaimers of responsibility pursuant to ORS 656.308(2). Specifically, we found that the effect of the carriers' noncompliance with the statute was limited to a preclusion of asserting the defense that another carrier was responsible for the claim without affecting the claimants' burden of proving compensability. See also Donald A. James, 46 Van Natta 1898 (1994) (carrier found responsible since it withdrew its compensability denial, compensability was not disputed, and the carrier failed to issue disclaimer of responsibility); Byron E. Bayer, 44 Van Natta 1686 (1992) (merits of the claimant's aggravation claim, including causation, considered while the insurer's defense that a prior employer was responsible was precluded for failure to comply with ORS 656.308(2)).

In deciding that claimant proved compensability, the Referee relied on Wayne D. Helgerson, 45 Van Natta 1800 (1993). Helgerson in part relied on Rene G. Gonzalez, 44 Van Natta 2483 (1992). Both cases concerned workers who developed occupational diseases in major part due to a long history of performing the same work for various employers. In both cases, only one carrier was joined in the hearing; neither complied with ORS 656.308(2). The issue presented was whether, in order to prevail, the claimants had to prove actual causation against the joined employer or if the claimants' work before and after the carriers came on the risk could be considered.

Based on Medford Corp. v. Smith, 110 Or App 486, 488-89 (1992), we found that the joined carrier could be held responsible "if the considerations that are relevant to the determination of responsibility" as between the joined carrier and the absent employers supported such a conclusion. Thus, in determining compensability, we examined whether the claimants' entire work period was the major contributing cause of the conditions. If that burden was satisfied, the joined carrier was found responsible if the work during its period of coverage did or could have caused the disease and claimant sought treatment while the carrier was on the risk.

Helgerson and Gonzalez are consistent with the court's subsequent decision in Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994). There, the claimant filed claims against two employers, alleging an occupational disease for hearing loss. The claimant then entered into a Disputed Claim Settlement (DCS) with the first employer in which the claimant agreed that his claim against that employer would remain in denied status. The claimant continued to hearing against the second employer concerning the issues of compensability and responsibility. The Board found that, because the claimant had entered into the DCS, he had elected to prove actual causation and could not rely on the last injurious exposure rule to establish compensability.

The court disagreed, finding no precedent or policy reason for limiting the application of the last injurious exposure rule against a single employer when compensability is at issue. Id. at 77-78. The court also found that the claimant had consistently asserted that both employers could have contributed to his hearing loss and that nothing in the DCS contradicted this position. Id. at 78. Accordingly, the court held that, once he had proved that work conditions at both employers was the major contributing cause of his hearing loss, the claimant could rely on the last injurious exposure rule "to prove the compensability of the claim against [the second employer] by showing that employment conditions there could have caused the condition." Id.

Our orders in Helgerson and Gonzalez both indicate that the claimants' consecutive employment exposures were the major contributing causes of their occupational diseases. 44 Van Natta at 2485; 45 Van Natta at 1801. Consistent with Bennett, once this finding was made, in effect we applied the last injurious exposure rule to determine if the claimants proved compensability of the claim against the single joined employer. In both cases, we found that employer liable on the basis that work exposure there did or could have caused the disease, and was on the risk at the time the claimant sought medical treatment. Id.

Here, claimant has not alleged an occupational disease claim or sought to apply the last injurious exposure rule. Instead, she has asserted that her right knee condition is compensable as an injury. As such, she cannot rely on the last injurious exposure rule as a rule of proof or assignment of liability. See, e.g., Runft v. SAIF, 303 Or 493, 499 (1987) (explaining that the last injurious exposure rule applies to those cases where more than one employer could have contributed to a claimant's occupational disease; the employer is successively insured by two or more carriers; and there are injuries/exposures at successive employers).[1] Therefore, we find this case distinguishable from Helgerson and Gonzalez. We proceed to determine if claimant proved compensability.

The record shows that claimant has a preexisting chondral fracture of the medial femoral condyle as a result of the August 1991 injury. (Exs. 39-1, 40-5). According to claimant's treating orthopedic surgeon, Dr. German, the January 1992 injury "aggravated" the preexisting condition. Examining physicians Dr. Fuller, orthopedic surgeon, and Dr. Reimer, neurologist, found that the January 1992 injury caused a "mild transient" right knee sprain that was superimposed on the preexisting condition. (Ex. 40-3).

Based on this evidence, we find that the preexisting right knee condition combined with the January 1992 right knee injury. Therefore, we apply ORS 656.005(7)(a)(B) to determine compensability. In this regard, we note that, when a preexisting condition combines with a compensable injury, compensability of the resultant condition is determined under ORS 656.005(7)(a)(B) whether or not the preexisting condition is compensable. SAIF v. Drews, 318 Or 1(1993). Therefore, in order to prevail, claimant must prove that her January 1992 injury is the major contributing cause of her resultant condition. See Tektronix, Inc. v. Nazari, 117 Or App 409, on recon 120 Or App 590, rev den 318 Or 27 (1993).

Dr. German reported that claimant's "primary injury was of 1991 with a very mild, if any, aggravation with her second injury [of January 1992.]" (Ex. 39-2). Drs. Fuller and Reimer found that claimant's disability and need for treatment related to the preexisting condition rather than the January 1992 injury. (Ex. 40-5). We find that this medical evidence shows that the January 1992 injury was not the major contributing cause of claimant's need for treatment of her right knee. Consequently, claimant failed to establish the compensability of her 1992 right knee injury claim. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra.

Inasmuch as we conclude that claimant did not establish the compensability of her right knee claim, we need not address responsibility. Furthermore, based on our holding that application of ORS 656.308(2) is contingent on finding a claim compensable, we further conclude that the effect of the employer's failure to issue a disclaimer of responsibility pursuant to the statute also need not be addressed. We also wish to emphasize that this proceeding does not concern the compensability of claimant's August 1991 injury since claimant did not file a claim for this injury and the employer of the foster care center was not joined. Therefore, we make no findings concerning any aspect of the August 1991 injury.

Finally, we stress that, when a carrier is faced with the possibility that responsibility for a claim is with another carrier, the best course is to issue a notice of disclaimer. Such action in no way

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[1] In the successive injury context, the last injurious exposure rule is applied when the prior injury or injuries is compensable. E.g., Boise Cascade Corp. v. Starbuck, 296 Or 238, 243-44 (1984). Inasmuch as there is no finding concerning the compensability of claimant's 1991 right knee injury, there is no cause for applying the last injurious exposure rule on the basis that claimant was "successively injured" in 1991 and 1992. Furthermore, even if compensability of the 1991 injury had been addressed and established, we find it questionable that the last injurious exposure rule, rather than ORS 656.308(1), would apply.

prejudices the carrier by exposing it to additional liability. On the contrary, a notice of disclaimer permits it to assert the defense that responsibility for the compensable claim lies with another employer or insurer regardless of whether or not the worker has filed a claim against that party. Issuing a disclaimer of responsibility also eliminates a basis for assessing a penalty for unreasonable claim processing.

ORDER

The Referee's order dated December 28, 1993 is reversed. The self-insured employer's denial of claimant's right knee condition is reinstated and upheld. The Referee's assessed attorney fee award of $2,500 also is reversed.

Board Members Gunn and Hall dissenting.

Although the majority begins its order as if it were going to address the effect of the employer's failure to comply with ORS 656.308(2) on claimant's burden of proving compensability, the majority dodges the issue. Instead, the majority holds that application of ORS 656.308(2) is contingent on the claim being proved compensable. The majority puts the cart before the horse. Before claimant can prove compensability, she must know the appropriate standard of proof. Because we disagree with the majority's analysis and conclusion, we respectfully dissent.

We suspect that one of the majority's problems is that it prefers to avoid interpreting ORS 656.308(2). Admittedly, the statute is, to say the least, puzzling. Nevertheless, it is our responsibility to interpret the statutes as best we can to provide some guidance for the parties.

The employer contends that ORS 656.308(2) applies only when a carrier is responsible for payment of compensation in a compensable claim and believes that a new compensable injury involving the same condition may have occurred in another employer's employment. Thus, the first issue to be addressed is whether the disclaimer requirements of ORS 656.308(2) apply when there is no prior accepted claim. 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.

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." (Emphasis added).

ORS 656.308(1) applies when a worker has an accepted claim for the condition. SAIF v. Yokum, 132 Or App 18 (1994). Section (1) of ORS 656.308 addresses the shifting of responsibility from an employer that is responsible for an accepted claim, to a later employer that has made some contribution to the disability or need for treatment of the same condition.

ORS 656.308(2) provides, in part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer." (Emphasis added).

Unlike ORS 656.308(1), ORS 656.308(2) does not refer to a "compensable injury." There is no requirement in ORS 656.308(2) that the worker must already have a compensable injury or disease before a carrier is required to issue a disclaimer of responsibility. The use of a term in one section and not in another section of the same statute indicates a purposeful omission. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611. Therefore, we would conclude that the disclaimer requirements of ORS 656.308(2) apply whether or not there is a prior accepted claim.

ORS 656.308(2) provides that if a carrier is going to assert that other employment has caused the worker's condition, it must so notify the worker so that the worker may file a claim with the other carrier(s). If a carrier has given proper notice, ORS 656.308(2) provides that 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." Thus, ORS 656.308(2) applies even when claimant has not, as in the instant case, filed a claim with the other potentially responsible employer.

The employer's position is that claimant's knee condition is not "compensable" because the major contributing cause of her condition is a preexisting injury she sustained in August 1991 at another employment. Notwithstanding that position, the employer contends that the disclaimer provisions in ORS 656.308(2) do not apply here because it is not asserting that "responsibility" for compensation lies with another employer or insurer.

It is undisputed that the employer failed to comply with ORS 656.308(2). In fact, the employer did not issue a denial of claimant's claim for a right knee condition.

Although the employer contends that it is denying "compensability," because the employer's defense is "on the basis of an injury or exposure with another employer or insurer," it is effectively asserting that "responsibility" for claimant's condition lies with another employer or insurer. See ORS 656.308(2). Moreover, since the employer is relying on a preexisting injury that occurred at another employment, it is attempting to "assert, as a defense, that the actual responsibility lies with another employer or insurer." See ORS 656.308(2). Consequently, regardless of the name the employer attaches to its defense ("compensability"), it is currently attempting to advance a "responsibility" defense, despite its failure to comply with the prerequisites of the statute.

The intent of ORS 656.308(2) is to notify claimant that the employer is going to assert that another employer is responsible.[1] Here, the employer failed to do so. Therefore, the employer has lost its right to assert that the prior employment injury is the major contributing cause of claimant's condition.

In Donald A. James, 46 Van Natta 1898 (1994), the carrier which had not complied with the disclaimer requirements under ORS 656.308(2) was precluded from asserting a responsibility defense. Notwithstanding that failure, a carrier may continue to contest compensability. In James, however, the carrier had expressly conceded compensability and the Board concluded that the carrier was thereby responsible for the claimant's bilateral hearing loss condition.

We would clarify the rule in Donald A. James, supra, to hold that a carrier which has failed to comply with the disclaimer requirements under ORS 656.308(2) is precluded from asserting as a defense that the actual responsibility lies with another employer or insurer. Although a carrier may continue to contest compensability under those circumstances, it may not do so if its defense is based on a prior work exposure because that defense is "on the basis of an injury or exposure with another employer or insurer." ORS 656.308(2). A carrier which has not complied with the disclaimer provisions in ORS 656.308(2) is precluded from asserting "as a defense, that the actual responsibility lies with another employer or insurer." See Donald A. James, supra.

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[1] Although we believe that ORS 656.308(2) is clear on its face, the conclusion that the statute's purpose is to notify claimant that the employer is going to assert that another employer is responsible is also supported by the legislative history. Section 2 of ORS 656.308 was an attempt by the legislature to clarify how employers can bring each other in and streamline the process in that regard. Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 4, Side A (Testimony of Ross Dwinnell, co-chair of the committee that drafted the 1990 amendments). The intent was that an employer disclaiming because it felt that another employer was responsible had an obligation to name that other employer to the employee in the notice. Id. (Testimony of Cecil Tibbetts, Member of the Governors Workers' Compensation Labor Management Advisory Committee, and Representative Edmunson). To further clarify that point, the legislature added language to ORS 656.308(2): "The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease." The concern was that if the employer was going to disclaim responsibility for a given injury or disease that they point the finger at the employer they felt was responsible. Joint Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 21, Side B.

On the other hand, a carrier which has failed to comply with the disclaimer requirements under ORS 656.308(2) may continue to contest compensability if its defense is not based on a prior work injury or exposure. For example, the evidence in an employer's possession could suggest a congenital or "off work" cause for a claimant's condition. Thus, the fact that a claimant has a preexisting injury or disease does not, by itself, trigger a duty for the employer to issue a disclaimer pursuant to ORS 656.308(2).

Here, however, the record establishes that the employer had early notice that claimant had a preexisting injury that had occurred at another employment. Claimant was injured while working at the present (subject) employer on January 5, 1992 and she filed a claim on January 12, 1992. (Ex. 7). On January 17, 1992, claimant completed a "Worker's Injury Report," which noted that she had surgery on her right knee in October 1991, as a result of a fall. (Ex. 11A). Also on January 17, 1992, claimant's statement was taken by the employer. Claimant told the investigator that in August she had taken two weeks off of her current job with the employer to care for five elderly people at an adult foster care center. (Ex. 11B). Claimant was paid for her services. While working at that job, she fell and injured her knee and had to have surgery in October 1991. Claimant reported to the investigator that she had not filed a workers' compensation claim for that knee injury.[2] The medical reports also establish that claimant had a previous work injury.

The employer does not dispute that claimant was injured at the employer on January 5, 1992, when she slipped on some salad dressing and fell on her back and twisted her knee. However, the employer relies on claimant's preexisting work injury to argue that her claim is not compensable. Because the employer failed to comply with the disclaimer requirements under ORS 656.308(2), it is precluded from asserting as a defense that the actual responsibility lies with another employer or insurer. Therefore, we would conclude that the employer is precluded from characterizing claimant's condition as a preexisting condition. Claimant should not have to establish that her employment activities with this employer were the major contributing cause of her condition.

The majority allows the employer to argue that the major contributing cause of claimant's current knee condition is a preexisting work-related injury. The effect of the majority's decision is to permit the employer to "assert, as a defense, that the actual responsibility lies with another employer or insurer," even though it did not comply with ORS 656.308(2). The majority's holding renders the provisions of ORS 656.308(2) meaningless. The holding allows a carrier who is contesting a claim based on other work exposures to escape liability based on a "responsibility" defense, even though the carrier failed to notify claimant of the right to file claims with other employers or insurers.

This is not a situation in which requiring the employer to issue a disclaimer under ORS 656.308(2) will expose it to additional liability. To the contrary, issuing a disclaimer under ORS 656.308(2) expressly allows the employer to "assert, as a defense, that the actual responsibility lies with another employer or insurer." Furthermore, ORS 656.308(2) permits a carrier which has issued a proper disclaimer to use that defense, regardless of whether or not the worker has filed a claim against the other employer or insurer. Thus, had this employer timely complied with the responsibility disclaimer requirement of ORS 656.308(2), it could have asserted this defense regardless of the validity or timeliness of claimant's injury claim with the alleged employer (or for that matter whether claimant even chose to file a claim with that alleged employer).

For the foregoing reasons, we respectfully dissent.

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[2] Claimant testified at hearing that she was told that that foster care center where she was injured in August 1991 did not have to carry worker's compensation insurance. Claimant's attorney at that time did not pursue a claim.

In the Matter of the Compensation of
HAROLD A. EDWARDS, Claimant
WCB Case No. C5-00427
ORDER DISAPPROVING 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 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 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).

We have previously disapproved CDA's involving or referring to denied claims. In Donald Rhuman, 45 Van Natta 1493 (1993), we disapproved a CDA on the ground that the disposition provided that a penalty dispute existed between the claimant and the insurer, and that a portion of the settlement was intended to compromise the claimant's claim for penalties. 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 other procedural avenues (such as stipulations and disputed claim settlements) were available to the parties to accomplish such objectives. Donald Rhuman, supra. Also see Frederick M. Peterson, 43 Van Natta 1067 (1991) (CDA disapproved on the ground that it provided that several denials would remain in full force and effect. Any denied condition that is pending litigation is a matter in dispute and cannot be considered to be "accepted.")

On March 20, 1995, the Board received the parties' response to our request to correct the above-stated language. The parties have 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 within ORS Chapter 656 except denial disputes."

After reviewing the parties' addendum, we conclude that the proposed addendum does not correct the problem identified by our addendum letter. The parties have attempted to provide that the CDA will settle disputes other than "denial" disputes. We construe the parties' language to mean that the CDA is not intended to settle disputes concerning compensability. To the extent that such language pertains to compensability disputes, it is not objectionable; however, the provision can also be interpreted as pertaining to the resolution of noncompensability disputes. As noted above, we have disapproved CDA's which attempt to settle disputes pertaining to such noncompensability matters because CDA's are intended for accepted (as opposed to disputed) claims, as the claim exists at the time the Board receives the CDA. Donald Rhuman, supra.

Consequently, because the addendum does not correct the language referring to settlement of "existing disputes," we conclude that the proposed CDA is not a proper matter for disposition under ORS 656.236 and the administrative rules.[1] Therefore, the CDA is disapproved on the ground that it is unreasonable as a matter of law. ORS 656.236.

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[1] We note that the parties' agreement also provides that the CDA shall "result in the dismissal with prejudice or otherwise dispose of all 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 have previously held that such language in a CDA is acceptable because it refers to disposing of only issues pertaining to the CDA which are raised or raisable before the Board. See Barbara L. Whiting, 46 Van Natta 1684 (1994). Therefore, we have no objection to the parties retaining such language in their proposed agreement. Similarly, we would have no objection to the insertion of a provision stating that, as a result of the CDA, the parties agree that any request for hearing will be dismissed. However, we find such provisions to be distinguishable from the parties' language in this CDA, which expressly attempts to settle disputed matters.

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.

March 29, 1995 Cite as 47 Van Natta 473 (1995)

In the Matter of the Compensation of
RONALD MARTIN, Claimant
WCB Case No. 93-07948
ORDER ON REVIEW
Peter J. Carini, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

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

The self-insured employer requests review of Referee Brown's order which set aside its denial of claimant's injury claim for a fractured pelvis. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant fractured his pelvis when the log skidder he was operating rolled down a hill. The injury occurred on Monday, June 7, 1993, at approximately 9:00 a.m. Blood and urine tests taken within 2 1/2 hours of the accident indicated that claimant ingested alcohol, methamphetamines, cocaine and marijuana. Based on the results of these tests, Dr. Burton opined that claimant had probably consumed the drugs and alcohol the evening prior to the accident. Although Dr. Burton acknowledged that there was not a direct relationship between the test screening levels and impairment, there was a dose-response relationship; i.e., the higher the dose, the more severe the toxicity. In other words, as the dosage[1] increases, the toxic effects and impairment from the toxicity also increases. Dr. Burton opined that the combined impairment from the effects of alcohol and drugs, and sleep deprivation was the most likely cause of claimant's accident.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, the employer has requested oral argument. We ordinarily do not entertain oral argument. OAR 438-11-015(2). Since the parties' briefing in this case, the Board has issued decisions which have addressed similar issues and concerns raised in the employer's request for oral argument. Accordingly, we are unpersuaded that oral argument would appreciably assist us in reaching our decision. Therefore, we decline to grant the employer's request.

Violation of the employer's drug and alcohol policy

The Referee found that even if claimant was under the influence of drugs and alcohol, the violation of the employer's drug and alcohol policy went to the method of work, rather than to the ultimate work to be done by claimant. The Referee, therefore, concluded that claimant's accident occurred within the course and scope of employment.

Relying on Underwood v. Pendleton Grain Growers, 112 Or App 170 (1992), the employer contends that claimant took himself out of the course and scope of employment when he violated the employer's policy prohibiting working while under the influence of either drugs or alcohol. We disagree.

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[1] The test results indicated the presence of methamphetamine at 977 ng/ml, cocaine metabolite at 2,560 ng/ml, and marijuana metabolite at 46 ng/ml. Claimant had a blood alcohol level (BAL) of .07 at the time of the accident.

In David Bottom, 46 Van Natta 1485 (1994), aff'd mem Liberty Northwest v. Bottom, 133 Or App 449 (1995), we stated that, in the absence of any causal connection between the claimant's drinking and his injury, the claimant's violation of the employer's drug and alcohol policy, by itself, did not constitute misconduct sufficient to take the claimant's injury out of the course and scope of his employment. In reaching our decision, we distinguished Underwood v. Pendleton Grain Growers, supra. In Underwood, the court focused on the facts that the claimant had been expressly prohibited from carrying out the employer's business after consuming alcohol or drugs, the length of the nonbusiness deviation and the nature of the claimant's acts. Id. at 173-74.[2]

In contrast, our decision in Bottom focused on whether the claimant's misconduct involved a violation of a regulation or prohibition relating to the method of accomplishing his work or whether the misconduct involved a prohibited overstepping of the boundaries defining the ultimate work to be done by the claimant. We determined that the employer's drug and alcohol policy manifested a method of performing the claimant's ultimate work and, therefore, violation of the employer's policy did not take the claimant out of the course and scope of employment. David Bottom, supra; see also Charles D. Turner, 46 Van Natta 1541 (1994).

Unlike Bottom, here, the employer contends that there is a causal relationship between claimant's drug and alcohol consumption and his injury. However, that question is resolved under ORS 656.005(7)(b)(C) rather than under the "ultimate work" test. We continue to hold that an employer's drug and alcohol policy defines the method of performing work and does not constitute an independent basis to defeat compensability where the claimant violates that policy.

Here, claimant was injured while performing his assigned job of skidding logs. Only the method in which he performed his work, i.e., working while under the influence, was prohibited. Thus, we conclude that the claimant's violation of the employer's drug and alcohol policy, although considerably increasing the hazards associated with operating a skidder, in itself, did not constitute misconduct sufficient to take claimant's injury out of the course and scope of his employment. See Charles D. Turner, supra.

ORS 656.005(7)(b)(C)

The Referee found that claimant's injury could have occurred because of driver inexperience or unfamiliarity with the particular skidder, or because the ground was wet, or because claimant was impaired due to drugs and alcohol. The Referee concluded that, because there was more than one plausible explanation for the injury, the employer had failed to prove, by clear and convincing evidence, that the major contributing cause of the injury was claimant's consumption of alcohol and unlawful controlled substances. We disagree.

Under ORS 656.005(7)(b)(C), claimant must first establish a prima facie case of compensability. If so established, then to defeat a finding of compensability, the employer must prove, by clear and convincing evidence, that claimant's consumption of alcoholic beverages and/or the unlawful consumption of any controlled substance was the major contributing cause of the injury. To be clear and convincing, the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). The employer cannot meet its burden by merely showing that claimant consumed alcohol or a controlled substance. Rather, the employer must establish that it is highly probable that claimant was impaired by the alcohol or controlled substance and that such impairment was the major contributing cause of the injury. Grace L. Walker, 45 Van Natta 1273 (1993) aff'd mem Walker v. Danner Shoe Manufacturing, 126 Or App 313 (1994); Dave D. Hoff, 45 Van Natta 2312 (1993).

The employer does not contest that claimant's disability was materially related to the accident. We have also found that the accident occurred within the course and scope of employment. Therefore, the employer must prove by clear and convincing evidence that claimant's consumption of alcohol and drugs was the major contributing cause of the accident. Grace L. Walker, supra. The employer has met its burden of proof.

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[2] The majority recognizes that, pursuant to the doctrine of stare decisis, that they must follow the holding of David Bottom, supra. However, were they reviewing on a clean slate, the majority would concur with the reasoning expressed in Member Haynes' dissenting opinion in Bottom.

The uncontroverted medical evidence establishes that claimant is a habitual drug user and that he had a high concentration of drugs and a significant concentration of alcohol in his system the evening prior to the accident. Dr. Burton, board certified in medical toxicology and occupational medicine, explained that methamphetamine and cocaine are central nervous system stimulants, which cause an increased sense of arousal, state of wakefulness, euphoria, a sense of well-being, an air of confidence, and a feeling that the user can do anything. (Ex. 18-21). Conversely, alcohol has depressant effects on the central nervous system and results in impaired sensory input causing difficulty correctly perceiving the environment and interpreting external stimuli. Claimant's judgment and decision making ability would be distorted and slowed. Motor ability to respond appropriately is also slowed.

Dr. Burton further explained that there is much greater impairment when the stimulant drugs are combined with alcohol. Claimant would perceive to have the ability to do things, and the confidence that those abilities exist, but the actual ability to carry out those tasks would be impaired by the effects of alcohol. Claimant would also be impaired from a drug-induced sleep disorder, which results in sleep deprivation. Thus, the next morning, claimant would still be significantly impaired from the combination of the alcohol, the stimulant drugs, and the sleep deprivation. (Exs. 16, 18 pp. 21-24). Dr. Burton concluded that the combined impairment from the effects of the drugs and alcohol and the sleep deprivation was the most likely cause of claimant's accident. (Exs. 16, 18).

Although Dr. Burton did not use the words "the major contributing cause" to quantify causation, "magic words" are not required. See McClendon v. Nabisco Brands, 77 Or App 412 (1986). Given his well-reasoned opinion, we find Dr. Burton's unrebutted opinion persuasively establishes that claimant's consumption of drugs and alcohol caused significant impairment and that impairment was the major contributing cause of claimant's injury.[3]

The employer, Mr. Blumenfeld, described how the accident occurred. He stated that the place where claimant was skidding logs was a little hazardous such that a prudent person would have pulled line (meaning that the skidder is stationary and the cable is pulled out and choked to logs and then the logs are winched to the skidder). (Tr. 28, 36). Mr. Blumenfeld explained that, instead of being uphill of the logs being skidded, claimant's skidder was below the logs and placed sideways, instead of uphill, and the winch line was too slack, which enabled the skidder to roll over. (Id. at 27, 29, 38-39). He also testified that there was no mechanical failure in the skidder. (Id. at 31). Mr. Blumenfeld, therefore, concluded that an error in operator judgment caused the accident. (Id. at 27).

The dissent attempts to discredit Mr. Blumenfeld's testimony as too speculative and thus, insufficient to establish "mechanical causation." However, the substance of Mr. Blumenfeld's testimony supports his conclusion. Mr. Blumenfeld is a self-employed logger, who viewed and investigated the scene of the accident shortly after it occurred. Based on his investigation, Mr. Blumenfeld concluded that claimant's error in judgment caused the skidder to roll. This conclusion is based on a number of factors: the location of the skidder; evidence that the skidder had lost control on the logs; prints and tire marks that the skidder was sideways, rather than uphill; and the mechanical condition of the

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[3] Claimant gives a number of reasons why expert medical opinion was unnecessary to rebut Dr. Burton's opinion. None of those reasons are persuasive. First, claimant contends that Dr. Burton failed to quantify the level of impairment caused by the consumption of drugs and alcohol. However, the degree of impairment is not the relevant inquiry. Rather, the question is whether claimant was impaired by his consumption of drugs and alcohol and, if so, whether that impairment was the major contributing cause of the injury.

Claimant also attempts to discredit Dr. Burton's opinion on the basis that there is no correlation between the amount of drugs found on testing with the level of impairment. As discussed above, Dr. Burton acknowledged such, but also testified that there was a dose-response relationship. Dr. Burton further provides a well-reasoned explanation of the impairing effects of drugs and alcohol as the causal connection to the injury.

Claimant next contends that Dr. Burton had incomplete information regarding claimant's experience as a skidder operator and the ground conditions at the time of the accident. However, Dr. Burton had obtained a history that claimant has approximately two and one-half years experience operating a skidder. Dr. Burton also reviewed an OSHA investigative report of the accident, which indicated that the ground was somewhat wet and soft, and which gave a description of the accident. Accordingly, we find that Dr. Burton had a complete history.

The remainder of claimant's contentions do not merit discussion.

skidder. Mr. Blumenfeld's observations and explanation of the accident correspond to his ultimate conclusion. There is no contrary evidence that Mr. Blumenfeld's observations were erroneous or that the foundation upon which he based his conclusion was flawed. Accordingly, we find Mr. Blumenfeld's uncontroverted testimony[4] establishes that operator error caused the skidder to roll.

In sum, based on Mr. Blumenfeld's persuasive opinion, we find that the skidder accident was attributable to claimant's error in judgment. Moreover, based on the expert medical opinion provided by Dr. Burton, we conclude that claimant's consumption of alcohol and drugs was the cause of this error in judgment. Consequently, in light of the persuasive medical and lay evidence, we hold that the employer has established, by clear and convincing evidence, that the major contributing cause of claimant's injury was his consumption of alcohol and of controlled substances. ORS 656.005(7)(b)(C); Richard A. Perry, 46 Van Natta 302 (1994) (uncontroverted medical evidence that the claimant's marijuana consumption caused impairment, which was the major contributing cause of the claimant's injury; and the claimant not credible regarding how the accident occurred); Dave D. Hoff, supra (Board relied on medical evidence that the claimant's consumption of alcohol (.13 BAL) caused significant impairment and that impairment was the major contributing cause of the accident). Therefore, the employer has established that the injury is not compensable.

ORDER

The Referee's order dated February 17, 1994 is reversed. The employer's denial is reinstated and upheld. The Referee's $2,800 attorney fee award is also reversed.

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[4] Claimant did not attend the hearing, but appeared through counsel. On review, claimant relies on Ex. 10A to establish how the accident occurred. However, Ex. 10A was admitted for the limited purpose of foundation for Dr. Burton's opinion and not as substantive evidence regarding how the injury occurred. (Tr. 10-11).

Board Member Hall dissenting.

I concur with the majority that claimant's violation of the employer's drug and alcohol policy did not take claimant out of the course and scope of employment. However, for the following reasons, I disagree with the majority's conclusion that the employer carried its burden of proof (by clear and convincing evidence) that claimant's impairment from his consumption of drugs and alcohol was the major contributing cause of the accident.

To begin with, we must recognize that ORS 656.005(7)(b)(C) has two very specific elements and that both elements must be proven by clear and convincing evidence: (1) consumption of alcohol and/or drugs (i.e., impairment of function); and (2) causation (i.e., the impairment, and not other factors, was the major contributing cause of the accident). To be true to the rule of law, we cannot accept evidence on one element (even when overwhelming) to make up for a lack of evidence on the other element. In the present case, I respectfully submit that the majority is allowing evidence of impairment to make up for a lack of reliable evidence on causation.

I do not dispute that the uncontroverted medical evidence establishes that claimant was impaired. However, the sole evidence on causation (i.e., the testimony of Mr. Blumenfeld) is based on an unacceptable level of speculation and conjecture. Here, the employer failed to prove what I would label "mechanical causation."

The question of consumption and resulting impairment is a medical question. The question of how the accident itself occurred, however, is beyond the scope of the doctor's expertise. In Grace Walker, supra, the employer presented mechanical expert opinion evidence which established that the accident would not have occurred if the claimant had been operating the machinery properly. Here, in contrast, the only evidence regarding how the accident occurred is the testimony of the employer, Mr. Blumenfeld. According to his testimony, Mr. Blumenfeld went to the accident scene late in the afternoon of the accident date to ". . . look and see what had happened." (Tr. 27). When asked what conclusion he reached, Blumenfeld stated:

> "A. It looked like the machine had gotten sideways, and somebody [claimant] had made an error in judgment. That's what caused the accident." (Tr. 27. Emphasis added).

When asked what error in judgment was made, Blumenfeld testified:

"A. It looked like he [claimant] had somehow got up top of some logs with the machine and had his winch line too slack which enabled the machine basically to roll on over." (Tr. 27; emphasis added).

" * * *

"Q. You thought that the skidder, to begin with, was in the wrong space?

"A. Well, there was logs there. You could see where the tires had chewed the bark off of them, and, you know, rubber-tired machines on wood just . . . there's no traction. I mean you just don't have any control. So that's a place you never . . . you don't get.

"Q. So did you think the operator was at fault for putting the machine on logs?

"A. Personally, yeah. I don't even know how he got down there myself. But that's immaterial." (Tr. 29, 30; emphasis added).

Mr. Blumenfeld also addressed the question of "too much slack" in a winch line as an error of judgment, stating:

"A. * * * [The winch] was hooked onto some logs that were stuck where they weren't going anywhere. If the line is tight, the skid--there's no possible way the skidder can roll over. If its loose, there's nothing to hold it up * * *.

" * * *

"A. Well, the position he was at . . . that's what I perceived." (Tr. 30, 31; emphasis added).

" * * *

"Q. You'd mentioned of the need sometimes to back up slowly to get out of a bad predicament. It's true that sometimes you do find yourself in a bad predicament on a skidder out in the woods. Is that correct?

"A. Yes.

" * * *

"Q. Would you agree that if you are in a precarious position on a skidder on a slope that wet ground could make matters worse?

"A. Depending upon which direction you were pointed and if there was logs in your way. I mean there's a lot of variables to be taken apart there." (Tr. 35; emphasis added).

" * * *

"A. I'm going on previous information from the other man. He was . . . at the time before . . . right before he rolled . . . he was straight up and down the hill. But I went up there the prints and the marks of the tires showed the machine to be sideways when it started rolling, which is virtually the only way it can roll. And from what I'm understanding, he went from being straight up and down the hill, safe position, going out, to being sideways somehow. I'm not sure how it happened, but that's how he ended up. And what caused him to roll from that sideways position . . . because the cable was still attached to the logs, was the fact there was too much slack in the line." (Tr. 38, 39; emphasis added). (Also see, testimony generally, p. 27-43).

Mr. Blumenfeld's testimony is based upon too much speculation to constitute reliable (let alone clear and convincing) evidence of the actual cause of this accident.

It is not clear what caused claimant to roll the skidder--his impairment or some other factor. Here, the lay evidence of Mr. Blumenfeld is insufficient to provide the answer. To answer the "mechanical causation" question, the employer could have subpoenaed claimant or the co-worker to testify how and why the skidder was in the position it was or it could have employed an accident reconstruction expert.[1] It was the employer's burden to do so. Without clear and convincing evidence of causation, I would find that the employer failed to carry its burden of proof under ORS 656.005(7)(b)(C). On these grounds, I respectfully dissent.

[1] An "expert" witness may not be needed in every case. After all, a lay witness may testify, e.g., that the light was red and the driver failed to stop thereby causing the collision. Whether expert or lay, the testimony is not probative if it is speculative or, in the case of ORS 656.005(7)(b)(C), not highly probable.

March 29, 1995 Cite as 47 Van Natta 478 (1995)

In the Matter of the Compensation of
DAVID B. WEIRICH, Claimant
WCB Case No. 94-01055
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Neal's order that affirmed an Order on Reconsideration that awarded no permanent disability. In his brief, claimant contends that the Referee erred in failing to admit Exhibit 47A into evidence. On review, the issues are evidence and extent. We affirm.

FINDINGS OF FACT

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

Claimant compensably injured his low back on November 30, 1992. SAIF accepted claimant's claim as a "lumbosacral sprain/strain." On February 27, 1993, claimant was examined by the Medical Consultants Northwest. The Consultants reported that claimant's strain had resolved without residuals. In early March 1993, claimant's treating doctor, Dr. Gray, released him for regular work. In a March 18, 1993 report, Dr. Gray agreed with the conclusion of the Consultants.

A May 18, 1993 Notice of Closure closed claimant's claim with an award of temporary disability, but no permanent disability. Subsequently, an October 28, 1993 Notice of Closure modified claimant's temporary disability award.

Claimant requested reconsideration of the Notice of Closure. He was examined by medical arbiter, Dr. Platt, on December 15, 1993. Dr. Platt reported impairment due to claimant's preexisting disc bulges and spinal stenosis.

On January 5, 1994, Dr. Gray replied to a request from claimant's attorney. Dr. Gray reported that claimant's compensable injury caused his preexisting degenerative disc disease to become symptomatic.

Based on the medical arbiter's report, a January 20, 1994 Order on Reconsideration affirmed the Notice of Closure award of no permanent disability.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

The Referee excluded Exhibit 47A, a January 5, 1994 report by claimant's attending physician, Dr. Gray, regarding the causal relationship between claimant's compensable injury and his permanent impairment. The Referee' s ruling was based on the ground that the exhibit's admission was prohibited by ORS 656.268(7) which limits medical evidence generated subsequent to the medical arbiter's report. For the following reasons, we agree with the Referee that the "post-medical arbiter" report of Dr. Gray is not admissible.

Evidence relating to a claimant's disability that was not submitted on reconsideration may be considered by a referee at hearing, provided that no other statutory limitations on evidence are applicable. See Safeway Stores v. Smith, 122 Or App 160 (1993). ORS 656.268(7) provides in part that, "[t]he findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure." ORS 656.268(7). The court has interpreted the statute as prohibiting the admission of medical evidence of the worker's impairment that was developed after the medical arbiter's report. See Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993).

Notwithstanding the aforementioned statute and case law, we previously concluded that medical evidence concerning the causal relationship between the compensable injury and the permanent impairment necessary to determine the extent of a worker's permanent impairment under ORS 656.214(5) was not excluded by ORS 656.268(7). Frank H. Knott, 46 Van Natta 364 (1994). In Knott, we strictly construed ORS 656.245(3)(b)(B) and concluded that, because the statute referred only to impairment findings, the limitation set forth in ORS 656.268(7) applied to impairment findings set forth in a post-medical arbiter medical report, but did not limit post-arbiter evidence concerning the causal relationship between a compensable injury and permanent impairment. See Frank H. Knott, supra; ORS 656.214(5). However, in light of our recent decision in Daniel L. Bourgo, 46 Van Natta 2505 (1994), we now re-examine our holding in Knott.

In Bourgo, we held that a "supplemental" medical arbiter report was not admissible at hearing. We reasoned that ORS 656.268(6)(a) had been amended to permit admission of an initial medical arbiter report that was requested, but not completed, before expiration of the statutory time limit for the Department's reconsideration. However, we held that a "supplemental," or "clarifying," arbiter report generated after a completed medical arbiter report constituted "subsequent medical evidence" of the workers' impairment, and, therefore, was prohibited from being admissible, pursuant to ORS 656.268(7). We have found exceptions to our holding in Bourgo, however, in cases in which an arbiter's report was incomplete (as represented by the arbiter or Department), and a supplemental arbiter's report was admitted at hearing in order to complete the prior report. Daniel L. Bourgo, supra; Ryan F. Johnson, 46 Van Natta 844 (1994).

Our reasoning in Bourgo was premised on the language of the statutes and an examination of the legislative history concerning the reconsideration process. Specifically, we found support for our decision in the expressed legislative intent of avoiding a litigious system and "dueling doctors" in the reconsideration process. Daniel L. Bourgo, supra.

Here, we find that the plain language of the statute, i.e., "medical evidence of the worker's impairment," pertains to the preclusion of medical evidence of not only impairment findings, but also causation of impairment. ORS 656.268(7). Furthermore, after again considering the legislature's intent to limit "dueling doctors" and prolonged litigation involving extent cases, we conclude that permitting subsequent medical evidence of causation does not further that intent. Moreover, we find that this interpretation of ORS 656.268(7) provides a "bright-line" for the parties litigating extent of permanent disability issues.

Consequently, other than the "arbiter-described" or "Department-acknowledged" incomplete report exception set forth in the Bourgo decision, "post-arbiter report" medical evidence is not admissible at hearing under ORS 656.268(7), regardless of whether the proposed medical evidence concerns "impairment" or "causation of impairment" for purposes of rating permanent disability.

Therefore, we now conclude 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).[1] Accordingly, because our decision in this case is directly contrary to our decision in Frank H. Knott , we disavow Knott.[2]

Here, the exhibit at issue, Exhibit 47A, is a letter from Dr. Gray, claimant's attending physician at the time of claim closure which addresses the causal relationship between claimant's compensable injury, his preexisting degenerative condition and his permanent impairment. Consistent with the reasoning set forth above, we conclude that, because Exhibit 47A was generated after the medical arbiter's report, it is not admissible. ORS 656.268(7); Daniel L. Bourgo, supra. The Referee's evidentiary ruling is, therefore, affirmed.

Extent of Unscheduled Permanent Disability

Because Exhibit 47A provided the only evidence supporting an award of permanent disability, and we have above held that the aforementioned exhibit is not admissible, we agree with the Referee's conclusion that claimant has failed to establish an entitlement to an award of permanent disability. We, therefore, adopt and affirm the Referee's conclusions on the issue of extent of permanent disability.

ORDER

The Referee's order dated April 28, 1994, as reconsidered on June 1, 1994, and June 6, 1994, is affirmed.

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[1] We further note that we have previously held that, in the absence of evidence that an arbiter rated impairment due to causes other than the claimant's compensable injury, we have attributed an arbiter's impairment findings as due to the compensable injury. See Edith N. Carter, 46 Van Natta 2400 (1994); David J. Schafer, 46 Van Natta 2298 (1994).

[2] In reaching this conclusion, we again acknowledge the potential impact our decision may have on cases in which an "erroneous" medical arbiter report has issued. However, as we explained in Bourgo, the parties are not without options. Daniel L. Bourgo, supra, 46 Van Natta at pages 2507-08, n. 2. Moreover, impairment determinations are based on the preponderance of the relevant medical evidence. See Raymond L. Owen, 45 Van Natta 1528 (1993), aff'd Roseburg Forest Products v. Owen, 129 Or App 442 (1994). Finally, as demonstrated by our recent decision in Georgia E. Wilson, 47 Van Natta 387 (1995), we are authorized to correct scrivenor's errors in medical arbiter reports which refer to the wrong body part.

Board Members Haynes and Neidig specially concurring.

It is with a certain degree of consternation that we concur with the majority's conclusion. Those concerns primarily center on the limited options available to an aggrieved party if an Order on Reconsideration has granted permanent disability for a noncompensable condition erroneously measured by a medical arbiter. Nevertheless, for the reasons expressed in the Bourgo holding, we share the majority's interpretation of the statutory scheme.

In other words, the prohibition of "post-medical arbiter report" medical evidence as contained in ORS 656.268(7) applies to all medical evidence. Whether that evidence is intended for impairment and/or causation purposes, the concerns contained in the legislative history regarding the reduction of litigation and the elimination of "dueling doctors" are no less relevant.

Likewise consistent with the aforementioned statutory scheme, a carrier can implement certain claim processing measures to appreciably reduce the potential for erroneous permanent disability awards. Specifically, prior to claim closure, the carrier should clearly and unambiguously identify a claimant's compensable and noncompensable conditions. Such information can be instructive to the Appellate Unit, as well as to the medical arbiter who is obligated to conduct an examination in accordance with the Unit's wishes.

In addition, pending issuance of the arbiter report and reconsideration order, the carrier must closely monitor the claim in order to immediately identify potential problems in impairment evaluations. Should such errors arise, the carrier can promptly alert the Appellate Unit to the problem preferably prior to issuance of the reconsideration order or, if not, shortly thereafter, in an effort to seek correction of the error. See OAR 436-30-008(1), (3).

Not only are these methods representative of efficient claim processing, but adherence to such principles can virtually eliminate the likelihood of an erroneous permanent disability award. Moreover, in light of the prohibitions of ORS 656.268(7), it would appear that such claim monitoring was intended by the creators of the claim evaluation system.

March 30, 1995 Cite as 47 Van Natta 481 (1995)

In the Matter of the Compensation of
RAYMOND A. BAKER, Claimant
WCB Case No. 94-06707
ORDER ON RECONSIDERATION
Black, Chapman, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of the Board's Order on Review dated February 28, 1995. In our order, we affirmed the Referee's dismissal of SAIF's request for hearing from an Order on Reconsideration/Notice of Closure as untimely.

On review, SAIF contended that its untimely hearing request should be excused because the May 25, 1994 Order on Reconsideration was mailed to another insurer (Liberty Northwest) rather than SAIF. Citing Anton V. Mortensen, 40 Van Natta 1177, 1179, on recon 40 Van Natta 1702 (1988), SAIF asserted that, because it was not properly mailed, the reconsideration order in this case was not issued until the date SAIF was actually notified that the May 25, 1994 order had issued. Relying on an interoffice memo of June 28, 1994 from a claims assistant (Ms. Coburn), SAIF alleged that it was not notified until June 1, 1994 that an Order on Reconsideration had issued. Under these circumstances, SAIF contended that its June 2, 1994 hearing request was timely because it was filed within one day of actual notice of the Order on Reconsideration. (Since claimant had requested reconsideration on the 180th day from the Notice of Closure, both parties had only one day from the mailing date of the reconsideration order within which to request a hearing. See ORS 656.268(6)(b)).

In our order, we found that Ms. Coburn's unsworn memorandum was insufficient evidence that the Department improperly mailed the reconsideration order. We also rejected SAIF's request that we infer a 30-day appeal period when a party requests reconsideration at the end of the 180 day period in which to request a hearing on a Determination Order or Notice of Closure under ORS 656.268(6)(b). While acknowledging that it may be burdensome for SAIF to maintain daily contact with the Department in order to determine when an Order on Reconsideration will issue, we concluded that this was a problem more appropriately addressed by the legislature.

In its request for reconsideration, SAIF makes several arguments in support of its contention that our order was incorrect. Based on the following reasoning, we are not persuaded by SAIF's contentions.

SAIF initially contends that the parties "in essence" stipulated that there was no issue about whether there was improper mailing and, therefore, that we erred in reaching the issue. However, we find nothing in the record, which was limited to the exhibits admitted into evidence, that amounts to a stipulation by claimant that the reconsideration order was improperly mailed to Liberty Northwest. Moreover, the Referee's order does not contain such a stipulation. In fact, claimant asserted in his respondent's brief that there was inadequate evidence in the record of improper mailing of the Order on Reconsideration. Thus, we conclude that there was an issue as to whether the reconsideration order was improperly mailed. For the reasons detailed in our prior order, the record does not support a finding of improper mailing.

In our order, we noted that there was no indication on the copy of the reconsideration order in the record that it had been mailed to Liberty Northwest. SAIF now encloses a copy of the reconsideration order which it alleges was sent to Liberty Northwest. It contains a May 26, 1994 date stamp in the right hand margin which SAIF asserts was made by Liberty and is, thus, proof that the reconsideration order was improperly mailed. SAIF requests that we take "administrative notice" of that copy of the Department's Order on Reconsideration.

SAIF is correct that we can take administrative notice of agency orders such as an order on reconsideration. See Helen J. Bohnenkamp, 46 Van Natta 1587, 1590 (1994). However, what SAIF is really asking the Board to do is take notice of a date stamp that it asserts was made by Liberty Northwest and find as a fact that Liberty mistakenly received the reconsideration order on May 26, 1994. Inasmuch as the date stamp (as opposed to the Order on Reconsideration itself) is not a fact that is "capable of ready determination by resort to sources whose accuracy cannot reasonably be questioned," we decline SAIF's request for administrative notice. See Rodney J. Thurman, 44 Van Natta 1572 (1992) (no administrative notice of an insurer prepared form 1502).

Moreover, we also decline SAIF's request that we remand this case to the Referee for further development of the record on the issue of improper mailing. We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

It is incumbent on a proponent of a position to be prepared to fully develop the record at the hearing. Because the Board's decision in Mortensen was in existence at the time of the hearing, SAIF should have known that it had to establish the fact of improper mailing of the reconsideration order. We, therefore, find no compelling basis for remand so as to permit SAIF the opportunity to further develop the record, when there has been no showing that evidence of improper mailing could not have been obtained with the exercise of due diligence.

SAIF next contends that the Board improperly based its decision on the hearsay nature of Ms. Coburn's memorandum. SAIF correctly points out that hearsay is admissible in workers' compensation proceedings, inasmuch as 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).

However, the basis for our finding of insufficient evidence of improper mailing did not turn on the admissibility of hearsay evidence. In other words, Ms. Coburn's memorandum was admissible, but its probative value was limited and was insufficient to establish, based on the record developed at hearing, that the reconsideration order was improperly mailed.

Finally, SAIF renews its contention that it has been denied "due process" because it lost an opportunity to request a hearing from an Order on Reconsideration because the 180-day appeal period ran before it had received the order. However, SAIF focuses on the date it received the reconsideration order, when ORS 656.268(6)(b) is based on date of mailing. In other words, SAIF had the opportunity at hearing to contest the reconsideration order by proving improper mailing. The fact that SAIF has failed to prove on this record that there was improper mailing, and, therefore, that its hearing request was timely filed, does not constitute a violation of its rights to due process of law.

Accordingly, we withdraw our February 28, 1995 order. On reconsideration, as supplemented herein, we republish our former 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
THOMAS R. JARRELL, Claimant
WCB Case No. 94-01374
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Claimant requests abatement and reconsideration of our March 2, 1995 Order on Review that modified the Director's order to award vocational assistance and awarded an out-of-compensation attorney fee. Claimant asserts that the insurer's notice of ineligibility for vocational assistance constitutes a denial of a claim for compensation and, because his attorney prevailed over such denial, he is entitled to an assessed attorney fee under ORS 656.386(1). Claimant relies on SAIF v. Allen, 320 Or 192 (1994), arguing that it effectively overruled Simpson v. Skyline Corp., 108 Or App 721 (1991).

In order to consider this matter, we withdraw our March 2, 1995 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
RALPH L. REED, Claimant
WCB Case No. 92-13721
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Jeffrey R. Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of that portion of Referee Neal's order that terminated his permanent total disability award. Claimant also moved to strike the testimony of the SAIF Corporation's vocational expert, Mr. Stipe. SAIF cross-requests review for clarification concerning the date that claimant's entitlement to permanent total disability benefits terminated. On review, the issues are evidence and entitlement to permanent total disability.

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

Preliminarily, claimant moves to strike the testimony of the SAIF Corporation's expert witness, Mr. Stipe (vocationalist). (App. Br. at 8). Claimant initially made this motion at hearing, asserting that Mr. Stipe was biased in favor of SAIF. (Tr. 550). We conclude that claimant's concerns regarding bias go to the weight afforded Mr. Stipe's testimony, not its admissibility. James A. Cross, 43 Van Natta 2475, 2476, on recon 43 Van Natta 2630 (1991) (Referee abused his discretion in excluding the offered testimony of a vocational expert regarding the merits of the claimant's entitlement to permanent and total disability). In any event, claimant had an opportunity to cross-examine Mr. Stipe regarding the objectivity of his testimony and any potential bias.

Claimant also contends that Mr. Stipe's testimony is not admissible because it was beyond the scope of rebuttal and could be properly admitted only during SAIF's case-in-chief. We disagree. The Referee is not bound by technical or statutory rules of procedure. ORS 656.283(7). Furthermore, claimant's opportunity to cross-examine Mr. Stipe again cured any potential prejudice that might have occurred.

Accordingly, we find no merit to claimant's motion to strike Mr. Stipe's testimony. The motion is denied.

When a carrier seeks to terminate or modify a permanent total disability award, it has the burden to prove that the claimant presently is able to engage in a gainful and suitable occupation. See Harris v. SAIF, 292 Or 683, 690 (1982). A "suitable occupation" is defined by ORS 656.206(1)(a) 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." "Gainful occupation" has been construed to mean work that provides "profitable remuneration." Tee v. Albertsons, Inc., 314 Or 633, 643 (1992).

Claimant argues that SAIF did not sustain its burden to prove that he is able to maintain gainful and suitable employment. We disagree.

Dr. Steinhauer (specializing in physical medicine and rehabilitation) performed a physical capacities evaluation of claimant in October 1991. (Ex. 29). Steinhauer also sat through all five days of the hearing proceedings and reviewed the exhibits, including surveillance films of claimant's activities at home. It was Dr. Steinhauer's opinion that claimant was presently capable of working eight hours each day in the "light category, which would be 25 to 30 pound range." (Tr. II at 124).

Dr. Binder (neuropsychologist) also evaluated claimant in October 1991. (Ex. 35). He found no objective evidence of cognitive impairment and opined that claimant "is capable of working successfully as a sorter/bagger, a wiper/cutter, a sorter, assembler, or a packager." (Ex. 35-5).

Ms. Bostwick (certified rehabilitation counselor) authored an employability evaluation of claimant in January 1992. (Ex. 36). She initially identified seven types of "light" duty occupations that claimant was capable of performing (e.g., garment sorter, cutlery or small parts assembler, metal finisher). (Ex. 36-4). In surveying the actual labor market for work within claimant's capacities, Ms. Bostwick found 277 potential job openings in the wage range of $5.27 to $5.65 per hour. Id. After viewing SAIF's surveillance evidence, Ms. Bostwick revised her earlier assessment of claimant's residual employability and identified approximately 1900 employment service openings with a median wage ranging from $4.75 per hour up to $9.42 per hour. (Ex. 67).

Additionally, SAIF presented testimony from Mr. Stipe (vocational counselor) that, based upon his observations of claimant and the evidence presented at hearing, claimant was "competitively employable and that there are suitable jobs out there within a reasonable commuting distance to his residence that are gainful and suitable." (Tr. II. at 590).

Based on the preponderance of evidence, we find that claimant is capable of full time employment at wages equivalent to or greater than minimum wage. See Kytola v. Boise Cascade Corp., 78 Or App 108, 112 (1986) (An award of permanent total disability can be modified if a preponderance of the evidence demonstrates that the claimant is presently employable). In reaching our conclusion, we rely upon the well-reasoned and complete expert opinions of Dr. Steinhauer, Dr. Binder, Ms. Bostwick and Mr. Stipe. See Somers v. SAIF, 77 Or App 259 (1986). Thus, we find that SAIF has met its burden of proving that claimant is currently able to engage in suitable and gainful employment. Harris v. SAIF, supra.

Regarding SAIF's cross-request for review, we conclude that claimant was no longer permanently and totally disabled as of March 2, 1994, the last date of hearing. SAIF is allowed to offset permanent total disability payments made after that date against the permanent partial disability awarded by the Referee.

ORDER

The Referee's order dated May 6, 1994 is modified in part and affirmed in part. Claimant's permanent total disability award is terminated as of March 2, 1994. The SAIF Corporation is allowed to offset permanent total disability payments made after March 2, 1994 against the permanent partial disability awarded by the Referee. The Referee's order is otherwise affirmed.

In the Matter of the Compensation of
DOUG S. WALLS, Claimant
WCB Case No. C5-00453
INTERIM ORDER REFERRING FOR HEARING
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

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.

On March 3, 1995, the Board requested that the parties provide their respective positions on two issues arising from the CDA. First, the Board noted that the CDA provided for an attorney fee, but claimant had informed the Board that he had fired his attorney. The CDA did not provide the signature of claimant's former counsel. Additionally, the Board noted claimant had submitted an unexecuted termination agreement along with the CDA. Claimant's letter accompanying the CDA indicated that he had refused to sign the termination agreement, but wished to obtain approval of the CDA.

In response to the Board's letter, the self-insured employer has submitted its written position. The employer contends that it offered claimant a total settlement amount of $24,000, to be apportioned between the CDA and the termination agreement. The employer contends that it would not have been willing to enter into a CDA unless claimant also signed the termination agreement. The employer argues that, because claimant obtained the CDA and submitted it without also signing the termination agreement, the CDA should be disapproved on the basis that the disposition is the result of an intentional misrepresentation of material fact. See ORS 656.236(1)(b).

Claimant's former counsel has also submitted his written response. Former counsel agrees with the employer that the settlement was negotiated as a "combination deal." Counsel takes no position on whether the CDA should be approved or disapproved. However, if the Board approves the CDA, claimant's former counsel seeks approval of the attorney fee provided for in the CDA.

Finally, claimant's response provides that when he first hired his attorney, he informed the attorney that he did not want a "combination deal." Claimant argues that he fired his attorney when counsel told him he would have to sign the termination agreement in order to receive the CDA settlement. Claimant contends that the termination agreement has nothing to do with the CDA, and therefore, the CDA should be approved. Claimant also agrees that, if the CDA is approved, an attorney fee for his former counsel, in the amount stated on the summary sheet of the CDA, should be paid to his former attorney.

As documented by the aforementioned summary of their respective versions of events, the parties have taken contrary positions on the issue of whether the CDA was part of a "combination deal" which included a termination agreement. In light of these contrary positions, we conclude that it is appropriate to refer this matter to the Hearings Division for the sole purpose of a fact finding hearing on the issue raised by the employer's letter; i.e., whether the proposed CDA is the result of an intentional misrepresentation of material fact.[1] In presenting their respective positions, the parties are also requested to address the effect, if any, that the Board's holding in Karen A. Vearrier, 42 Van Natta 2071 (1990)(Board disapproved a CDA which purported to release the claimant's right to reemployment under

[1] In referring this matter for a fact finding hearing, we conclude that the present case is distinguishable from Michael L. Clark, 43 Van Natta 61 (1991). In Clark, we found that the claimant had not adequately explained discrepancies between employment records and his representations during CDA negotiations. Accordingly, based on the record, the CDA was set aside on the basis that the agreement was the result of an intentional misrepresentation of material fact. In the present case, however, claimant contends that he has never agreed to a "combination deal," involving a CDA and a termination agreement. Therefore, because claimant's statements and the employer's statements cannot be reconciled, we find that this case involves an issue of credibility, and a fact finding hearing is necessary in order to gauge the credibility and/or reliability of the parties involved.

Chapter 659, as such matters are not proper for disposition under ORS 656.236) has on this dispute. A copy of the Vearrier decision is included with claimant's, the employer's attorney's, and claimant's former counsel's copies of this order.

Finally, by this order, we appoint Monte Marshall as special hearings officer to preside over the hearing. We retain jurisdiction over this matter. Following the hearing, Hearings Officer Marshall is instructed to issue a recommendation concerning what action we should take regarding this claim disposition matter. Hearings Officer Marshall's recommendation should also discuss the implications of the Vearrier holding on this matter. Once Hearings Officer Marshall's recommendation is issued, a briefing schedule will be implemented to provide the parties with an opportunity to respond to the recommendation. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Complying Status of
DAN J. LANE and GISELLE LANE, Employers
WCB Case No. 92-08414
and, In the Matter of the Compensation of
MARSHALL K. BIRDWELL, Claimant
WCB Case No. 92-09931
ORDER ON REMAND
Susak, Dean & Powell, Claimant Attorneys
Schwabe, et al., Attorneys
Roderick D. Peters (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Lane v. SAIF, 132 Or App 372 (1995). The court has reversed our prior order that affirmed and adopted the Referee's order determining that Dan and Giselle Lane were noncomplying employers and upholding the SAIF Corporation's acceptance of claimant's head and back injury claim on behalf of Dan and Giselle Lane. Citing S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614 (1994), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In December 1990, claimant fell while roofing a house owned by Dan and Giselle Lane and filed a claim for his injuries. In June 1992, the Department declared Dan and Giselle Lane to be noncomplying employers. In July 1992, SAIF accepted the claim. The Lanes requested a hearing contesting the Department's order and SAIF's acceptance.

Applying ORS 656.600, the Referee found that Dave Robertson, who the Lanes hired to work on the roofing project, was not an independent contractor but a subject worker. Because the Lanes also did not have workers' compensation insurance, the Referee agreed that the Lanes were noncomplying employers and affirmed the Department's order. The Referee further determined that claimant was a subject worker of the Lanes, and not Robertson, and upheld SAIF's acceptance. On review, we affirmed and adopted the Referee's order.

Following the Lanes' appeal to the Court of Appeals, the Supreme Court issued S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra, holding that, when deciding whether a person comes under the workers' compensation law, the first inquiry is whether the person is a "worker" under ORS 656.005(28) and the "right to control" test and, if so, whether the worker is "nonsubject" under one of the exceptions in ORS 656.027. 318 Or at 630-31. Only when there is an issue whether one is a "nonsubject worker" under ORS 656.027(7), (8), or (9) does a determination under ORS 656.600 become necessary. Id. at 623.

In this case, the court accepted SAIF's concession that our order should be reconsidered under the legal test announced in S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra, and reversed and remanded. Lane v. SAIF, supra. We proceed with our reconsideration.

As indicated above, to determine whether the relationship between the parties is that of "worker" and "employer," we first apply the "right to control" test. Woody v. Waibel, 276 Or 189, 196 (1976). The factors to consider in applying such test include: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Castle Homes, Inc. v. Whaite, 95 Or App 269, 272 (1989).

While constructing his house, Dan Lane made an arrangement with Dave Robertson to build a roof whereby Robertson bought the roofing material at cost in exchange for a specific tool; both would provide the labor. After Lane and Robertson realized that they needed a third person to build the roof, Robertson contacted claimant and offered him work. Claimant was injured when he fell from the roof. The dispute is not whether claimant was a "worker"; rather, the issue is whether such factors show that the Lanes, particularly Dan Lane, was claimant's "employer."

With regard to the first factor, we determine whether Dan Lane had control over the method of performance and not just the result to be reached. See, e.g., Cy Investment, Inc. v. Natl. Council on Comp. Ins., 128 Or App 579, 583 (1994). Although there is evidence that Robertson directed the roofing activity because he had the greater expertise in such work,[1] we find proof that Lane also exercised control over claimant's performance. According to claimant's credible testimony, while roofing, he took direction from both men. (Tr. 144, 148). Claimant also performed other work on the house at Lane's request in Robertson's absence when the weather was not suitable for roofing, such as caulking windows, working on the soffits, and helping Lane dig a ditch. (Id. at 145, 182).

With regard to the second factor, the record clearly shows that claimant was paid by the hour, which is strong evidence of employee status. See Kaiel v. Cultural Homestay Institute, 129 Or App 471, 476 (1994) (citing 1B Larson, Workmen's Compensation Law 8-107, § 44.33(a) (1993)). Furthermore, Lane paid claimant for the hours that he worked.[2] (Tr. 93).

Claimant furnished no equipment except a hammer. (Id. at 143). Claimant used a tool belt that had been used by Robertson's former employee. (Id. at 84, 144). Although there was evidence that Lane provided some equipment, including some scaffolding and a scissors lift, Robertson furnished the bulk of the equipment, including the roofing materials, an orchard ape, rope, scaffolding, and screw guns. (Id. at 85, 87, 146, 178).

With regard to the last factor, Lane testified that he would have told Robertson to fire claimant if he had not liked his work. (Id. at 122-23). We consider such testimony proof that Lane had some right to fire claimant, although limited to directing Robertson to perform his authority to terminate claimant.

Considering the factors together, we agree with the Referee that there was an employer/employee relationship between Lane and claimant. We are especially persuaded by the evidence described above showing that Lane exercised control over claimant's work performance and paid claimant for his work. Such evidence is more convincing regarding the relationship between Lane and claimant than the fact that Robertson furnished the bulk of the equipment. Thus, we conclude that

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[1] For instance, Lane's neighbor testified that he witnessed Robertson directing Lane and claimant from the ground while both men were roofing. (Tr. 30). Lane also testified that Robertson determined when the weather permitted them to roof and no roofing was performed in Robertson's absence. (Id. at 96, 89).

[2] During initial Board review and before the Court of Appeals, Lane argued that his payment for claimant's work should not be considered evidence that he was claimant's employer since he did so only because Robertson had not paid claimant. We find that the preponderance of evidence shows that Lane expected to pay claimant for his work. Both Lane and claimant testified that, before claimant began working, Lane told claimant to keep track of his hours. (Tr. 143, 184). Lane also testified that he told Robertson he would "reimburse" him for claimant's labor costs. (Id. at 82-83, 119). We find that such evidence shows that Lane considered himself ultimately responsible for paying claimant's wages, although he may have expected Robertson to initially pay claimant. This finding is further supported by Lane himself paying claimant when he discovered that Robertson had not done so.

Lane had the right to control claimant's work.[3] Furthermore, we find no application of any of the exceptions listed in ORS 656.027 which would render claimant a "nonsubject worker." Hence, we affirm the Referee's order finding Dan and Giselle Lane to be noncomplying employers.

Accordingly, on reconsideration, we republish our June 30, 1993 order, as supplemented and modified herein, including the assessed attorney fee award of $1,000 for services on review payable by SAIF, on behalf of the Lanes.

[3] In reaching this conclusion, we emphasize that Robertson is not a party to this proceeding. Rather, the issue is limited to whether there was an employer/employee relationship between Dan Lane and claimant. Because we find sufficient evidence that Dan Lane had the right to control claimant's work, we conclude that claimant was a "worker" for Dan Lane whether or not the "right to control" test also would be satisfied with regard to the relationship between claimant and Robertson.

In the Matter of the Compensation of
NORMAN H. PERKINS, Claimant
WCB Case No. TP-94007
THIRD PARTY DISTRIBUTION ORDER
Lundeen, et al., Defense Attorneys

Liberty Northwest Insurance Corporation (Liberty), as paying agency, has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute concerns Liberty's entitlement to a share of the proceeds resulting from claimant's settlement with a third party. We conclude that a distribution in which Liberty receives reimbursement for its claim costs from the remaining balance of settlement proceeds would be "just and proper."

FINDINGS OF FACT

In September 1993, while performing his work activities, claimant was injured in a motor vehicle accident. The car he was driving was rear-ended by another vehicle.

Claimant filed a claim for "chest pains, neck and back injury." Thereafter, the insurer accepted claimant's injury claim for "chest wall sprain, sinus bradcardia secondary to 9/27/93 injury." To date, the insurer has incurred claim costs totalling $5,581.06. These expenses are comprised of temporary disability ($366.30) and medical bills ($5,214.76).

In August 1994, claimant settled his potential negligence action with the third party. The settlement, which was achieved without Liberty's approval, totalled $9,800.

When Liberty sought to recover a share of the settlement proceeds, claimant refused. Claimant reasoned that Liberty had not previously indicated that it was entitled to a share of the third party recovery. Moreover, claimant assumed that it was Liberty's responsibility to satisfy its lien with the third party insurer.

Liberty has petitioned the Board for resolution of the parties' dispute. Although it does not challenge the settlement, Liberty seeks its "just and proper" share of the proceeds.

CONCLUSION OF LAW AND OPINION

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). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury as a result of the negligence or wrong of a third person. The claim was accepted by Liberty, who has provided compensation. Inasmuch as Liberty has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576. Moreover, when claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable. In other words, by virtue of the aforementioned statutory provisions, Liberty's lien for its claim costs automatically attaches to claimant's recovery and that lien is preferred to all other claims.

Since claimant settled his third party claim and Liberty has approved that settlement, Liberty 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 he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). 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).

Here, because claimant was not represented in settling his third party claim, no deduction for attorney fees or litigation expenses is necessary. After claimant's statutory 1/3 share of the $9,800 settlement is deducted ($3,267), a balance of $6,533 remains. That remaining balance is the portion of the settlement proceeds from which Liberty seeks satisfaction of its $5,214.76 lien. Thus, we proceed to determine whether it is "just and proper" for Liberty to recover its lien from the remaining balance of settlement proceeds.

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.

Here, Liberty contends that, following distribution of claimant's statutory 1/3 share ($3,267), it is entitled to full reimbursement of its $5,214.76 in claim costs from the $6,533 remaining balance of settlement proceeds. Based on the following reasoning, we agree with Liberty's contention.

In resolving this dispute, we are mindful of the court's admonishment that we must refrain from automatically applying the third party judgment scheme when determining a "just and proper" distribution for third party settlement proceeds. Urness v. Liberty Northwest, supra. 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. In other words, in exercising our statutory authority under ORS 656.593(3), we do not arbitrarily adhere to the specific distribution scheme set forth in ORS 656.593(1). Rather, 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 Liberty to receive in partial satisfaction of its lien.

Pursuant to ORS 656.593(1)(c), the paying agency shall be paid and retain the balance of a third party recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service. "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8). Where a paying agency has incurred expenditures for compensation attributable to an accepted injury claim and the claimant has not challenged the payment of those benefits, we have found it "just and proper" for a paying agency to receive reimbursement for such claim costs. Jack S. Vogel, 47 Van Natta 406 (March 9, 1995).

Claimant does not contest Liberty's assertion that it incurred the aforementioned $5,214.76 in temporary disability and medical expenses while processing claimant's injury claim. Instead, asserting that he "made every effort to be a responsible party" and contending that Liberty did not notify him of its lien rights, claimant argues that Liberty should not be entitled to a share of the settlement proceeds.

Claimant has apparently interpreted Liberty's lack of interest in his decision to individually pursue a third party action as also an indication that it would have no claim to a portion of any third party recovery. However, as explained above, regardless of whether a worker chooses to initiate a third party action on his own behalf, the statutory scheme provides for the automatic attachment of the insurer's lien to any third party settlement. It is unfortunate that claimant did not fully comprehend his statutory rights and accompanying obligations as an injured worker seeking a third party recovery. Nevertheless, the statute clearly and unambiguously secures an insurer's right to recover a "just and proper" share of a third party settlement in reimbursement of its claim costs incurred as a result of the compensable injury involving the negligent third party.

Here, as previously mentioned, claimant does not dispute Liberty's claim that it incurred $5,214.76 in claim expenses for temporary disability benefits and medical bills. Inasmuch as these expenditures constitute "compensation" which has previously been provided to claimant, we find it "just and proper" for Liberty to receive reimbursement for these expenses from claimant's third party settlement. See ORS 656.593(3); Jack S. Vogel, supra.

Consequently, the settlement proceeds shall be distributed in the following manner. Claimant is entitled to retain his statutory 1/3 share ($3,267), as well as the balance of proceeds remaining ($951.94) after he distributes $5,214.76 to Liberty as reimbursement for its claim costs.

Accordingly, claimant is directed to distribute $5,214.76 of the proceeds to Liberty as its "just and proper" share of the third party settlement.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

Cite as 131 Or App 382 (1994) November 23, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James J. Hinkley, Claimant.

James J. HINKLEY, *Petitioner,*
v.
OREGON STATE POLICE and SAIF Corporation, *Respondents.*
(92-12151, 92-12150; CA A82873)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 21, 1994.
Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi Wilson Atchison.
Steven R. Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Rossman, Presiding Judge, Richardson, Chief Judge, and Leeson, Judge.
ROSSMAN, P. J.
Affirmed.

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131 Or App 384> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in refusing to award interest on compensation paid in installments after the lifting of a stay on payment of compensation.

In 1987 and 1990, claimant experienced compensable injuries. In January, 1992, a referee awarded claimant permanent partial disability benefits. SAIF appealed to the Board and obtained a stay of payment of the entire award pursuant to ORS 656.313(1)(a). However, in July, 1992, the Board issued an order affirming the referee. SAIF did not appeal.

ORS 656.313 provides for the stay of payment of compensation pending a request for Board review. Interest accrues on compensation that has been stayed and is ultimately found payable:

> "If ultimately found payable under a final order, *benefits withheld under this subsection* shall accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through the date of payment." ORS 656.313(1)(b). (Emphasis supplied.)

On August 25, 1992, SAIF made a payment on the compensation due under the referee's and Board's orders. SAIF computed the total amount of compensation due to be $19,555.20 and chose, pursuant to ORS 656.216 and ORS 656.230(2), to pay the compensation in installments over 12 months, the last payment to be made in July, 1993. Claimant's counsel requested payment of interest due, and on September 4, 1992, SAIF paid claimant $1,123.49 in interest for the period of January 16, 1992, the date of the order, through September 4, 1992, the date of the interest payment. Claimant contends that, under the provisions of ORS 656.313(1) (B), he is entitled to interest each month on the remaining compensation due until the entire amount was paid in July, 1993.

We agree with the Board that benefits paid by monthly installment subsequent to the lifting of the stay are not "benefits withheld" pursuant to the stay. The insurer was required, absent application to the director by claimant under ORS 656.230(1), to pay claimant his benefits monthly, rather than in a lump sum. ORS 656.216(1); ORS 656.230(2); **<131 Or App 384/385>** OAR 436-60-060(1); OAR 436-60-150(6), (7). Claimant made no request for lump sum payment. Any amounts owed to claimant after SAIF began making monthly payments were not pursuant to the stay that issued under ORS 656.313, but a result of the statutory provisions making benefits payable in installments. We hold that permanent partial disability awards paid in installments do not constitute benefits withheld under ORS 656.313 and that interest does not accrue during the period the insurer is making installment payments.

Affirmed.

Cite as 131 Or App 519 (1994) December 7, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael S. Blackwell, Claimant.

SAIF CORPORATION and US/LTA Corporation, *Petitioners*,
v.
Michael S. BLACKWELL, *Respondent*.
(93-01486; CA A83105)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 16, 1994.
James W. Moller, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Allison Tyler argued the cause and filed the brief for respondent.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P. J.
Affirmed.

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131 Or App 521> SAIF seeks review of an order of the Workers' Compensation Board that awarded claimant a carrier-paid attorney fee under ORS 656.386(1) for having succeeded, without a hearing, in having SAIF issue an express acceptance of claimant's knee conditions requiring treatment. We affirm.

Claimant injured his left knee at work on May 27, 1992. The injury was initially diagnosed as a strain. By written notice dated June 16, 1992, SAIF accepted a non-disabling claim for left knee strain due to hyperextension.

In the meantime, claimant's doctor began to suspect a ligament injury. Claimant had surgery on June 19, 1992, to repair a medial meniscus. The surgery also disclosed tears of the anterior cruciate ligaments as well as minor scoring of the medial femoral condyle.

On June 26, 1992, SAIF wrote to claimant to advise him that his claim was reclassified as disabling. On July 6, 1992, SAIF received its first notice that claimant might have a torn medial meniscus. The next day, SAIF received the operative report from claimant's June 19, 1992, surgery. SAIF paid for the surgery. Claimant had additional surgery on September 16, 1992, for anterior cruciate ligament reconstruction and lateral meniscus repair. SAIF processed and paid for that surgery as well. SAIF also paid for eight weeks of physical therapy. SAIF never expressly accepted or denied any of the conditions for which claimant Underwent surgery and treatment.

On February 4, 1993, claimant's counsel requested a hearing, challenging SAIF's "*de facto* denial" of the meniscal and cruciate ligament tears and the scoring of the medial femoral condyle. Claimant also challenged SAIF's initial failure to classify the claim as disabling. At the time the hearing was requested, all of claimant's medical bills had been paid and the claim was classified as disabling.

On March 23, 1993, SAIF's claims adjuster wrote a letter to claimant's counsel indicating that, although, based on what was known of claimant's condition at the time of acceptance, the originally accepted condition was left knee strain, benefits had been paid for all the conditions that have **<131 Or App 521/522>** subsequently come to light, and those conditions "are accepted as part of the original injury." The adjuster completed a Form 1502, indicating a change in the acceptance so as to include the other conditions.

At the hearing on May 5, 1993, the only issue was claimant's entitlement to a carrier-paid attorney fee under ORS 656.386(1). No evidence was taken. The referee concluded that SAIF's failure to formally accept claimant's conditions within 90 days was a *de facto* denial of the conditions, that claimant's attorney had been instrumental in obtaining compensation for claimant, and that claimant was entitled to attorney fees. The Board affirmed.

Under the Supreme Court's recent opinion in *SAIF v. Allen,* 320 Or 192, 881 P2d 773 (1994), the reports showing that claimant was in need of medical treatment for knee conditions other than knee strain were "claims" for compensation for purposes of ORS 656.386(1). Further, SAIF's conduct in failing to expressly accept or deny the claims within the required statutory period were *de facto* denials of those claims.

As the Supreme Court indicated in *SAIF v. Allen, supra,* there are at least two circumstances under which an insurer-paid attorney fee might be available under ORS 656.386(1) when no hearing is held on the merits. Attorney fees are available if the condition or injury itself has been denied, either expressly or *de facto,* and the claimant's attorney succeeds in gaining the acceptance of the condition or injury. *See Jones v. OSCI,* 107 Or App 78, 810 P2d 1318, *mod* 108 Or App 230, 814 P2d 558 (1991). Additionally, insurer-paid attorney fees are available under ORS 656.386(1) if a claim for medical treatment has been denied, either expressly or *de facto,* and it is not possible to determine whether the denial encompasses the compensability of the condition or injury for which treatment is sought, and the claimant's attorney succeeds in gaining acceptance of the treatment. *SAIF v. Allen, supra,* 320 Or at 222.

By failing to expressly accept treatment of claimant's ligament injury, SAIF denied that injury *de facto.* Before **<131 Or App 522/523>** hearing, claimant succeeded in gaining SAIF's express acceptance of the conditions as well as their treatment. Accordingly, claimant's attorney is entitled to an insurer-paid attorney fee for gaining acceptance of the denied conditions and medical bills.

SAIF contends that, because all bills had been paid, claimant's attorney was not "instrumental in obtaining compensation," as required by the statute, and he is not entitled to an insurer-paid attorney fee. We conclude that, under the Supreme Court's interpretation of the statute, it is not necessary that there be unpaid medical bills for the claimant to be entitled to insurer-paid attorney fees. The gaining of the express acceptance of the conditions is in and of itself a sufficient basis on which to award attorney fees. Considering the words "instrumental in obtaining compensation" in the context of the statute and in the light of *SAIF v. Allen, supra,* and *Jones v. OSCI, supra,* we conclude that the legislature did not intend to limit the claimant's entitlement to insurer-paid attorney fees to cases involving unpaid bills.

In summary, under *SAIF v. Allen, supra,* the compensability of a condition or injury can be denied *de facto,* because of the insurer's failure to either accept or deny the claim within the time prescribed by ORS 656.262(6), or by virtue of the insurer's failure to limit the scope of it denial of medical treatment by confining it to the amount of compensation or the extent of disability. If the claimant's attorney succeeds in gaining acceptance of a denied condition or injury or payment of the medical treatment, then the attorney has been instrumental in obtaining compensation, and the claimant is entitled to an insurer-paid attorney fee under ORS 656.386(1).

Affirmed.

Cite as 131 Or App 572 (1994) December 14, 1994

IN THE COURT OF APPEALS OF THESTATE OF OREGON
In the Matter of the Compensation of Scott Turo, Claimant.

Scott TURO, *Petitioner,*
v.
SAIF CORPORATION and Fausett Mine Service, Inc., *Respondents.*
(TP-92012; CA A80250)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 7, 1994.
Steven J. Pierce argued the cause for petitioner. With him on the brief was Pierce & Stoddard.
Michael O. Whitty, 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 Richardson, Chief Judge, and Riggs, Judge.
RICHARDSON, C. J.
Reversed and remanded for reconsideration.

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131 Or App 574> Claimant seeks review of an order of the Workers' Compensation Board, issued under ORS 656.593, distributing the proceeds of a settlement of a third-party action. He contends that the Board erred by awarding SAIF, the paying agent, reimbursement from the third-party settlement for vocational expenses and payments made to him in satisfaction of a Claim Disposition Agreement (CDA). We reverse and remand for reconsideration.

Claimant sustained a compensable injury to both feet while working as a shaft miner in 1989. SAIF, as insurer for claimant's employer, accepted the claim, provided compensation, and ultimately awarded claimant scheduled permanent disability for each foot.

In October, 1990, SAIF initiated a vocational assistance program for claimant. For about two years, claimant and SAIF engaged in a dispute about the program but claimant did not participate in any vocational program. After several proceedings about this dispute, SAIF and claimant executed the CDA. It provided that the parties agreed to

> "settle claimant's claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except compensable medical services, for the total sum of $15,000."

Claimant received the $15,000 provided in the agreement.

Coincidently with his claim for workers' compensation, claimant pursued a tort action against third parties for his injury. In April, 1992, that action was settled for $220,000. SAIF approved the settlement, ORS 656.593(3), and asserted a lien for $49,151.99 for reimbursement of claim costs under ORS 656.593. Claimant objected, *inter alia,* to reimbursement of about $7,710 for vocational expenses and for the $15,000 payment, pursuant to the CDA. Pursuant to ORS 656.593(3), the Board determined that SAIF was entitled to the full amount claimed.

In his petition for judicial review to this court, claimant only disputes SAIF's entitlement to reimbursement for vocational expenses and CDA payments. ORS 656.593(3) provides:

> **132 Or App 575>** "A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be just and proper distribution shall be resolved by the board."

A "just and proper" share of a settlement for the paying agent is an amount equal to or less than what a paying agency would be entitled to receive from a judgment in a third-party action under ORS

656.593(1) and (2). *Estate of Troy Vance v. Williams*, 84 Or App 616, 734 P2d 1372 (1987). In other words, SAIF can receive reimbursement under ORS 656.593(3) only for the types of claim expenditures authorized by ORS 656.593(1)(c).[1]

The latter provision, after describing the types of reimbursable costs includable in the lien, says that the costs "do not include any compensation which may become payable under ORS 656.273 or 656.278."

Claimant first argues that SAIF is not entitled to reimbursement for payments made under the CDA, because they are not compensation but are payments in exchange for his relinquishment of future compensation. ORS 656.005(8) provides:

> "'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries * * *."

Under the wording of the CDA, the $15,000 paid to claimant was a lump sum payment of past, present and future benefits of an accepted injury claim. We agree with the Board that the payments are "compensation."

We disagree, however, with the Board's conclusion that the entire $15,000 of CDA payment is reimbursable to SAIF. Under ORS 656.593(1)(c), the paying agent is not entitled to recover "any compensation which may become payable under ORS 656.273 or 656.278." In exchange for the $15,000, claimant released rights to future compensation **<131 Or App 575/576>** under ORS 656.273 and ORS 656.278. The portion of the CDA payment attributable to the release of those benefits is not subject to reimbursement from the proceeds of a third-party action. The Board, in allowing recovery of the full amount of the CDR payment, may have given SAIF recovery for a type of claim cost to which it was not entitled under ORS 656.593(1)(c). The full amount of the payment was not necessarily includable as part of a "just and proper" distribution under ORS 656.593(3). Because the Board, in the first instance, must determine what is a just and proper distribution, we remand for it to reconsider what portion of the CDA payment is properly reimbursable.

Claimant also contends that the Board erred in determining that SAIF should be reimbursed for vocational costs it incurred on his behalf. Vocational costs expended on the claim are "expenditures for compensation" and would be lienable under ORS 656.593(1)(c). Claimant nevertheless argues that it is not just and proper to reimburse SAIF for those costs, because SAIF's conduct in managing his vocational assistance actually prevented him from participating in a vocational program. The Board said:

"Claimant's objections to SAIF's 'vocational' lien primarily center on his dissatisfaction with SAIF's actions or inactions during the development of, and eventual rejection of, a vocational assistance program. Yet, the appropriate forum for consideration of such disputes rests with the Director. *See* ORS 656.340; OAR 436-120-001, *et seq.* In this regard, we note that, on three separate occasions, claimant exercised his right to contest SAIF's conduct regarding the processing of his vocational assistance claim. Each of these requests for administrative review were resolved (one via dismissal order and two via 'Letter of Agreement'). Moreover, claimant entered into a CDA, which provided that claimant was releasing his past, present, and future rights to a number of benefits, one of which was vocational assistance.

> "Inasmuch as claimant chose not to fully pursue the appropriate statutory and administrative avenues for resolution of his vocational assistance disputes and also actually disposed of his past, present, and future vocational assistance rights through the approved CDA, we decline claimant's invitation to prohibit SAIF from receiving reimbursement for its vocational assistance costs which were **<131 Or App 576/577>** actually incurred during the processing of claimant's compensable injury claim."

The Board's decision to allow reimbursement of the vocational costs was proper and within its discretion under ORS 656.593(3).

Reversed and remanded for reconsideration.

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[1] ORS 656.593(1)(c) has been amended in ways that do not affect the outcome of this case. *See* Or Laws 1993, ch 445, § 1.

Cite as 131 Or App 610 (1994) December 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald G. Stacy, Claimant.

Donald G. STACY, *Petitioner,*
v.
CORRECTIONS DIVISION and SAIF Corporation, *Respondents.*
(WCB Nos. 91-06613, 91-05641; CA A82556)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 18, 1994.
Max Rae 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 Deits, Presiding Judge, and Riggs and Haselton, Judges.
DEITS, P. J.
Affirmed.

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131 Or App 612> Claimant seeks review of an order of the Workers' Compensation Board denying his claim for an occupational disease and dismissing for lack of jurisdiction his aggravation claim. We affirm.

Claimant was a boiler plant operations supervisor at the Oregon State Penitentiary for 13 years. In 1985, he began experiencing stress because of problems on the job. His symptoms included headaches, stomach problems, insomnia, fatigue, depression, memory loss and irritability. He was treated by Dr. Klass, who diagnosed chronic stress disorder with depression. He also was seen by Dr. Colbach, who diagnosed chronic neurotic depression. Colbach concluded that claimant's condition would continue as long as he remained in his current job environment. Claimant was also seen by Dr. Klein, an independent medical examiner, who concluded that he had a "clinically significant depression."

Claimant filed a mental stress claim with employer, which was accepted in October, 1987. Following the acceptance of his claim, claimant's condition improved. However, his symptoms returned in 1988 and gradually worsened. He obtained further treatment from Klass and received counseling from Alderson, a clinical social worker, beginning in July, 1991. Claimant's symptoms improved in the fall of 1991, when he went on an extended vacation. However, when he returned to work, he again experienced significant stress-related problems. Klass authorized time loss in December, 1991, for a "stress-related work disorder." Claimant then filed a new occupational disease claim and an aggravation claim for his current condition. SAIF denied both claims.

Claimant sought review of the denials. The referee upheld the denial of the occupational disease claim, explaining:

> "In reaching this conclusion, I reject claimant's alternative contention that his current condition is compensable as a new occupational disease. To establish compensability under that theory, claimant must prove that his work activity *after* SAIF's 1987 acceptance of claimant's mental stress claim was the major contributing cause of his current condition. ORS 656.802. There is no medical opinion identifying claimant's subsequent work activity as the major contributing **<131 Or App 612/613>** cause of his current condition, as distinct from his prior work stresses and his underlying chronic neurotic depression. Consequently, claimant has not established compensability as a new occupational disease. His current condition should, therefore, be treated as an aggravation of his prior compensable claim." (Emphasis in original.)

The referee initially allowed claimant's aggravation claim. However, on reconsideration, the referee determined that claimant's condition worsened after his aggravation rights had expired and, therefore, there was no jurisdiction to consider the aggravation claim and SAIF's denial of that claim also should be upheld. The Board affirmed the referee's order. Claimant seeks review of the Board's order.

Claimant argues that the Board erred, as a matter of law, in upholding the denial of his new occupational disease claim. According to claimant, the Board erred because it assessed whether his work activities after his accepted 1986 disease claim were the major contributing cause of his entire current condition, rather than whether those work activities were the major contributing cause of the incremental worsening, after 1986, of his accepted compensable condition. According to claimant, under the occupational disease statute, ORS 656.802(2), a new and separate disease claim may be established by proving an incremental worsening of an accepted condition. Under claimant's approach, in deciding whether the incremental worsening qualifies as a separate occupational disease, the contribution of the work activities after the accepted claim would be considered in assessing causation, but the preexisting compensable condition would not be considered.

ORS 656.802(2) does appear to allow a worsening of a disease or condition to be established, in itself, as a separate disease. It provides:

> "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." (Emphasis supplied.)

However, contrary to claimant's position, even assuming that an incremental worsening may be proven to be a separate occupational disease, ORS 656.802(2) still requires that the **<131 Or App 613/614>** employment activities be the major contributing cause of claimant's new condition. Because a determination of major contributing cause requires the assessment of the relative contribution of different causes, *Dietz v. Ramuda,* 130 Or App 397, 882 P2d 618, *rev pending* (1994), it is necessary to consider the effect of all possible causes of a condition. In this case, that includes assessing the contribution to claimant's new condition of his underlying preexisting condition. We conclude that the Board's analysis was proper and that it did not err in concluding that claimant's subsequent work activity was not the major contributing cause of his current condition. We agree with the Board that claimant has not established a separately compensable occupational disease.

Claimant also argues that the Board erred in concluding that his aggravation rights had expired prior to the worsening of his condition. Claimant contends that the Board's finding that his condition worsened in December, 1991, was wrong. He argues that his condition worsened before his aggravation rights expired on July 11, 1991, and that, therefore, his aggravation rights had not expired. Claimant argues, relying on *Meyers v. Darigold, Inc.,* 123 Or App 217, 861 P2d 352, *rev den* 320 Or 453 (1994), that his receipt of medical treatment before July 11, 1991, for his condition established a worsening as a matter of law. *Meyers v. Darigold, Inc., supra,* does not so hold.

The Board found here that claimant established a worsening as of December 5, 1991. Substantial evidence supports that finding. Accordingly, the Board was correct that claimant's aggravation rights had expired before his condition worsened.

Affirmed.

Cite as 131 Or App 653 (1994) December 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jo Wanda Orman, Claimant.

Jo Wanda ORMAN, *Petitioner,*
v.
SAIF CORPORATION, and Universal Rubber Company, *Respondents.*
(93-01697; CA A81058)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 13, 1994.
Darris K. Rowell argued the cause and filed the brief for petitioner.
Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
RIGGS, J.
Affirmed.

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131 Or App 655> Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's dismissal of claimant's request for a hearing based on lack of subject matter jurisdiction. We affirm.

Claimant suffered a compensable injury in 1976. In 1990, after her aggravation rights expired, ORS 656.273(4)(a), claimant was hospitalized for three days for treatment of a disabling psychological condition. That treatment was later determined to be necessary medical care for claimant's previously accepted injury, and therefore compensable.[1]

On November 25, 1992, the Board reopened the claim and issued an own motion order[2] that directed SAIF to pay claimant temporary disability benefits beginning July 7, 1990, the date that she was hospitalized. The Board did not simultaneously set a closure date; therefore, SAIF was required to close the claim when claimant became medically stationary. OAR 438-12-055. SAIF did not pay claimant the temporary disability benefits,[3] and on January 21, 1993, she requested a hearing seeking enforcement of the own motion order, penalties for SAIF's failure to comply with the order and attorney fees. The referee dismissed the case, because

> "the issues raised before the trial forum are 'inherently within' the Board's Own Motion jurisdiction. Enforcement of an Own Motion Order is not 'a question concerning a claim' as that phrase is used in ORS 656.283(1)."

On appeal, the Board affirmed the referee's decision.

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[1] That determination was made in a separate proceeding before the Hearings Division which was later affirmed by the Board. SAIF does not challenge it.

[2] ORS 656.278 provides that the Board

> "may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified * * *."

Orders issued by the Board under that provision are therefore referred to as "own motion" orders.

[3] OAR 438-12-035 requires insurers to make the first payment of temporary disability compensation within 14 days of the date of an own motion order reopening the claim.

Claimant first assigns error to the Board's determination that the Hearings Division lacked jurisdiction to **<131 Or App 655/656>** enforce the own motion order.[4] We review for errors of law. ORS 183.482(8)(a). Claimant contends that the Hearings Division has original jurisdiction, or at least concurrent jurisdiction with the Board, to enforce own motion orders. We disagree.

Claimant's request raised a question regarding enforcement of the Board's own motion order. Any questions regarding her written request for compensation or her compensable injury were previously resolved by the Board's opinion and order, which affirmatively established her right to temporary disability benefits.

Claimant correctly points out that the statute establishing the Board's own motion jurisdiction, ORS 656.278, does not expressly grant the Board authority to enforce its own motion orders. However, that statute does not automatically preclude the Board from exercising original jurisdiction over enforcement of own motion orders. ORS 656.726(4) provides, in part:

> "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.*" (Emphasis supplied.)

Pursuant to its rulemaking authority, the Board enacted OAR 438-12-062, which provides:

> "The Board *may refer a request to enforce an Own Motion order to the Hearings Division* for an evidentiary hearing and recommended findings of fact and conclusions." (Emphasis supplied.)

This rule necessarily implies that the Board has original jurisdiction to enforce its own motion orders, and may submit the case to the Hearings Division if an evidentiary hearing is needed. Here, claimant initially sought enforcement of the **<131 Or App 656/657>** own motion order through the Hearings Division, which lacks original jurisdiction to enforce that order. Therefore, the Board did not err in dismissing claimant's hearing request on jurisdictional grounds.

Claimant next assigns error to the Board's determination that the Hearings Division lacked jurisdiction to consider claimant's entitlement to penalties under ORS 656.262(10). We again review for errors of law. ORS 183.482(8)(a). There was no statutory authority to request a hearing on that issue.

Affirmed.

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[4] After claimant filed the request for a hearing, but before the hearing took place, SAIF issued a notice of closure indicating that claimant became medically stationary July 10, 1990. SAIF contends that claimant is dissatisfied with the medically stationary date and is attempting to challenge that determination in this proceeding. However, claimant does not challenge the closure date, nor is she seeking additional benefits; therefore, we address only whether the Hearings Division had authority to enforce the own motion order and assess penalties and attorney fees in this case.

Cite as 131 Or App 700 (1994) December 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Brian M. Lundquist, Claimant.

Brian M. LUNDQUIST, *Petitioner,*
v.
TRI-COUNTY METROPOLITAN TRANSIT DISTRICT OF OREGON (TRI-MET), *Respondent.*
(91-14573; CA A79121)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 29, 1993.
Dennis O'Malley argued the cause and filed the brief for petitioner.
Kenneth L. Kleinsmith argued the cause for respondent. With him on the brief was Meyers & Radler.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed.

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131 Or App 702> Claimant petitions for review of an order of the Workers' Compensation Board that upheld employer's denial of his claim for treatment of his right carpal tunnel syndrome (CTS). We affirm.

Claimant is a 34-year-old bus driver, who has worked for employer as a relief driver since 1986. As part of his work, he punches transfer tickets with a hand grip punch, and, for most of his years of service, he had to change route signs by turning a manual crank that rolls up a continuous sheet of mylar containing up to 82 different route designations.

On January 14, 1988, while claimant was being treated for an upper respiratory infection, he mentioned to his physician that he had experienced numbness and tingling in his hands while at work. The doctor noted that the symptoms indicated "possible carpal tunnel syndrome" and gave him a wrist wrap. The doctor told him to come back for tests if his hands did not improve within the week, but he did not charge claimant for the advice or for the wrist wrap. Claimant did not miss any work.

After a few months of wearing the brace, the CTS symptoms cleared up. However, claimant filled out a notice of injury form. In processing the form, employer sent claimant a letter notifying him that it had not received a report of any medical treatment. On March 21, 1988, employer sent claimant another letter, which said, in part:

> "The information we have received indicates your industrial incident of January 21, 1988[,] did not necessitate medical treatment, nor was there any disability associated with this incident. Accordingly, this is not a compensable workers' compensation injury."

Claimant agreed that there was no basis for compensation, so he did not request a hearing.

In 1989, employer changed the driver's seats in its buses. Although the old seats were air-cushioned, the new seats were spring-loaded and required manual adjustment based on the driver's weight. To adjust the seat, a driver must turn a knob to increase or decrease the tension on the spring mechanism. As a relief driver, claimant usually changed **<131 Or App 702/703>** buses once or twice a day, but occasionally as many as 15 times in a day, and each time he changed buses, he had to adjust the driver's seat by turning the weight knob as many as 29 full revolutions. After working with the new seats for about a year, claimant noticed that after adjusting a spring-loaded seat to his weight, his right hand would tingle for 20 to 30 minutes. In May, 1991, he sought medical treatment for the pain and numbness. Medical tests disclosed moderate right carpal tunnel syndrome and mild left carpal tunnel syndrome. The doctor concluded that "[t]he findings on the right side [were] severe enough to consider surgical intervention."

Employer referred claimant to Dr. Button, who agreed that claimant required carpal tunnel release and noted that there was "an element of significant amount of overtime which seems to contribute to his symptoms." However, Button reported that, in his view, driving a bus was not commonly associated with CTS. He wrote:

> "[Claimant] fits a fairly common physical pattern of a large framed and overweight, if not obese individual. Although there is no strong published statistical evidence to link these two, they are still commonly associated factors seen with carpal tunnel syndrome. Therefore, for these reasons I believe his condition falls within the category of being idiopathic."

On September 13, 1991, employer denied the claim. Claimant requested a hearing on the denial. The hearings officer set aside the denial.

The Board reversed. It held that claimant's claim was precluded by *res judicata* to the extent that it was based on work activity before 1988, because he had failed to seek a hearing on the 1988 denial. It therefore characterized the 1991 claim as one for "a worsening of a preexisting noncompensable condition." As a consequence of that characterization, the Board held that claimant had the burden to prove by a preponderance of the evidence that his work activities after March, 1988, were the major contributing cause of a pathological worsening of his preexisting condition. Relying on Button's report, it found that claimant's work activities were not the major contributing cause of his right CTS and that **<131 Or App 703/704>** claimant's right CTS had not pathologically worsened since March, 1988.

For his first assignment of error, claimant contends that the Board erred in concluding that *res judicata* principles operated to prevent him from claiming that his work before 1988 contributed to the cause of his CTS condition. However, he does not point to anything in the record that suggests that he offered any evidence that the Board excluded. Instead, according to claimant, the Board's application of *res judicata* led it to assign claimant an erroneous burden of proof. He contends that we should remand his claim "for redetermination under the correct standard of proof." We disagree with claimant's understanding of the effect of the Board's ruling.

In any claim for workers' compensation, the burden of proof initially is on the claimant:

> "The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred." ORS 656.266.

CTS is an occupational disease under ORS 656.802(1)(c). In order to prove compensability of an occupational disease,

> "[t]he 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 656.802(2).

In other words, claimant must prove that his employment was the major contributing cause of his need for compensation, whether claimant's 1991 claim is regarded as a new claim for an occupational disease or as a claim for the worsening of a preexisting condition. Therefore, the Board applied the correct burden of proof, even if it articulated the wrong reason for doing so.

In his second assignment of error, claimant asserts that, even if the Board applied the correct standard of proof, it erroneously found that claimant failed to meet his burden to **<131 Or App 704/705>** prove that his employment was the major contributing cause of his condition. The Board examined the evidence presented by the various physicians. In Button's opinion, claimant's work did not involve the kinds of activities that cause CTS. He concluded that claimant's condition was idiopathic. The Board articulated reasons for finding that Button's reasoning and conclusions were more persuasive than the medical opinion supporting claimant's claim. In short, the Board's finding that claimant did not prove that work was the major contributing cause of his CTS is supported by substantial evidence.

Affirmed.

Cite as 131 Or App 753 (1994) December 14, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ralph L. Witt, Claimant.

Ralph L. WITT, *Petitioner,*
v.
EBI INSURANCE COMPANY and Bear Creek Electric, *Respondents.*
(WCB 88-07709; CA A82969)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 9, 1994.
Robert L. Chapman argued the cause for petitioner. With him on the brief was Black, Chapman, Webber & Stevens.
Howard Nielsen argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Affirmed.

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131 Or App 754> Claimant seeks review of an order of the Workers' Compensation Board after our remand in *EBI Ins. Co. v. Witt,* 113 Or App 7, 830 P2d 599 (1992), *rev den* 317 Or 583 (1993). The issue involves claimant's entitlement to temporary partial disability (TPD) after an initial two year period of TPD had been ordered. We affirm.

A recitation of the procedural history of this case would not be of assistance to the parties or other readers. Suffice it to say that, after this case had been submitted, the parties verified that a final determination order has issued in this case, which awarded claimant TPD for the entire period in question on review, and that claimant has been paid the TPD that the determination order awarded. In light of those facts, there is nothing that claimant can gain by a decision in his favor. Because he has already received all of the compensation to which he argues he is entitled, there is nothing left for us to decide.

Affirmed.

Cite as 132 Or App 7 (1994) December 21, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Brian G. Vogel, Claimant.

Brian G. VOGEL, *Petitioner*,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and Portland Fence Company, *Respondents*.
(WCB 91-12115; CA A83304)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 3, 1994.
Steven T. Fagenstrom argued the cause for petitioner. With him on the brief were Alan M. Scott and Galton, Scott & Colett.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P. J.
Affirmed.

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132 Or App 9> Claimant seeks review of an order of the Workers' Compensation Board that failed to award him permanent partial disability (PPD) for loss of grip strength and from a refusal to remand the claim to the Department of Insurance and Finance (DIF) for adoption of temporary rating rules.[1] We affirm.

Claimant compensably injured his right hand. The insurer closed the claim by notice of closure, but did not award PPD. Claimant requested reconsideration of the notice of closure and the appointment of a medical arbiter. DIF affirmed, without appointing an arbiter, because it could not complete the reconsideration within the statutory time limit. Claimant requested a hearing on the reconsideration order. At about the same time, DIF appointed a medical arbiter, who found that claimant had limited range of motion and lost grip and wrist strength in his right hand and forearm.

The referee dismissed the request for hearing, concluding that, under *Olga I. Soto*, 44 Van Natta 697 (1992), she did not have jurisdiction to review DIF's reconsideration order. However, she made findings "in the event that an appellate court alters the precedent of *Soto*." The referee then found that claimant had a permanent range of motion loss of 5 percent and a strength loss of 37 percent in his right forearm, and observed:

> "Claimant's loss of strength is not due to peripheral nerve damage, * * * loss of muscle or disruption of the musculotendinous unit. Therefore, the loss is not measured under [*former*] OAR 436-35-110(2). ORS 656.283(7) provides that the referee shall apply those 'standards' to the rating of claimant's disability. However, *the 'standards' do not cover this situation*, where medical evidence is that the loss of strength and range of motion is due to algesic paresis and reflex inhibition. In such a case, I am guided by the same statutory section, which provides that the hearing may be conducted in any manner that will achieve substantial justice.
>
> **132 Or App 10>** "Since the director's standards to [*sic*] not consider this medically verified permanent impairment, I rate the disability without regard to the standards. However, I look to [*former*] OAR 436-35-110(2) for guidance * * *." (Emphasis supplied.)

The referee then combined the range of motion loss and the strength loss and awarded claimant 40 percent PPD for loss of use or function of the right forearm.

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[1] DIF is now known as the Department of Business and Consumer Services.

Claimant requested review, asserting that the referee erred:

> "1. In denying the jurisdiction of the Hearings Division and dismissing Claimant's Request for Hearing [and]
>
> "2. In finding that [*former*] OAR 436-35-110(2) does not apply to Claimant's injuries."

Claimant, however, requested that review be held in abeyance, because

> "[the referee's] decision in this * * * case was that she did not have jurisdiction, relying on *Olga I. Soto,* 44 Van Natta [697 (1992)]. It is my understanding from checking that the *Soto* decision has been appealed to the Oregon Court of Appeals. Under these circumstances, in order to protect the rights of our client, * * * we have requested review of the Referee's decision. The sole reason for this appeal is so that if the *Soto* case is reversed and it is determined that the Hearings Division did have jurisdiction, *we will have preserved our client's rights.*" (Emphasis supplied.)

The Board granted claimant's request to hold the petition for review in abeyance and said:

> "Upon issuance of the *Soto* decision, the parties shall advise the Board of their respective positions concerning further action regarding this case."

Later, after we reversed, *see Soto v. SAIF,* 123 Or App 358, 860 P2d 824 (1993), the Board issued its decision on review, adopting the referee's findings, reinstating the request for hearing, and modifying the order on reconsideration, concluding:

> "The applicable standards provide that '[d]isability is rated on the permanent loss of use or function of a body part due to an on-the-job injury. These losses, as defined and used in these standards, shall be the sole criteria for the rating of **<132 Or App 10/11>** permanent disability in the scheduled body parts under these rules.' *Former* OAR 436-35-010(2) (WCD Admin. Order 2-1991). The standards provide a rating for loss of strength in the upper extremities when the cause is a peripheral nerve injury, loss of muscle or disruption of the musculotendinous unit. *Former* OAR 436-35-110(2)(a). The rating allowed depends on which nerve is affected or impaired. *Id.*
>
> "There is no medical evidence that claimant's losses of grip or wrist strength are due to a peripheral nerve injury, loss of muscle or disruption of the musculotendinous unit. Contrary to claimant's assertion on review, a diagnosis of tendinitis does not, in and of itself, establish a disruption of the musculotendinous unit. Rather, 'tendinitis' is merely an inflammation of tendons and of tendon-muscle attachments. Dorland's Illustrated Medical Dictionary 1315 (26th ed. 1981). 'Disruption,' on the other hand, means an abnormal separation. *Id.* at 397. Absent evidence that claimant suffered a tendon separation, we do not find that claimant's losses of grip or wrist strength are ratable under *former* OAR 436-35-110(2)(a) * * *."

Claimant requested reconsideration from the Board of its order on review. He sought an award for his loss of strength or, alternatively, that his claim be remanded to DIF for adoption of a temporary rule amending the standards to address that loss. On reconsideration, the Board adhered to its order on review, and declined to remand to DIF for adoption of a temporary rule amending the standards, asserting that claimant did not preserve that issue on review.

Claimant's first assignment is that the Board erred in concluding that he was not entitled to PPD for loss of strength. He argues that the Board's interpretation of "disruption" in *former* OAR 436-35-101(2)(a) (*renumbered* OAR 436-35-110(9)(a) in 1992), was too restrictive, and that "other definitions are equally reasonable and better serve the general policy of the Workers' Compensation system." Claimant asserts that one meaning of "disrupt" is "[t]o cause disorder or turmoil."[2] Based on that definition, he argues that the inflammation of his tendons "causes disorder or turmoil within [his] hand and wrist."

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[2] Although claimant's assertion is correct, we note that the *first* definition of the term "disrupt" in *Webster's Third New International Dictionary* 656 (unabridged 1976) is "to break apart."

132 Or App 12> The Board's interpretation of the word "disruption," found in a rule promulgated by the director of DIF, presents a question of law. Accordingly, we review for errors of law. ORS 183.482(8). We look to the text and context of the rule to determine whether the Board erred, as a matter of law, in concluding that claimant was not entitled to PPD under *former* OAR 436-35-110(2)(a). *See Stone Forest Industries, Inc. v. Employment Div.*, 127 Or App 568, 572, 873 P2d 474 (1994); *see also PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993).

Former OAR 436-35-110(2) provided, in part:

> "(9) Loss of strength is rated when the cause is a peripheral nerve injury. * * *
>
> "(a) Loss of strength due to loss of muscle or disruption of the musculotendinous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired."

The term "disruption" is not defined in the rule. The words "injury" and "loss of muscle" in the rule suggest that disruption, too, means some kind of physical trauma. However, because that is not dispositive, we look to the context in which the rule appears. OAR chapter 436 provides standards for rating permanent disability suffered by a claimant as a result of an *injury*. The standards are couched in medical terms. In that context, we agree with the Board that the rule used the term disruption as a medical term, *i.e.*, an abnormal separation. The Board did not err in concluding that claimant was precluded from receiving PPD for loss of strength.

Claimant's next assignment is that the Board erred in refusing to remand his claim to DIF for adoption of a temporary rule to address his disability. He argues that the Board was required to remand, because the issue of whether his loss of strength was ratable under existing standards did not exist until the Board determined that those standards did not apply. We disagree. As we have noted, claimant knew after the referee issued her opinion that his injuries could not be rated under existing rating standards. Before it decided the case, the Board alerted the parties that they should "advise the Board of their respective positions" regarding the merits of claimant's case. The focus of claimant's argument on review, however, was that his injuries were in fact ratable under *former* OAR 436-35-110(2)(a). He did not seek a **<132 Or App 12/13>** remand to DIF for the adoption of a temporary rule. Rather, he raised that issue for the first time in his request for reconsideration of the Board's order on review. At that time, the Board had the discretion to consider a remand to DIF, but it was not *required* to do so. *Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252, 814 P2d 185 (1991); *Larsen v. Taylor & Company*, 56 Or App 404, 406 n 1, 642 P2d 317 (1982).

Affirmed.

Cite as 132 Or App 18 (1994) December 21, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael Yokum, Claimant.

SAIF CORPORATION and Asphalt Maintenance Associates, Inc., *Petitioners,*
v.
Michael YOKUM;
American States Insurance/Productive Painting;
SAIF Corporation/Mid-Coast Marine;
EBI Companies/Reedsport Machine and Fabrication;
SAIF Corporation/Pacific Marine Ship Repair;
SAIF Corporation/Turner Painting
and SAIF Corporation/E & C Painting, *Respondents.*

(WCB 91-14304, 91-14305, 91-14306, 91-14307, 91-14308, 91-14309, 91-17992; CA A78726)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 14, 1994.
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.
Paul A. Dakopolos argued the cause for respondents SAIF Corporation/Turner Painting. With him on the brief was Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.
Deborah L. Sather and Stoel Rives Boley Jones & Grey filed the brief for respondent American States Insurance/Productive Painting.
Darren L. Otto and Scheminske & Lyons filed the brief for respondents SAIF Corporation/E & C Painting.
Douglas A. Swanson waived appearance for respondent Michael Yokum.
132 Or App 19> Jerald P. Keene waived appearance for respondents SAIF Corporation/Mid-Coast Marine.
Howard R. Nielsen waived appearance for respondents EBI Companies/Reedsport Machine & Fabrication.
Richard Wm. Davis waived appearance for respondents SAIF Corporation/Pacific Marine Ship Repair.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P. J.
Affirmed.

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132 Or App 21> Employer Asphalt Maintenance Associates, Inc. (AMA), seeks review of an order of the Workers' Compensation Board assigning to it responsibility for claimant's occupational disease claim.[1] We affirm.

Since 1974, claimant has worked as a painter for a number of employers, including AMA and Turner Painting (Turner). During his employment as a painter, he was exposed to organic solvents through inhalation and skin contact. Throughout his employment, he occasionally experienced feelings of intoxication, including light-headedness, dizziness and disorientation. He first sought treatment for that condition in 1990, when he was working for Turner. Claimant worked for AMA for part of 1990 and 1991. In 1991, as a result of increasingly serious neurological symptoms, claimant sought medical treatment and filed workers' compensation claims against AMA and Turner. Both employers denied the compensability of and their responsibility for the claim.

The Board concluded that claimant has an organic brain disorder, and that the disorder is compensable as an occupational disease. Neither employer challenges that portion of the order. The Board also determined that AMA is the employer responsible for the claim. The Board applied the last

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[1] Other employers have appeared in this review. They make arguments that track one or the other of the employers that we specifically name. We will not separately address their arguments.

injurious exposure rule, and concluded that Turner was "initially" responsible, because it was the last employer for which claimant worked before he first sought medical treatment for his condition. However, Turner argued, and the Board agreed, that AMA should be assigned responsibility for the claim, because it was a subsequent employer that actually contributed to a worsening of the condition. *See Oregon Boiler Works v. Lott,* 115 Or App 70, 836 P2d 756 (1992).

AMA seeks review, arguing that the Board erred in applying the last injurious exposure rule to hold it responsible for claimant's occupational disease. It argues that ORS 656.308(1) applies instead of the last injurious exposure rule. ORS 656.308(1) provides:

> **132 Or App 22>** "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

According to AMA, under ORS 656.308(1), responsibility "shifts" from Turner to AMA only if the work activity with AMA was the major contributing cause of the claimant's disability or need for medical treatment, pursuant to ORS 656.005(7)(a)(B). *See SAIF v. Drews,* 318 Or 1, 860 P2d 254 (1993). Turner responds first that AMA did not preserve its argument that ORS 656.308(1) should apply and that, therefore, we should not address it. *See* ORAP 5.45. It further argues that the Board correctly applied the last injurious exposure rule, because ORS 656.308(1) does not apply to a determination of responsibility in an initial claim context.

We disagree with Turner's contention that the issue of the application of ORS 656.308(1) was not preserved. Although AMA did not cite ORS 656.308(1) in its brief to the Board, it did make the argument that it could be responsible only if the evidence showed that employment with AMA was the major contributing cause of claimant's worsened condition. The Board, in its order, applied the last injurious exposure rule, citing its own opinion in *Fred A. Nutter,* 44 Van Natta 854 (1992). In *Nutter,* the Board considered whether to apply ORS 656.308(1) in an initial claim context, and concluded that the statute did not apply. Thus, it is apparent that the Board in this case understood that there was an issue regarding the applicability of ORS 656.308(1), and relied on its earlier decision to conclude that the last injurious exposure rule did apply and that ORS 656.308(1) did not apply. Therefore, we will address AMA's argument on review.

We agree with Turner that ORS 656.308(1) does not apply to this case. ORS 656.308(1) provides that, "[w]hen a worker sustains a compensable injury, the responsible employer shall remain responsible * * * unless the worker sustains a new compensable injury involving the same condition." In determining whether that subsection applies, we **<132 Or App 22/23>** consider first its text and context. *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993). AMA argues that ORS 656.308(1) applies when there is a "compensable injury," which includes occupational diseases, ORS 656.804, and that claimant sustained a compensable injury when he sought medical treatment in 1990 while working for Turner. According to AMA, the term "compensable injury" as used in ORS 656.308(1) does not require that the condition be one for which a claim has been accepted. Turner focuses on the language in the statute that "the responsible employer shall remain responsible," and asserts that there cannot be an employer that has continuing responsibility unless there is an accepted claim for which some employer has the responsibility to pay.

We agree with Turner. The term "compensable injury" is used in workers' compensation statutes sometimes to mean an injury or disease for which there is an accepted claim, *e.g.,* ORS 656.202(1); ORS 656.245, and other times to mean an injury or disease that is work related, regardless of whether a claim has been filed or accepted. *e.g.,* ORS 656.018; *Errand v. Cascade Steel Rolling Mills, Inc.,* 126 Or App 450, 869 P2d 358, *rev allowed* 319 Or 80 (1994). Thus, the language of the term in isolation does not resolve the issue in this case. The context in which the term is used, however, makes its meaning clear. The statute says that, "[w]hen a worker sustains a compensable injury, the responsible employer shall remain responsible * * *." On its face, the statute addresses the issue of when a responsible employer can shift responsibility to a subsequent employer. It begins from the premise that there is an employer that is responsible to pay for a particular compensable condition. There is no responsible employer until

there is an accepted claim and a determination of responsibility, if there is more than one potentially responsible employer. Thus, for the statute to be triggered, there must be an accepted claim for the condition, for which some employer is responsible. In an initial claim context, no employer is responsible until responsibility is fixed. The reading of "compensable injury" offered by AMA disregards the context in which the term is used.

AMA's fundamental error is in treating this case as a "shifting responsibility" case. In an initial claim context, the **<132 Or App 23/24>** last injurious exposure rule provides a method by which to assign presumptive responsibility, which can only be overcome by proof that subsequent employment actually contributed to a worsening of the condition. From that, AMA argues that the presumptively responsible employer is the "responsible employer" referred to in ORS 656.308(1). However, that reasoning misses the basic point that there cannot be a *shift* of responsibility from one responsible employer to another until there is first a responsible employer. A presumptively responsible employer under the last injurious exposure rule may or may not be found responsible for the claim; the determination of presumptive responsibility is merely one step in the determination of which employer, in fact, is responsible. Accordingly, "shifting" of responsibility is not an issue in an initial claim context.

Our conclusion that ORS 656.308(1) does not apply to initial claim determinations is consistent with what we have said before about ORS 656.308(1). In *Bennett v. Liberty Northwest Ins. Corp.*, 128 Or App 71, 75 n 1, 875 P2d 1176 (1994), we said that ORS 656.308(1) does not have

> "any effect on the last injurious exposure rule in an initial claim context. Both ORS 656.308(1) and *SAIF v. Drews, supra,* address the shifting of responsibility from an employer that is responsible for an accepted claim, to a later employer that has made some contribution to the disability or need for treatment of the same condition. The statute has no application in this case, because there is no accepted claim."

That statement is also in accord with our opinions in *ITT Hartford Ins. Group v. Young,* 126 Or App 117, 866 P2d 524 (1994), and *Crawford & Company v. Liberty Northwest Ins. Corp.*, 126 Or App 110, 866 P2d 523 (1994), in which we said that *Drews* holds that ORS 656.308(1) places the burden on the employer *with an accepted claim* to prove that the subsequent employment is the major contributing cause of the condition. We have never read *Drews* as requiring application of ORS 656.308(1) to an initial claim responsibility determination.

When the last injurious exposure rule is applied to determine responsibility among employers in an initial claim for compensation, that rule not only assigns "presumptive" **<132 Or App 24/25>** responsibility to the last employer that could have contributed to the condition before the claimant sought medical treatment; it also works to allow rebuttal of the presumption, if a subsequent employer independently contributed to the worsening of the condition. There is no indication that ORS 656.308(1) was intended to apply to change that rule. Therefore, the Board did not err in applying the last injurious exposure rule to make a determination of responsibility in this initial claim case.

Affirmed.

Cite as 132 Or App 98 (1994) December 21, 1994

IN THE COURT OF APPEALS OF THESTATE OF OREGON
In the Matter of the Compensation of Nellda Morris, Claimant.

FIRST INTERSTATE, *Petitioner,*
v.
Nellda MORRIS, *Respondent.*
(91-15691; CA A80449)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 26, 1994.
Jerry K. Brown argued the cause for petitioner. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C.
No appearance for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Reversed and remanded for reconsideration.

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132 Or App 100> Employer petitions for judicial review of the Workers' Compensation Board's decision that claimant was entitled to temporary total disability (TTD) benefits from August 1, 1991, through November 17, 1991. We reverse.

We take the facts from the Board's unchallenged findings. Claimant compensably injured her knee at work. She was released to work part time and her claim was closed on July 18, 1986. When she continued to have pain, she consulted her family physician, Dr. Bomengen. In March of 1990, claimant changed her attending physician to Dr. Chamberlain. In March of 1991, Chamberlain transferred claimant's care to Dr. Saviers, who became her attending physician. In June of 1991, Saviers approved claimant to return to modified work. Claimant then returned to Bomengen. On July 3, 1991, Bomengen gave her an excuse from work "due to extreme pain in her left knee."

On July 5, 1991, the processing agent informed claimant that she had exceeded the number of attending physicians allowed by statute and needed the insurance company's approval of any change of attending physician. On July 8, 1991, claimant sent a form to the insurer requesting that Bomengen be made her attending physician. That same day, she mailed a request to the Department of Insurance and Finance, Medical Review and Abuse Section, requesting assistance in having Bomengen designated as her attending physician. Meanwhile, on the basis of Saviers's approval of modified work, employer informed claimant that she needed to return to work at the modified position or face disciplinary action.

On July 18, 1991, the processing agent informed claimant that it had refused to authorize the change in attending physicians, and that Saviers would continue to be regarded as her sole attending physician. On July 22, 1991, Saviers informed claimant that, effective August 1, 1991, he would no longer serve as her physician. On July 23, 1991, claimant was terminated from her employment for failing to return to work. Following her termination, employer failed to pay TTD benefits, and claimant requested a hearing, seeking benefits beginning August 1, 1991.

132 Or App 101> On November 18, 1991, the Medical Review and Abuse Section told claimant that, because Saviers had terminated the physician-patient relationship with claimant, and not vice-versa, claimant was entitled to select a new attending physician, effective on the date of the section's decision. The parties then stipulated that the question for hearing was whether claimant was entitled to TTD benefits for the period from August 1, 1991, through November 17, 1991.

The referee held that claimant was entitled to the benefits. The referee reasoned that an "attending physician" is defined in workers' compensation law as the doctor who is primarily responsible for a patient's treatment and that claimant was entitled to have such a physician between August 1, 1991, and November 18, 1991. ORS 656.005(12)(b). The referee concluded that, notwithstanding the Medical Review and Abuse Section's order, Bomengen was claimant's attending physician from August 1, 1991, through November, 18, 1991, and therefore, Bomengen could authorize TTD payments. Consequently, the referee ordered that claimant was entitled to TTD payments for that time period. The Board affirmed and adopted the referee's order. Employer then petitioned for judicial review.

Employer argues that the Board erred in concluding that claimant is entitled to TTD benefits for the period from August 1, 1991, through November 17, 1991. According to employer, claimant is entitled to those benefits only if her attending physician authorized the time loss, and in this case, claimant had no attending physician during the period at issue. We agree that claimant is not entitled to TTD. Even assuming that the Board correctly applied the Medical Review and Abuse Section's order retroactively,[1] the effect of that decision is to approve the appointment of Bomengen as claimant's attending physician for the period from August 1, 1991, through November 17, 1991. Bomengen's time loss authorization, however, is dated July 3, 1991, at which time he was not claimant's attending physician. Because only an attending physician may authorize a worker's time loss, **<132 Or App 101/102>** claimant was not entitled to TTD benefits for the period from August 1, 1991, through November 17, 1991. ORS 656.245(3)(b)(B). The Board, therefore, erred in awarding claimant those benefits.

Reversed and remanded for reconsideration.

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[1] Employer does not argue, and we do not address, the question whether, because no one sought review of the order of the Medical Review and Abuse Section, it was final and not subject to review or modification by the Board in a collateral proceeding.

Cite as 132 Or App 108 (1994) December 21, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Vena K. Mast, Claimant.

Vena K. MAST, *Petitioner,*
v.
CARDINAL SERVICES, INC., and Liberty Northwest Insurance Corporation, *Respondents.*
(92-04030; CA A82765)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 5, 1994.
James L. Edmunson argued the cause for petitioner. On the brief were Jon C. Correll and Malagon, Moore, Johnson, Jensen & Correll.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Richardson, Chief Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Affirmed.

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132 Or App 110> Claimant seeks review of an order of the Workers' Compensation Board. She assigns error to the Board's denial of permanent partial disability (PPD) for loss of strength and its failure to award a penalty under ORS 656.268(4)(g). We affirm and write only to address the Board's failure to assess a penalty.

Claimant developed bilateral carpal tunnel syndrome while working as a waitress. Her claim was accepted, and she underwent carpal tunnel release surgery on both wrists. Insurer closed her claim and awarded temporary total disability (TTD), but did not award PPD. Claimant filed a request for reconsideration, and the Department of Insurance and Finance[1] (DIF) awarded 10 percent PPD for each arm for loss of strength and pronation. DIF did not assess a penalty under ORS 656.268(4)(g). Both claimant and insurer requested a hearing. The Board reduced claimant's PPD award to two percent for each arm for loss of pronation. It did not assess a penalty under ORS 656.268(4)(g).

The issue before us is whether the Board erred by not assessing a penalty under ORS 656.268(4)(g) when it reduced the PPD award below the 20 percent minimum level. ORS 656.268(4)(g) provides:

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

Claimant argues that DIF should have assessed a penalty, because, on reconsideration, it increased her PPD award by more than 25 percent from 0 percent to 20 percent, and that the Board should have assessed the penalty that DIF failed to assess. Claimant maintains that, because ORS 656.268(4)(g) provides that a penalty *shall* be assessed when **<132 Or App 110/111>** DIF increases the disability award above the threshold levels, it is of no consequence that the disability award is subsequently reduced. Insurer contends that, because the Board ultimately reduced claimant's award to two percent PPD per arm, which is less than the 20 percent threshold required by the statute, claimant is no longer entitled to a penalty.

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[1] The department has since been renamed the Department of Consumer and Business Services.

Claimant is correct that DIF should have assessed a penalty. *See Nero v. City of Tualatin,* 127 Or App 458, 873 P2d 390, *rev den* 319 Or 273 (1994). However, we do not believe that the legislature intended that a penalty be sustained if the award on which it is based is subsequently reduced below the threshold levels. Both claimant and insurer were entitled to request a hearing regarding the department's reconsideration order awarding PPD. ORS 656.268(6)(b). The hearing and the Board's review of the disability award are conducted *de novo.* ORS 656.283(7); ORS 656.295(5). Because the assessment of a penalty under ORS 656.268(4)(g) is directly linked to the award of disability, we conclude that the penalty is also subject to review and modification consistent with the Board's action on the disability award. If DIF had assessed a penalty against insurer under ORS 656.268(4)(g), that penalty, as well as the award, would have been subject to review by the referee and the Board. Because the Board reduced claimant's PPD award below the level required for a penalty to be assessed under ORS 656.268(4)(g), she is not entitled to a penalty. Accordingly, the Board did not err.[2]

Affirmed.

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2 Insurer also maintains that only DIF is authorized to assess a penalty if the requirements of ORS 656.268(4)(g) are met and that neither the referee nor the Board may assess a penalty under that provision. We need not reach the issue of whether, or under what circumstances, the Board may assess a penalty under ORS 656.268(4)(g).

Cite as 132 Or App 128 (1994) December 21, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Darrel L. Hunt, Claimant.

EBI COMPANIES and Silver Wheel Freight, *Petitioners,*
v.
Darrel L. HUNT, *Respondent.*
(91-11602; CA A78147)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 21, 1994.
Thomas M. Sheridan argued the cause for petitioners. On the brief were Michael G. Bostwick and Bostwick, Sheridan & Bronstein.
Glen H. Downs argued the cause for respondent. With him on the brief were Gerald C. Doblie and Doblie & Associates.
Before Rossman, Presiding Judge, and Richardson, Chief Judge, and Leeson, Judge.
LEESON, J.
Affirmed.

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132 Or App 130> Employer seeks review of an order of the Workers' Compensation Board that awarded claimant permanent total disability (PTD). We review for errors of law. ORS 656.298(6); ORS 183.482(8). We affirm and write only to address whether the Board erred in considering evidence from a doctor who was not claimant's treating physician.

Claimant suffered a compensable back injury in 1977 while working for employer as a truck driver. He reinjured his back in 1979 and 1980. In 1982, he suffered yet another injury when he was struck by a hit-and-run motorist. Since 1982, he has had seven back and neck surgeries. Claimant's long-term treating physician is Dr. Misko, an Oregon neurosurgeon. After claimant moved to Montana, however, Misko referred claimant to Dr. Gray, a Montana physician, for pain management and evaluation. Claimant was declared medically stationary on August 3, 1990. A determination order issued on January 16, 1991, which awarded temporary disability but stated that claimant was "entitled to no additional compensation for permanent disability." An order on reconsideration issued August 30, 1991, which affirmed the January 16, 1991, determination order. Claimant sought a hearing.

At the hearing, the referee took evidence from Misko, who testified that he believed that claimant was physically capable of performing certain sedentary jobs. The referee also took evidence from Gray, who considered claimant to be permanently and totally disabled. The referee found:

> "Claimant's neck is stiff and constantly painful. He [h]as residual headaches, numb hands and arms; focal seizures of the left arm and left buttock and leg pain and numbness. The nerve root at L5-S1 on the left is scarred and swollen from previous surgeries. Claimant does not rest well and the effects of long term weariness and pain are evident on his face. He spends two-thirds of his day in bed or in a recliner. He is limited to standing no more than 3 to 4 minutes in one place. He is limited to sitting no more than one-half an hour. He sits at an angle leaning on his elbow to reduce his left hip pain. He walks only around his house and then only occasionally. He is required to climb 10 to 12 steps to bed. He has fallen while ascending this stairway. Low back bending is extremely painful."

132 Or App 131> The referee concluded that claimant is permanently and totally disabled, because he is "unable to regularly perform suitable and gainful employment." Permanent total disability is

> "the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a).[1]

The Board affirmed. It found Misko's opinion inconsistent and unpersuasive and relied on Gray's opinion.[2]

Employer argues that, in determining whether claimant is entitled to PTD, ORS 656.245(3)(b)(B) requires the referee and the Board to consider impairment findings and that only the attending physician may make such findings.[3] ORS 656.245(3)(b)(B) provides:

> "A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability."

Claimant argues that, because his claim is for an unscheduled disability, impairment findings are not **<132 Or App 131/132>** required. OAR 436-35-005(8) defines unscheduled disability as

> "the permanent loss of earning capacity due to a compensable on the job injury or disease as described in these rules, arising from those losses contemplated by ORS 656.214(5) and not to body parts or functions listed in ORS 656.214(2)(a) through (4)."[4]

The Board concluded that Gray's opinion considered claimant's "total condition, including the effects of the medications prescribed for the compensable condition," and did not constitute impairment findings as described in ORS 656.245(3)(b)(B).

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[1] OAR 436-30-055 provides:

> "(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. * * *
>
> "(a) 'Incapacitated' from regularly performing work means that the worker does not have the necessary physical and mental capacity and the work skills to perform work."

Claimant has the burden of proving that he is permanently and totally disabled, that he is willing to seek regular, gainful employment and that he has made reasonable efforts to obtain such employment. OAR 436-30-055(3).

[2] The Board noted that

> "the Referee found that the opinion of Dr. Misko * * * was not persuasive because Dr. Misko recognized that claimant needed to be taken 'off medications and to improve his situation so he can become employable,' yet Dr. Misko continued to prescribe such medications and concluded that claimant was not permanently and totally disabled."

[3] OAR 436-35-005(5) defines impairment as

> "a decrease in the function of a body part or system as measured by a physician according to the measurement methods described in the American Medical Association Guides to the Evaluation of Permanent Impairment."

[4] ORS 656.214(2)(a) through (4) addresses the degrees assigned for permanent partial disability due to the loss of use or function of a body part such as an arm, leg, foot, hand, hearing or sight. ORS 656.214(5) provides:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f). The number of degrees of disability shall be a maximum of 320 degrees determined by the extent of the disability compared to the worker before such injury and without such disability. For the purpose of this subsection, the value of each degree of disability is $100."

Neither the relevant statutory sections nor the relevant regulations require impairment findings as a prerequisite to a finding of PTD for an unscheduled disability. In *Gornick v. SAIF,* 92 Or App 303, 307, 758 P2d 401 (1988), we said that "[p]ermanent total disability may be established by *any evidence* that demonstrates to the satisfaction of the trier of fact that, as a consequence of a compensable injury, the claimant has been rendered unable to sell h[is] services on a regular basis in a hypothetically normal labor market." (Emphasis supplied.)

Here, the referee and the Board rejected the opinion of claimant's attending physician, Misko. Claimant's consulting physician, Gray, and both employer's and claimant's vocational counselors offered evidence that the referee and the Board considered in making their determination that claimant is permanently and totally disabled. That evidence demonstrated to the satisfaction of the Board that "claimant has been rendered unable to sell h[is] services on a regular basis" in the labor market. Because ORS 656.206(1)(a) does **<132 Or App 132/133>** not require the Board to make impairment findings when deciding whether to award PTD for an unscheduled disability, the Board did not err in relying on the opinion of a nonattending physician.

Affirmed.

Cite as 132 Or App 165 (1994) December 28, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald W. Jocelyn, Claimant.

Donald W. JOCELYN, *Petitioner,*
v.
WAMPLER WERTH FARMS and Liberty Northwest Insurance Corporation, *Respondents.*
(WCB 92-08595; CA A80290)

In Banc
Judicial Review from Workers' Compensation Board.
Submitted on record and briefs February 8, 1994; resubmitted in banc August 8, 1994.
Martin J. McKeown filed the brief for petitioner.
Alexander D. Libmann filed the brief for respondents.
WARREN, J.
Reversed and remanded for reconsideration.
De Muniz, J., dissenting.

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132 Or App 167> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in determining that his aggravation claim is not compensable, because he has not satisfied the requirement of ORS 656.005(7)(a)(B) and shown that the initial compensable injury is the major contributing cause of his worsened condition. We reverse.

Claimant experienced a compensable low back injury in 1987 while working for employer. The injury was diagnosed as a strain, superimposed on a preexisting, non-work related degenerative disc condition. Before and after the 1987 injury, CT scans revealed that claimant had a bulging disc at L4-L5, and that that condition had remained unchanged. Employer accepted the claim and it was closed in 1988. It was reopened in 1989 and 1990 for awards of permanent partial disability.

In March, 1992, defendant was at home when he sneezed while bending over to tie his shoe. He felt immediate sharp pain in his back. Claimant tried to work, but could not. ACT scan revealed increasing disc derangement and herniation at L4-L5. Claimant's doctors recommended a diskectomy and fusion. Claimant filed an aggravation claim under ORS 656.273 for the worsening of his accepted condition, which employer denied. The referee found that the medical evidence shows that claimant's 1987 injury is not the major contributing cause of his current increased disc herniation. The Board, in affirming the referee, held that, because claimant's current condition is caused by a combination of his compensable injury and his preexisting disc condition, he is required to show, pursuant to ORS 656.005(7)(a)(B), that the compensable 1987 injury is the major contributing cause of the worsened condition. The question on review is whether the Board was correct to apply that standard of proof of causation to claims for aggravation under ORS 656.273.

A claimant is entitled to additional compensation for the worsening of an accepted condition, pursuant to ORS 656.273(1), which provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, **<132 Or App 167/168>** including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

The Board held that, because claimant had a preexisting back condition, in order to prove a claim for aggravation under ORS 656.273, claimant had to prove that the accepted compensable injury was the major contributing cause of the worsened condition, pursuant to ORS 656.005(7)(a)(B). That subparagraph 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."

Because claimant did not prove that the compensable injury was the major contributing cause of his worsened condition, the Board held that the claim was not compensable.

Claimant argues that the Board erred in applying the major contributing cause standard of ORS 656.005(7)(a)(B) to this claim for aggravation under ORS 656.273(1). He asserts that the aggravation statute has long been interpreted to require a claimant to show only that the compensable injury was a material contributing cause of the worsening of a compensable condition, and that standard was not changed by the 1990 amendments to the workers' compensation law. Employer argues that the language of ORS 656.005(7)(a)(B), which was added by the 1990 amendments, applies by its terms to any claim for compensation involving a preexisting condition, including claims for additional compensation for the worsening of a preexisting compensable condition under ORS 656.273(1).

We have touched on this issue in *Tektronix, Inc. v. Nazari*, 117 Or App 409, 844 P2d 258 (1992), *on recon* 120 Or App 590, 853 P2d 315, *rev den* 318 Or 27 (1993), and *Gray v. SAIF*, 121 Or App 217, 854 P2d 1008 (1993). In *Nazari*, the issue was the compensability of the claimant's *initial* low back injury claim. We said:

> **132 Or App 169>** "It is not clear how the statute [ORS 656.005(7)(a)(B)] is to be applied in the context of an *initial claim for compensation,* when the injury combines with a preexisting condition to cause or prolong disability or a need for treatment." 120 Or App at 594. (Emphasis supplied.)

We concluded that the legislature intended to "adopt the major contributing cause standard of proof with respect to *any* claim for benefits or disability related to a preexisting, noncompensable condition." 120 Or App at 594. (Emphasis supplied.) However, we were then more precise in recognizing that the issue before us was initial claims:

> "We conclude that the statute is applicable in the context of an *initial injury claim* if the injury combines with a preexisting, noncompensable condition to cause or prolong disability or a need for treatment. If, in an *initial claim,* there is disability or a need for treatment as a result of the injury alone, then the claim is compensable if the injury is a material contributing cause of the disability or need for treatment. If, in an *initial claim,* the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition, then the injury is compensable only if it is the major contributing cause of the disability or need for treatment." 120 Or App at 594. (Emphasis supplied.)

We went on to say that,

> "[i]n order to obtain further compensation for disability or a need for treatment that is the result of a combination of the injury and a preexisting, noncompensable condition, the claimant must show that the injury is the major contributing cause of the disability or need for treatment." 120 Or App at 594.

To the extent that the quoted material could be read as saying that ORS 656.005(7)(a)(B) applies to aggravation claims, we reject that reading, because it would address an issue that was not presented in the case, *i.e.*, the legal test for aggravation claims. By definition, an aggravation claim under ORS 656.273 is a claim for additional compensation for the worsening of an already accepted claim.

The overly broad language in *Nazari* regarding application of ORS 656.005(7)(a)(B) to *any* claim for compensation went beyond the specific issue before us in that case and touched on an issue that was *not* before us: the standard for **<132 Or App 169/170>** proving aggravation. As the dissent says, the "*difficult*" issue in *Nazari* was whether and how ORS 656.005(7)(a)(B) applied to *initial injury claims,* 132 Or App at 179; however, it was also the *only* issue. We do not feel compelled to follow the broad *dictum* in *Nazari* that the major contributing cause standard applied to "any claim for benefits or disability related to a preexisting, noncompensable condition."

In *Gray v. SAIF, supra,* we did say that ORS 656.005(7)(a)(B) applied to aggravation claims; however, we should be free to reconsider that bald and truncated assertion. Our entire discourse on the subject in that case reads:

> "Even assuming, as claimant contends, that she has experienced an aggravation of her compensable claim, her condition is not compensable, because she has not satisfied the requirements of ORS 656.005(7)(a)(B). *See Tektronix, Inc. v. Nazari, [supra].*" 121 Or App at 219.

Making an assumption about what type of claim was being asserted in *Gray,* and then relying on *dictum* from *Nazari,* is hardly the kind of consideration and analysis that should preclude us from a thorough examination of the issue. If our *dictum* in *Nazari* was wrong, and our reliance on it in *Gray* misplaced, we ought to recognize that and set it right, rather than perpetuate the error. Because we conclude both that the *dictum* in *Nazari* was wrong and that our reliance on it in *Gray* misplaced, we reverse the Board's order.

The question is whether the 1990 amendment to ORS 656.005(7), providing the major contributing cause standard for conditions resulting from the combination of a compensable condition and a preexisting condition, was intended to change the legal standard that applies to a claim for aggravation under ORS 656.273(1). In interpreting a statute, we are to discern the intent of the legislature. ORS 174.020; *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993). We do that by looking first to the text and context of the statute. A claim for "aggravation," *i.e.,* additional compensation for the worsening of a compensable condition, arises under ORS 656.273(1). The language of that statute that is at issue in this case is:

> "[A]n injured worker is entitled to additional compensation * * * for worsened conditions resulting from the original injury."

132 Or App 171> The phrase "resulting from" in the aggravation statute has long been interpreted to require a claimant to prove only that the original compensable injury or occupational disease was a material contributing cause of the worsened condition. That interpretation becomes part of the statute as if it had been written into it at the time of enactment. *Stephens v. Bohlman,* 314 Or 344, 350 n 6, 838 P2d 600 (1992). The first and most compelling indication that the legislature did not intend ORS 656.005(7)(a)(B) to change the causation test in ORS 656.273(1) is that it did not change the critical language of ORS 656.273(1), requiring that a worsened condition be one "resulting from the original injury." Because "resulting from" has always been held to mean material contributing cause, the legislature's failure to change that language precludes a conclusion that the legislature intended a change in its meaning.

The dissent does not explain how a legislature's *failure* to change statutory language can result in a change of the meaning of that language. Instead, it discerns a legislative intent to change the meaning of "resulting from" in ORS 656.273(1) by its 1990 enactment of ORS 656.005(7)(a)(B). We disagree. ORS 656.005(7)(a)(B) was added to the definition of "compensable injury" contained in ORS 656.005(7)(a); it was not added to the aggravation statute, ORS 656.273. The definition statute does not refer to the aggravation statute, ORS 656.273(1), or *vice versa.* Nor does ORS 656.273(1) use the term "compensable injury." Therefore, there is no indication in the text or the context of the two statutes that ORS 656.005(7)(a)(B) should apply to a claim for aggravation under ORS 656.273(1).

The few changes that the 1990 legislature did make to ORS 656.273(1) are consistent with the established meaning. ORS 656.273(1) *was* amended in 1990 to provide that, "if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable." If the legislature had intended that a claimant with a preexisting condition has to meet the major contributing cause test to prove a claim for aggravation under ORS 656.273(1), it makes no sense that the legislature also would have amended ORS 656.273(1) to **<132 Or App 171/172>** provide that a claim for a worsened condition is *not* compensable if an off-the-job injury is the major contributing cause. Because there can be only one major contributing cause, once a claimant proved that the original injury was the major contributing cause of the worsened condition, the off-the-

job injury provision would be superfluous.[1] We are not at liberty to interpret the language in a way that makes part of it redundant.

The dissent also asserts that our reliance on the legislature's failure to change the "resulting from" language is misplaced, saying it is "likely that the legislature made no additional changes to ORS 656.273, because it believed that the changes made to ORS 656.005(7) encompassed aggravation claims." 132 Or App at 180. That argument ignores the fact that the 1990 legislature made some identical additions to both ORS 656.005(7)(a) and ORS 656.273(1), when it provided that a claimant must establish a claim "by medical evidence supported by objective findings." If changes to ORS 656.005(7)(a) apply to aggravation claims, there was no reason to make that change in ORS 656.273(1) as well.

To the extent that the text and context are not definitive, the legislative history also supports a conclusion that there was no intent to change the legal standard for aggravation claims, except those involving off-the-job injuries. *See PGE v. Bureau of Labor and Industries, supra,* 317 Or at 611. Jerald Keene, in explaining the proposed changes in ORS 656.273 to the Joint Interim Special Committee on Workers' Compensation, said:

> "On aggravations the standard is unchanged. * * * *Material contributing cause is still the standard* for an aggravation claim, which is a natural worsening of a pre-existing compensable condition. When you injure a condition that's permanently a problem, once it gets worse you can reopen your **<132 Or App 172/173>** claim if the original injury remains a material contributing cause of the worsening. The things that this statute does change, though, is [*sic*] situations where that worsening, rather than being a natural progression of the original compensable injury, instead is caused by some supervening incident like falling off a roof or getting in a car accident." Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B. (Emphasis supplied.)

At the House Special Session, Representative Mannix explained:

> "In regard to aggravations. The standard right now is whether or not there's been some material contribution to worsened condition. The best example I can come up with is, you've got a low back strain and your back is still hurting you, on a weekend at home you go up on the roof and you are trying [to] reroof your own house, and you fall off. Those result[ant] medical services involving that low back strain are still considered compensable and you probably got an aggravation a worsening under the workers' comp[ensation] system. What we're saying here is the worsening is going to have to [be] something which -- where the industrial injury is a major contributing cause of the worsening." House Special Session, May 7, 1990, Tape 2, Side A.

There is nothing in the legislative history of ORS 656.273 that mentions the major contributing cause standard of ORS 656.005(7)(a)(B) or that suggests that the legislature intended ORS 656.005(7)(a)(B) to apply in the aggravation context.

Just as the legislative history of ORS 656.273 does not refer to ORS 656.005(7)(a)(B), the legislative history of ORS 656.005(7)(a)(B) does not mention aggravation claims or ORS 656.273(1). In light of the legislative history of both ORS 656.273(1) and ORS 656.005(7)(a)(B), and of the legislature's failure to amend the "resulting from" language in ORS 656.273(1), and of the specific changes to that subsection that the legislature did make, we conclude that the legislature did not intend to affect the standard of proof for aggravation claims. Accordingly, we hold that 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. **<132 Or App 173/174>** That standard applies even if the claimant had a condition that preexisted the compensable injury.[2]

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[1] The dissent fails satisfactorily to address that problem, saying only that, once a claimant shows that the compensable injury is the maj or contributing cause of the worsening, "the employer would be able to show that the subsequent injury is its major contributing cause," citing *Fernandez v. M & M Reforestation,* 124 Or App 38, 860 P2d 898 (1993). 132 Or App at 180. Of course, because there can be only one *major* contributing cause, once the claimant meets the major contributing cause test, the employer cannot defeat the claim. *Fernandez* is both logical and correct under our reading of ORS 656.273(1). It is not logical under the dissent's reading. That is another indication that the legislature did not intend the meaning the dissent ascribes to ORS 656.273(1).

The consequence of the dissent's reasoning is absurd. The language "resulting from the original injury," in ORS 656.273(1), would have two different meanings, depending on whether or not the claimant has a condition that preceded the initial compensable injury. Under the dissent's reading of the statutes, if the claimant does not have a condition that preceded the initial compensable injury, he or she could prove the compensability of the worsening of a compensable injury or disease by showing that the original injury or disease is the material contributing cause of the worsening. If, however, the claimant does have a preexisting condition, the claimant would have to prove that the compensable injury or disease is the major contributing cause of the worsening. Absent express language in the aggravation statute or some other specific legislative directive, we know of no authority for attributing two different meanings to the same statutory language.

Because the legislature never intended to change the standard for proving an aggravation claim under ORS 656.273(1) when it enacted ORS 656.005(7)(a)(B) in 1990, we hold that the Board erred in applying the major contributing cause standard to claimant's claim.

132 Or App 175> We reject without discussion claimant's second assignment of error.

Reversed and remanded for reconsideration.

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[2] This result is consistent with our holding in *Beck v. James River Corp.*, 124 Or App 484, 863 P2d 526 (1993), *rev den* 318 Or 478 (1994), in which we held that ORS 656.005(7)(a)(B) does not apply to claims for continued medical services for "conditions *resulting from* the injury" under ORS 656.245(1). (Emphasis supplied.) The standard remains material contributing cause. Similarly here, we hold that ORS 656.005(7)(a)(B) does not apply to a claim for additional compensation for "worsened conditions *resulting from* the original injury" under ORS 656.273(1). (Emphasis supplied.) Although ORS 656.245 and ORS 656.273 both contain the same language, the dissent fails to explain why the major contributing cause standard of ORS 656.005(7)(a)(B) *does not* apply to continuing medical treatment, but *does* apply to aggravation claims. There is no way to justify giving a different meaning to "resulting from" as used in ORS 656.273(1) than we gave its use in ORS 656.245(1).

This result is also consistent with *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993), in which the Supreme Court held that the preexisting condition provision of ORS 656.005(7)(a)(B) does apply to a determination of whether there is a new injury in the shifting responsibility context of ORS 656.308(1). A new injury claim can arise when work causes a worsening of a preexisting condition. However, a claim under ORS 656.273(1) for the worsening of an accepted compensable condition is not a claim for a new injury.

De MUNIZ, J., dissenting.

Just over one year ago, considering the same statutes and the same legislative history now examined by the majority, we held, in *Tektronix, Inc. v. Nazari*, 117 Or App 409, 844 P2d 258 (1992), *on recon* 120 Or App 590, 853 P2d 315, *rev den* 318 Or 27 (1993), that by enacting ORS 656.005(7)(a)(B), the legislature intended to adopt the major contributing cause standard of proof with respect to any claim for benefits or disability related to a preexisting condition. More recently, in *Gray v. SAIF*, 121 Or App 217, 854 P2d 1008 (1993), relying on *Nazari*, we held that ORS 656.005(7)(a)(B) applies to a claim for an aggravation. The majority's new inclination aside, there is nothing in either the statutes or the legislative history that warrants a change in the holdings of those two cases.

ORS 656.005(7)(a) defines "compensable injury." It provides, in part:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.
>
> "(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."

132 Or App 176> Until 1990, when subparagraphs (A) and (B) were added requiring application of the "major contributing cause" standard of proof in the two circumstances described, the standard by which a claimant was required to prove that an injury "aris[es] out of" the employment was understood to be the "material contributing cause" standard. In *Olson v. State Ind. Acc. Com.*, 222 Or 407, 352 P2d 1096 (1960), the Supreme Court said:

> "Reduced to its simplest form "arising out of" as used in the act means the work or labor being performed was a causal factor in producing the injury suffered by the workman. * * * It need not be the sole cause, but is sufficient if the labor being performed in the employment is a material, contributing cause which leads to the unfortunate result." 222 Or at 414. (Citations omitted.)

That case is regarded as having established "material contributing cause" as the standard of proof of medical causation applicable to original injury claims.

ORS 656.273(1) provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. *A worsened condition resulting from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable.*" (Emphasis supplied.)

The emphasized language was added by the 1990 legislature. Like the pre-1990 version of ORS 656.005(7), the pre-1990 version of ORS 656.273(1) made no reference to the standard by which a claimant must show that the worsened condition "results from" the original injury, but it too has been interpreted to require a "material contributing cause" standard of proof. In fact, the cases reveal that the "material contributing cause" standard for proof of aggravation claims was derived directly from the cases describing the standard of proof applicable to original claims. In *Lemons v. Compensation Department*, 2 Or App 128, 467 P2d 128 (1970), citing without discussion *Olson v. State Ind. Acc. Com., supra,* we adopted the material contributing cause standard as the **<132 Or App 176/177>** standard applicable to proof of aggravation claims. In *Standley v. SAIF*, 8 Or App 429, 495 P2d 283 (1972), we cited *Lemons* for the same rule.

In *Grable v. Weyerhaeuser Company*, 291 Or 387, 631 P2d 768 (1981), the Supreme Court considered an aggravation claim in which the claimant's compensable injury became worse after an off-the-job injury. The court grappled with the question of medical proof of aggravation claims generally. It noted that *Olson* had involved an original claim for injury and that our opinions in *Lemons* and *Standley* had applied the *Olson* "material contributing cause" standard of proof to aggravation claims. The court considered Professor Larson's analytical approach to medical proof of aggravation claims, 1 Larson *Workmen's Compensation Law*, 3-348, § 13.00 (1978), which focused on whether the subsequent injury was an "independent intervening cause" of the claimant's need for treatment or disability. The court said that, although that approach appeared to apply a standard of proof different from the material contributing cause standard, the difference was only superficial, because the two differently phrased tests were, essentially, the converse of each other and lead to the same result. The court said:

> "We conclude that if the claimant establishes that the compensable injury is a 'material contributing cause' of his worsened condition, he has thereby necessarily established that the worsened condition is not the result of an 'independent, intervening' nonindustrial cause. We hold that an employer is required to pay worker's compensation benefits for worsening of a worker's condition where the worsening is the result of both a compensable on-the-job back injury and a subsequent off-the-job injury to the same part of the body if the worker established that the on-the-job injury is a material contributing cause of the worsened condition." 291 Or at 401.

Thus, *Grable* provided an independent rationale for application of the material contributing cause standard of proof in the context of aggravation claims generally. *See also Peterson v. Eugene F. Burrill Lumber*, 294 Or 537, 542, 660 P2d 1058 (1983).

In 1990, the legislature added subparagraphs (A) and (B) to ORS 656.005(7)(a), thus requiring, in those two specific **<132 Or App 177/178>** circumstances, that the claimant show that the compensable injury is the major contributing cause of the condition for which compensation is sought. ORS 656.005(7)(a)(B) provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

Subparagraph (B) would appear to be directly applicable to the facts of this case, as it is conceded that claimant's current need for surgery is the result of a combination of his preexisting disc disease and his compensable injury.

The legislature made other changes as well. It amended ORS 656.273(1) to add its last two lines:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings. *However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable.*" (Emphasis supplied.)

The emphasized language overrules the Supreme Court's holding in *Grable*. A worsened condition is no longer compensable if its major contributing cause is a subsequent off-the-job injury, even if the compensable on-the-job injury is a material contributing cause of the worsening.

Taken together, the changes to ORS 656.005(7)(a) and ORS 656.273(1) reflect an apparent legislative intention that a condition not be compensated if its primary cause is not work related. If there is a pre-existing condition involved, it is no longer enough for the claimant to show that the work is the material contributing cause. As we said in *Tektronix, Inc. v. Nazari, supra,* the legislative history shows that, by enacting ORS 656.005(7)(a)(B), the legislature intended that, any time a claimant's current condition is the result of a combination of a compensable injury and a preexisting condition, the claimant must show that the compensable injury, rather than the preexisting condition, is the major contributing cause. **<132 Or App 178/179>** More recently, in *Gray v. SAIF, supra,* relying on *Nazari,* we applied that same rule in the context of an aggravation claim involving a worsened condition caused by a combination of a compensable injury and a preexisting disease. That is the circumstance here.

The majority takes issue with my reliance on *Nazari,* contending that that case is not relevant here, because our holding in *Nazari* was limited to the question of whether ORS 656.005(7)(a)(B) is applicable in the context of an "initial claim." How quickly the majority forgets. It is true that the *difficult* question presented by *Nazari* was *not* whether ORS 656.005(7)(a)(B) was applicable in the context of an aggravation claim or in any other circumstance when there had been a previously accepted claim: We said in *Nazari* that the statute was obviously applicable in those circumstances.[1] The difficult question in *Nazari* was whether, in the light of the statute's apparent assumption of the existence of a compensable injury, ORS 656.005(7)(a)(B) could ever be applicable in the context of an initial claim. In holding that the statute applied in the context of an initial claim, we referred to the legislative history, which we concluded showed that the objective of the legislature "was to adopt the major contributing cause standard of proof with respect to any claim for benefits or disability related to a preexisting, noncompensable condition." 120 Or App at 590.

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> "When the claimant has an injury that has been determined to be compensable under [the material contributing cause] standard of medical causation, the words of subparagraph (B) are easily understood: A condition resulting from a combination of the injury and a preexisting condition is compensable only if the compensable injury is the major contributing cause of the disability or need for treatment of the 'resultant condition.'" 120 Or App at 592.

Because *Nazari* did not involve an aggravation claim, the majority is correct that it is not direct authority for the result in this case. However, our comments in *Nazari* regarding the legislature's intent certainly lent support to our opinion in *Gray v. SAIF, supra,* which expressly holds that ORS 656.005(7)(a)(B) is applicable in the context of an aggravation claim. The relevant facts of *Gray* were similar to those here. The claimant experienced a back strain at work, which the employer accepted as compensable. The claimant's doctor later diagnosed a preexisting degenerative condition. The **<132 Or App 179/180>** claimant sought to be compensated for surgery for the preexisting condition. We held that the claim was not compensable as. an initial claim or as an aggravation claim, because the claimant had not satisfied the "major contributing cause" standard of proof set out in ORS 655.005(7)(a)(B).

The majority is of the view that there is no indication that the legislature intended to change a claimant's burden of proof with regard to aggravation claims. We would agree, were it not for the words of ORS 656.005(7)(a)(B). Even without an express reference to ORS 656.273, those words aptly indicate that the major contributing cause standard is intended to apply in the context of an aggravation claim involving a preexisting condition. We are remiss in our duty to interpret the statute according to its plain language in ignoring the very words chosen by the legislature.

The majority surmises that, in the light of the fact that the legislature made some changes to ORS 656.273(1) in 1990, had it sought to change the claimant's burden of proof in an aggravation claim, it would have made additional changes to the statute similar to those made to ORS 656.005(7). I think it more likely that the legislature made no additional changes to ORS 656.273, because it believed that the changes made to ORS 656.005(7) encompassed aggravation claims.

Contrary to the majority's view, the application of ORS 656.005(7)(a)(B) to aggravation claims would not lead to an absurdity. If there is no preexisting condition, then the standard of proof in an aggravation claim, as in an initial claim, would be the material contributing cause standard. If there is a preexisting condition that contributes to the worsening, then the claimant must show, as in an initial claim, that the work is the major contributing cause of the worsened condition. In either case, if a subsequent off-the-job injury contributes to the worsened condition, then the employer would be able to show that the subsequent injury is its major contributing cause. *Fernandez v. M & M Reforestation,* 124 Or App 38, 860 P2d 898 (1993). There is no illogic to the way the statutes work together. They simply deal with different potential aspects of a claim and may or may not be relevant to a particular case.

132 Or App 181> As I interpret the statutes, if a claimant has previously established, in the context of an original claim, that because of the effects of the employment, a preexisting condition is itself compensable, then there would be no need for the claimant to reprove the relationship between the employment and the preexisting condition in a later aggravation claim. The preexisting condition, once shown to be compensable, remains compensable.[2] Here, claimant's preexisting condition was noted in the medical reports at the time of the original claim, and he has perhaps received medical treatment and compensation for the effects that the compensable injury had on the preexisting condition; however, the preexisting condition itself is not compensable, nor is it claimed to be. It is that preexisting condition that has worsened and for which claimant now seeks compensation. If claimant's 1987 injury bears *any* relationship to his current disc condition, it is only to the extent that it combines with the preexisting condition. I would hold that ORS 656.005(7)(a)(B) is applicable and that claimant must show that the initial compensable injury is the major contributing cause of the worsened condition. I would hold that substantial evidence supports the Board's determination that he has not met that burden.

Richardson, C. J., and Rossman and Leeson, JJ., join in this dissent.

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[2] Similarly, a claim for medical treatment of a compensable condition is compensable if the compensable condition remains the material contributing cause of the need for treatment. *See, e.g., Beck v. James River Corp.,* 124 Or App 484, 488, 863 P2d 526 (1993), *rev den* 318 Or 478 (1994).

Cite as 132 Or App 182 (1994) December 28, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Janet K. Jackson, Claimant.

Janet K. JACKSON, *Petitioner,*
v.
TUALITY COMMUNITY HOSPITAL and SAIF Corporation, *Respondents.*
(88-13477; CA A80451)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted April 11, 1994; resubmitted in banc October 12, 1994.
Helen T. Dziuba argued the cause and filed the brief for petitioner.
Steven Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
DEITS, J.
Affirmed.
Riggs, J., concurring in part; dissenting in part.

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132 Or App 184> Claimant seeks reversal of a Workers' Compensation Board order reducing her unscheduled permanent disability award resulting from a low back injury, and refusing to award her additional scheduled permanent disability. We affirm.

Claimant first injured her back in 1983, and then reinjured it in 1984. In May, 1985, her claim was closed, and she was awarded 20 percent unscheduled permanent partial disability and 10 percent scheduled permanent partial disability to the left foot (lower leg). In 1989, claimant experienced increasing low back and leg pain and, consequently, in February 1990, underwent surgery. On October 9, 1990, a Determination Order awarded an additional 4 percent unscheduled permanent partial disability, for a total of 24 percent. In April, 1991, claimant requested reconsideration, disputing the impairment used in rating her disability.

Thereafter, the Department of Insurance and Finance (DIF)[1] scheduled a medical arbitration pursuant to ORS 656.268(7), but claimant refused to attend that examination. The medical arbiter did not issue any findings. On August 23, 1991, DIF issued an order on reconsideration, increasing claimant's total unscheduled award to 29 percent. Claimant then requested a hearing. At the hearing, she offered two reports from her treating physicians that were prepared after the order on reconsideration. The referee ruled that those exhibits were inadmissible under ORS 656.268(7). However, the referee agreed with claimant that DIF's temporary rules defining standards for rating permanent disabilities were invalid. Without applying the temporary rules, the referee fixed claimant's unscheduled permanent partial disability at 36 percent, but refused to award additional scheduled disability for claimant's left leg.

On claimant's appeal to the Board, it reversed the referee's ruling that the temporary rules were invalid and affirmed the referee's exclusion of the treating physician's reports. The Board applied the temporary rules insofar as they had been incorporated by subsequently promulgated **<132 Or App 184/185>** permanent rules,[2] reduced claimant's unscheduled permanent partial disability to 29 percent and agreed with the referee that claimant should not be awarded additional scheduled disability.

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[1] This department is now known as the Department of Consumer and Business Services.

[2] *See* OAR 438-10-010 (2) (incorporating by reference temporary rules defining standards for rating disabilities).

"We are also going to require workers who disagree with the initial disability of evaluation decision to seek a reconsideration. Right now this is voluntary. What this means in lay terms is that once a person gets a determination order from the evaluation section of the department, and they are dissatisfied with the extent of disability award, they would have a mandatory reconsideration of that before they went on to hearing. * * * *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. (Emphasis supplied.)

On appeal, claimant first assigns error to the Board's conclusion that under ORS 656.268(7), the medical exhibits that were prepared after the order on reconsideration, that claimant sought to introduce at the hearing, must be excluded. ORS 656.268(7) establishes the process to be followed when a claimant requests reconsideration of a determination order disputing the impairment used in rating a disability. The claimant must advise the director of any objections to the impairment decision, and the director is required to appoint a medical arbiter. The arbiter or panel of arbiters may examine the worker and perform such tests as deemed necessary. The arbiter or panel then is to submit findings to the department to be used in the reconsideration of the impairment decision.

In deciding whether ORS 656.268(7) requires the exclusion of the exhibits claimant sought to offer, we look first to the text and context of the statute. *PGE v. Bureau of Labor and Industries,* 317 Or 606, 859 P2d 1143 (1993). The pertinent language of ORS 656.268(7) provides:

> "The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure."

Claimant argues that "subsequent medical evidence" as used in ORS 656.268(7) refers to evidence generated *after* "the findings of the medical arbiter * * * [are] submitted to the department." She reasons that because no medical arbiter's findings were ever generated here, the bar on submitting "subsequent medical evidence" does not apply.

We conclude that the pertinent text and context of this statute are not clear as to whether the submission of **<132 Or App 185/186>** findings by the medical arbiter is an absolute prerequisite to the preclusion of subsequent medical evidence. Accordingly, it is necessary to look at the legislative history of the statute. *PGE v. Bureau of Labor and Industries, supra.* It is apparent from the legislative history that the purpose of the reconsideration process created by ORS 656.268(7) was to cut down on the number of appeals and hearings relating to impairment decisions and, consequently, the delay and expense involved in such hearings, by requiring claimants to go through a reconsideration process at the department level. As explained by Representative Shiprack:

Under claimant's reading of the statute, however, claimants who refuse to fully participate in the reconsideration process could prolong the appeal process as well as gain a tactical advantage. By refusing to participate in the reconsideration process, a claimant could submit medical reports generated after the reconsideration decision, while those who fully participated in the reconsideration process would be precluded from doing so. That result would frustrate the legislative purpose of promoting the reconsideration process and concomitantly reducing hearings and appeals on impairment decisions. We conclude that the legislative history does not support claimant's reading of the statute.

Claimant also argues that our decision in *Scheller v. Holly House,* 125 Or App 454, 865 P2d 475 (1993), *rev den* 319 Or 36 (1994), compels the result that she advocates. In *Scheller,* we held that where no medical arbiter had been appointed, the statutory exclusion of subsequent medical evidence was not triggered. 125 Or App at 454. However, the distinction between the director's failure to comply with the requirement of ORS 656.268(7) to appoint an arbiter when **<132 Or App 186/187>** there is an objection to the impairment decision, as in *Scheller,* and claimant's refusal to be examined by an appointed arbiter in this case is material and, ultimately, dispositive. In *Scheller,* the director's failure did not allow claimant a full and fair opportunity to complete the reconsideration process. Here, claimant was given a full and fair opportunity to complete the statutory process and to submit all pertinent medical evidence. However, she voluntarily boycotted that process. The Board correctly concluded that the statute does not allow claimant to circumvent the subsequent medical evidence bar of ORS 656.268 by refusing to participate in the medical arbitration.

Finally, we are not persuaded by claimant's challenge to the temporary rules. By the time that the order on reconsideration issued in this case, August 23, 1991, the temporary rules had expired and the permanent disability rating rules, which claimant does not challenge, were in effect. *See* OAR 438-10-010(7). To the extent that the Board applied the temporary rules, that application was pursuant to the permanent rules incorporating the temporary rules, and not pursuant to the temporary rules themselves.

Consequently, claimant's challenge to the temporary rules is moot. *See Edmundson v. Dept. of Ins. and Finance,* 314 Or 291, 295, 838 P2d 589 (1992); *Ferguson v. U.S. Epperson Underwriting,* 127 Or App 478, 873 P2d 393 (1994).

Affirmed.

RIGGS, J., concurring in part; dissenting in part.

I agree with the majority's disposition of claimant's argument regarding the Board's application of the temporary rules. However, I do not agree with the majority's conclusion that the Board correctly excluded the medical exhibits offered by claimant. Accordingly, I dissent.

ORS 656.268(7), which controls our disposition of this issue, provides:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. At the request of either of the parties, a panel of three medical arbiters shall be appointed. * * * The **<132 Or App 187/188>** medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment. * * * *The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for the purpose of making findings of impairment on the claim closure."* (Emphasis supplied.)

In interpreting a statute, our task is to discern the intent of the legislature. ORS 174.020; *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993). The best evidence of legislative intent is the statute itself. 317 Or at 610-11. I disagree with the majority's conclusion that the language in ORS 656.268(7) is not clear. The plain, ordinary and natural meaning of the emphasized language is that medical evidence, prepared after the findings of a medical arbiter are submitted to DIF on reconsideration, is not admissible in any proceeding. The trigger for the exclusion of medical evidence is the submission of an arbiter's report, not the appointment of an arbiter. Where, as here, no report has been submitted, the exclusion does not operate.

The majority distinguishes *Scheller v. Holly House,* 125 Or App 454, 865 P2d 475 (1993), *rev den* 319 Or 36 (1994), because claimant here "voluntarily boycotted [the] process," *i.e.,* she refused to submit to the arbiter's examination. However, in *Scheller,* the claimant also voluntarily boycotted the process. In *Scheller,* it was the claimant's action in not challenging impairment on reconsideration that led the director not to appoint an arbiter. 125 Or App at 456; *see also* ORS 656.268(2). In both cases, a claimant's unilateral action allows medical evidence prepared after the reconsideration process to be considered by the referee. Any distinction between the two cases is illusory.

My reading of the statute does not allow a claimant to completely circumvent the statutory procedures. The statute only provides that "[t]he medical arbiter or panel of medical arbiters *may* examine the worker." (Emphasis supplied.) The statute does not require an examination by a medical arbiter. If a claimant refuses to cooperate in the examination process, the medical arbiter may nevertheless prepare and submit a **<132 Or App 188/189>** report using the medical evidence already before DIF. That was not done here. Had it been done, my reading of ORS 656.268(7) would potentially result in the proper exclusion of claimant's medical evidence prepared after the findings of the medical arbiter.

The Board erred when it decided that the medical evidence prepared after the appointment of the medical arbiter should be excluded. Because I believe that the majority misreads ORS 656.268(7), I dissent.

Landau and Haselton, JJ., join in this concurring and dissenting opinion.

Cite as 132 Or App 288 (1995) January 4, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Linda D. Renald, Claimant.

HEWLETT-PACKARD COMPANY, *Petitioner,*
v.
Linda D. RENALDS, *Respondent.*
(92-05094; CA A82452)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 18, 1994.
Eli Stutsman argued the cause for petitioner. On the brief were Janet M. Schroer and Hoffman, Hart & Wagner.
Quentin B. Estell argued the cause for respondent. With him on the brief was Estell & Bewley.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
RIGGS, J.
Affirmed.

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132 Or App 290> Employer seeks review of a Workers' Compensation Board order holding that claimant's occupational disease is compensable. ORS 656.298. It argues that the Board erred by deciding the claim on a theory that was not properly argued. We affirm.

Claimant began working for employer in 1979, and worked in a variety of capacities. In late 1987, claimant experienced bilateral hand and forearm pain, swelling, numbness and tingling. In December, 1988, claimant sought treatment from Dr. Miller, who diagnosed right arm overuse syndrome. Nerve conduction studies revealed bilateral carpal tunnel syndrome (CTS). Claimant filed a workers' compensation claim with employer for a strain of her left hand and right arm. Employer issued a letter to claimant accepting her "right arm overuse syndrome" as a non-disabling injury and paid for all of claimant's treatment.

In August, 1991, claimant quit her job with employer and returned to school. In September, she began cleaning houses on a part-time basis but, after her first house, she experienced increased symptoms of numbness and swelling in both hands. Claimant went to Dr. Pribnow, who diagnosed bilateral hand and wrist pain and paresthesias. Nerve conduction studies again revealed bilateral CTS, greater on the right, with a slight progression since 1988. Claimant was referred to Dr. Yamanaka, who requested surgical authorization to perform a right carpal tunnel release in December, 1991. Employer refused authorization and denied the compensability of the CTS. Claimant requested a hearing. The referee analyzed the claim as one for aggravation of the accepted 1988 claim and concluded that claimant's earlier accepted claim for right arm overuse syndrome was a material contributing cause of her current need for treatment. The referee ordered employer's denial set aside. Employer sought review, and the Board concluded that the referee's analysis was "too limited," in that it focused solely on an aggravation theory, that is, on the causal relationship between the previously accepted condition and the current CTS condition. The Board determined that claimant's work activities with employer were the major contributing cause of her bilateral **<132 Or 290/291>** CTS and, therefore, her claim was compensable as an occupational disease. ORS 656.802(2).

Employer assigns error to the Board's conclusion that claimant established a claim for an occupational disease. It argues that the occupational disease theory was not properly before the Board, because claimant failed to raise the theory before the referee. We disagree.

At all stages of this case, the relationship between the CTS and claimant's working conditions has been at issue. Employer's denial states:

> "[I]t has been determined that the bilateral carpal tunnel syndrome is unrelated to your compensable workers' compensation claim for right arm overuse syndrome and, additionally, that your employment [at employer] is not the major contributing cause of your bilateral carpal tunnel syndrome.

> "Therefore, we must issue this denial. Our denial is based on the fact 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,* within the meaning of the Oregon Workers' Compensation Law." (Emphasis supplied.)

In her request for a hearing, claimant checked the box requesting review of the compensability of her claim. Before opening statements at the hearing, the referee asked:

> "The sole issue before me is an aggravation denial for bilateral carpal tunnel syndrome conditions. That was denied on April 2, 1992. Is that right?"

Both counsel agreed with the referee's statement. However, during opening argument, claimant's counsel stated that "[i]t is our contention that the conditions are the result of the original work exposure." The implications of this were made clear later in the hearing, when the following colloquy occurred:

> "[CLAIMANT's COUNSEL]: At the beginning of the hearing, you asked if this was a straight aggravation case. We said yes. Actually, there's a little more to it than that. They say 'the bilateral carpal tunnel syndrome is unrelated to your compensable workers' compensation claim for right arm overuse syndrome. *Additionally, your employment at* **<132 Or App 291/292>** *[employer] is not the major contributing cause of your bilateral carpal tunnel syndrome,' which goes beyond a simple aggravation.* So, certainly, that raises more issues than saying we agree that all these problems were at one time our responsibility, but they are no longer." (Emphasis supplied.)

The colloquy makes clear that, at the hearing, claimant raised the issue of whether her current CTS was the result of her work with employer.

The fact that claimant had not previously labeled her claim as one for an occupational disease is immaterial. As the Supreme Court recognized in *DiBrito v. SAIF,* 319 Or 244, 875 P2d 459 (1994), a claim may be cognizable under either an occupational disease or an accidental injury theory. In such a case, "the Board's first task is to determine which provisions of the Workers' Compensation Law are applicable." 319 Or at 248. That is exactly what the Board did here; it determined that the provisions concerning occupational disease were applicable to claimant's claim.[1] Thus, we conclude that the issue of claimant's occupational disease was properly before the Board.

Affirmed.

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[1] Employer does not argue that CTS is not an occupational disease.

Cite as 132 Or App 293 (1995) January 4, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Hartmut Karl, Claimant.

Hartmut KARL, *Petitioner,*
v.
CONSTRUCTION EQUIPMENT COMPANY and Liberty Northwest Insurance Corporation,
Respondents.
(92-04048; CA A82608)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 23, 1994.
Bruce A. Bottini argued the cause for petitioner. On the brief were John M. Oswald and Bottini & Bottini, P.C.
Douglas A. Schoen argued the cause for respondents. On the brief was Alexander D. Libmann.
Before Richardson, Chief Judge, and De Muniz and Leeson, Judges. De MUNIZ, J.
Reversed and remanded for award of attorney fees.

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132 Or App 295> Claimant seeks review of an order of the Workers' Compensation Board holding that he is not entitled to an award of insurer-paid attorney fees for having prevailed on a claim for medical treatment. We conclude that claimant is entitled to attorney fees under *SAIF v. Allen,* 320 Or 192, 881 P2d 773 (1994), and reverse and remand.

Claimant injured both knees in April, 1990, while employed at Construction Equipment Company. His claim was accepted and closed by a determination order in October, 1990, with an award of permanent partial disability.

After claim closure, claimant suffered increased pain in his left knee. Medical opinions confirmed that the knee condition had worsened. Insurer denied claimant's aggravation claim. The referee upheld the denial, and claimant requested Board review. In the meantime, claimant continued to seek and receive treatment for his left knee. Claimant requested a hearing concerning *insurer's "de facto* denial" of his claim for medical services related to the compensable knee injury, *i.e.,* its failure to pay claimant's medical bills. The referee stated that, because it was unclear whether the bills were contested on the basis of their causal relationship to the compensable injury or on a "proprietary ground," he could not determine whether he had jurisdiction to consider the insurer's refusal to pay claimant's medical bills, or whether the matter was exclusively within the jurisdiction of the Director. Claimant again appealed to the Board.

Thus, two matters were pending simultaneously before the Board: the question of the compensability of the aggravation claim, and the denial of medical treatment for the compensable knee injury. In December, 1992, the Board ruled that the denial of the aggravation claim should be set aside. It held that claimant's knee condition was causally related to his compensable injury and that he had established an aggravation claim. It awarded insurer-paid attorney fees to claimant "for services regarding the aggravation issue." Insurer did not seek review of that order.

In October, 1993, the Board issued its order concerning the medical treatment dispute. The Board ruled that the prior litigation concerning the aggravation claim had **<132 Or App 295/296>** involved the causal relationship between claimant's current knee condition and Ms compensable injury. In the light of the fact that the referee had expressly found a relationship between the need for treatment and the compensable injury, the Board held, as a matter of law, that the disputed medical bills were related to the compensable injury, and that insurer was precluded from asserting that the medical bills were not related to the compensable injury. It held that insurer is obligated to pay the bills pursuant to the Board order setting aside the aggravation claim denial. The Board awarded claimant an additional attorney fee under ORS 656.386(1) for having prevailed on the question of the compensability of medical treatment. On reconsideration, and relying on our opinion in *SAIF v. Allen,* 124 Or App 183, 861 P2d 1018 (1993), the Board withdrew the award of attorney fees, reasoning that the dispute concerned only the payment of medical bills related to a compensable claim.

In the light of *SAIF v. Allen, supra,* we conclude that this case must be remanded to the Board for an award of insurer-paid attorney fees. There is no indication in this record that insurer's denial of medical bills was limited to the amount of compensation due. Accordingly, for purposes of ORS 656.386(1), the denial is assumed to encompass the compensability of the condition for which treatment was sought.

Reversed and remanded for award of attorney fees.

Cite as 132 Or App 325 (1995) January 4, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dale A. Weckesser, Claimant.

Dale A. WECKESSER, *Petitioner,*
v.
JET DELIVERY SYSTEMS and SAIF Corporation, *Respondents.*
(93-10648; CA A85412)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1994.
Susan L. Frank argued the cause for petitioner. With her on the brief was Pozzi Wilson Atchison.
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 Richardson, Chief Judge,* and De Muniz and Leeson, Judges.
LEESON, J.
Reversed and remanded for reconsideration.

* Richardson, C. J., *vice* Rossman, P. J., retired.

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132 Or App 327> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in holding that he has failed to prove that his compensable foot injury includes chronic impairment, for which he could be entitled to an additional permanent partial disability award. We reverse and remand.

OAR 436-35-010(6) provides that

> "[a] worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition * * *."

The rule does not define the term "chronic." However, Board orders applying that rule have interpreted it to permit an award of up to five percent scheduled PPD if there are medical findings from which the Board can conclude that there is least a partial loss of ability to repetitively use the body part." *Donald E. Lawry,* 45 Van Natta 1452 (1993).

Evidence in the record includes a report by Dr. Wisdom, claimant's attending physician, which describes claimant's permanent disability to include

> "decreased flexor/invertor strength in the foot or ankle, easy fatiguability in the foot and the leg with long standing and wall{lug, probable discomfort in the foot and ankle with same, ongoing need for orthotic correction and high top shoes."

At the request of SAIF, claimant was examined by Dr. Hunt on May 18, 1993. Hunt's report following that examination rated claimant's impairment. Wisdom expressly concurred in Hunt's report. Subsequently, on August 16, 1993, claimant sent Hunt a questionnaire asking whether claimant had a chronic condition with at least a partial loss of ability to repetitively use his left foot. Hunt answered affirmatively. Wisdom was not asked to and did not concur in that opinion.

ORS 656.245(3)(b)(B) provides that only the attending physician may rate a claimant's impairment. Because Wisdom did not separately concur in Hunt's response to the **<132 Or App 327/328>** questionnaire, the Board, in affirming the referee, held that it could not consider Hunt's response to the questionnaire for the purpose of determining whether claimant has a chronic condition. Claimant contends that, because Wisdom had once concurred in Hunt's opinion, it was not necessary for Wisdom to concur separately in the answer to the questionnaire, which claimant characterizes as merely an addendum to Hunt's full report.

We agree with the Board that, like other impairments, chronic condition "impairment" must be rated or concurred in by the attending physician. It is for the attending physician to determine whether the "addendum" or subsequent report of another rating physician is consistent with the attending physician's opinion of impairment.

Having refused to consider Hunt's response to the questionnaire, the Board said:

> "There is no medical opinion which may be considered on the issue of permanent impairment that claimant has a 'chronic medical condition' as a medical term of art."

The Board's characterization of "chronic medical condition" as a medical "term of art," and its apparent conclusion that there is no admissible medical opinion directed to that issue, suggests that the Board believes that the record must contain a medical opinion using the word "chronic." However, that is not necessarily consistent with what the Board has held in other cases. For example, the Board has held that a doctor's use of the words "chronic condition limiting repetitive use" is not sufficient, in and of itself, to support an award. There must be evidence of a permanent inability to repetitively use the body part. *Donald E. Lawry, supra.*

There is no indication in this record that the meaning of the term "chronic" is different when used in medical contexts than when used in common parlance. We think that the administrative rule permits the Board to make an award for "chronic condition impairment" even if the record contains no express medical finding that the condition is "chronic," so long as the record contains a medical opinion of the claimant's attending physician, or one in which the attending physician has concurred, *from which it can be found* that the worker is unable to repetitively use a body part **<132 Or App 328/329>** "due to a chronic and permanent medical condition." The Board erred in concluding that it could not consider Hunt's first opinion and Wisdom's opinion for the purpose of determining whether claimant is entitled to an award for chronic condition impairment.

Reversed and remanded for reconsideration.

Cite as 132 Or App 349 (1995) January 4, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Linda BIRD, *Respondent,*
v.
NORPAC FOODS, INC., an Oregon cooperative, dba Stayton Canning Company, *Appellant,*

Donald Gale MORELAND, an individual, *Defendant.*
(850500C; CA A65075 (Control))

OREGON INSURANCE GUARANTY ASSOCIATION, an association, and Norpac Foods, Inc., dba Stayton Canning Company, a cooperative, and Donald Moreland, *Respondents,*
v.
Linda BIRD, *Appellant,*

AMERICAN MOTORISTS INSURANCE COMPANY, an Illinois corporation, and Farmers Insurance Company of Oregon, an Oregon Corporation, *Defendants.*
(C900682CV; CA A68732) (Cases Consolidated)

Appeal from Circuit Court, Washington County.
Gregory E. Milnes, Judge.
Argued and submitted October 10, 1994.
132 Or App 350> John L. Langslet argued the cause for appellant Norpac Foods, Inc. With him on the briefs in CA A65075 were Michael G. Harting and Martin, Bischoff, Templeton, Langslet & Hoffman.
John E. Uffelman argued the cause and filed the brief in CA A65075 for respondent Linda Bird.
John E. Uffelman argued the cause and filed the briefs in CA A68732 for appellant Linda Bird.
John L. Langslet argued the cause for respondents Oregon Insurance Guaranty Association, Norpac Foods, Inc., and Donald Moreland. With him on the brief in CA A68732 were Michael G. Harting and Martin, Bischoff, Templeton, Langslet & Hoffman.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
HASELTON, J.
Order denying Norpac Foods, Inc., and Donald Moreland's motion to direct satisfaction in CA A65075 reversed and remanded; judgment in CA A68732 affirmed.

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132 Or App 352> These two consolidated appeals involve contradicting dispositions that present the same question: Where the Oregon Insurance Guaranty Association (OIGA) has assumed the rights and responsibilities of an insolvent insurer under ORS 734.510 et seq, and a plaintiff obtains a personal injury judgment against a defendant insured by that insolvent insurer, must the judgment be deemed satisfied to the extent the plaintiff has received workers' compensation and uninsured motorist benefits for the same injury? Because we answer that question in the affirmative, we reverse in the first appeal and affirm in the second.

In 1983, plaintiff Linda Bird was injured in the course of her employment when the car she was driving collided with a car driven by Donald Moreland, who was in the course of his employment with Norpac Foods, Inc. Bird filed a workers' compensation claim based on her injuries and collected $84,607.84 in benefits from her employer's workers' compensation insurer, American Motorists Insurance Company (AMIC). She also filed an uninsured motorist claim against her own motor vehicle insurer, Farmer's Insurance Company of Oregon, and ultimately collected $5,664.49 on that claim.[1]

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[1] Moreland qualified as an uninsured motorist under Bird's policy because his motor vehicle insurer had been declared insolvent.

Bird also filed a personal injury claim against Moreland and Norpac. At the time of the accident, Norpac and Moreland, as its agent, were insured by Mission Insurance Company. Mission was later declared insolvent, and OIGA assumed its rights and responsibilities vis-a-vis Moreland and Norpac, including the defense of Bird's action, pursuant to ORS 734.570(1) and (2). A jury awarded Bird damages of $104,742.26, including $94,742.26 in economic damages and $10,000 in non-economic damages; the trial court entered judgment against Norpac and Moreland, jointly and severally, in that amount.

Norpac and Moreland, at OIGA's instigation, filed a motion for an order directing satisfaction of the judgment. In that motion, they argued that, because OIGA had assumed **<132 Or App 352/353>** the responsibilities of their insolvent insurer and was ultimately responsible for paying the judgment against them, the judgment was subject to ORS 734.640. That statute provides:

> "(1) Any person who has a claim under an insurance policy against an insurer other than an insolvent insurer which would also be a covered claim against an insolvent insurer must first exhaust the remedies under such policy.
>
> "(3) Any recovery under ORS 734.510 to 734.710 from [OIGA] shall be reduced by the amount of any recovery pursuant to subsection (1) * * * of this section."

Under that provision, they argued, Bird's judgment must be offset and deemed satisfied to the extent of her workers' compensation and uninsured motorist recoveries.[2]

Bird opposed the motion, arguing, among other things, that her claim did not qualify as a "covered claim" and that her workers' compensation recovery did not qualify as "a claim under an insurance policy," as those terms are used in ORS 734.640(1). The trial court denied the motion:

> "ORS 734.640 is a claim priority matter and has nothing to do with the plaintiff in this matter. It talks about 'any recovery under 734.514 to 734.710' and I do not believe that 'covered claim under 734.510(4)(a)' has anything to do with the plaintiff in this case."

Norpac appealed that denial. ORS 19.010(c). That appeal (CA A65075) is the first of the consolidated appeals before us. In filing the appeal, Moreland was not named as an appellant. Because the limitations period for appealing that decision has long since elapsed, the trial court's decision is final and unappealable with respect to Moreland.

While Norpac's appeal was pending, OIGA filed a complaint against Bird, AMIC and Farmer's in its own name, as well as Norpac's and Moreland's, seeking a declaratory judgment that OIGA, Norpac, and Moreland had no duty to **<132 Or App 353/354>** pay Bird's judgment. As its insureds had argued in their motion to direct satisfaction, OIGA alleged that, under the OIGA statutes, and ORS 734.640 in particular, Bird's workers' compensation and uninsured motorist recoveries must be offset against the judgment in her personal injury action.

Bird moved to dismiss, arguing, *inter alia,* that another action involving the same claim was pending (*ie.*, Norpac's appeal) and that the present action was barred under principles of *res judicata* and collateral estoppel. Bird also moved for summary judgment, asserting the same substantive arguments that had prevailed against Norpac's and Moreland's motion to direct satisfaction. OIGA filed a cross-motion for summary judgment. The trial court denied Bird's motions, granted OIGA's cross-motion for summary judgment, and entered a judgment declaring that Bird's $104, 742.26 judgment against Norpac and. Moreland should be offset by the $90,272.33 she had recovered from AMIC and Farmer's. Bird appeals that judgment in CA A68732.

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[2] In their motion for an order directing satisfaction, Norpac and Moreland alleged that AMIC and Farmers had paid Bird more than $103,000. All parties now agree that the total amount paid to Bird by AMIC and Farmers was $90,272.33. To avoid confusion over amounts that are not in dispute, OIGA, Norpac, and Moreland have since paid the undisputed portion of the judgment, $15,014.33, to Bird, leaving only the $90,272.33 at issue.

We first address Norpac's appeal. Norpac argues that the trial court's denial of its motion to satisfy is contrary to ORS 734.640(3) and, in particular, to the Supreme Court's interpretation of that provision in *Carrier v. Hicks*, 316 Or 341, 851 P2d 851 (1993). Bird counters that the denial of satisfaction was proper for a number of reasons. She argues, variously, that: (1) *Carrier v. Hicks, supra,* is inapplicable to her workers' compensation recovery; (2) Norpac failed to establish that Bird's personal injury claim was a "covered claim" under the OIGA statutes; and (3) the satisfaction procedure invoked by Norpac was not available under the circumstances. We consider, and reject, each argument in turn.

The relevant statutes, which are set out at ORS 734.510 to ORS 734.710, provide a scheme for guaranteeing payment on claims falling within the coverage of insurance policies issued by insurers that are later declared insolvent. Under those statutes, OIGA, an association of insurers doing business in Oregon, collects funds from its members, and uses those funds to pay certain insurance claims, *i.e.*, "covered claims," filed against insurers that have been declared insolvent. OIGA is required to:

> **132 Or App 355>** "(1) * * * pay *covered claims* existing at the time of determination of insolvency of an insurer or arising within 30 days after the determination of insolvency * * *.
>
> "(2) Be the insurer to the extent of the association's obligation on the *covered claims* and to such extent have all the rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent." ORS 734.570. (Emphasis supplied.)

A "covered claim" is

> "an unpaid claim * * * that arises out of and is within the coverage and limits of an insurance policy to which ORS 734.510 to 734.710 apply and which is in force at the time of the occurrence giving rise to the unpaid claim, made by a person insured under such policy or by a person suffering injury or damage for which a person insured under such policy is legally liable * * *." ORS 734.510(4)(a).

The term "covered claim" does not include any amount owed to an insurer "as subrogated recoveries or otherwise." ORS 734.510(4)(b).

The statutory scheme recognizes that a person who has a claim under a policy issued by an insolvent insurer might also have claims, based on the same accident or occurrence, against insurance policies issued by solvent insurers. Thus, ORS 734.640 ensures that, in those situations, OIGA funds will not be used "until all other available insurance sources of payment have been used up." *Carrier and Hicks, supra,* 316 Or at 348. In particular, under ORS 734,640(1), claimants are required to exhaust their remedies under policies issued by solvent insurers, by filing any available "claim[s] under an insurer policy * * * which would also be a covered claim," before they turn to OIGA for payment. In addition, any recovery from OIGA must be reduced by the amount recovered as a result of those claims. ORS 734,640(3).

Norpac argues, and Bird does not dispute that, under the analysis of *Carrier v. Hicks, supra,* Bird's uninsured motorist recovery was obtained pursuant to a "claim under an insurance policy * * * which would also be a covered claim." Thus, subject to our disposition of Bird's alternative arguments, ORS 734.640(3) operates to reduce her judgment to that extent.

132 Or App 356> Whether her workers' compensation recovery was obtained pursuant to a "claim under an insurance policy" is a closer and more difficult question. The text of ORS 734.640 is unenlightening. Neither that section, nor the OIGA statutes generally, defines "insurance." Nor, obviously, does the statutory text refer expressly to workers' compensation coverage. *See PGE v. Bureau of Labor and Industries,* 317 Or 606, 859 P2d 1143 (1993).

Resort to context is more useful. The OIGA statutes expressly treat claims under workers' compensation policies as "claims arising out of 'insurance policies'" for some purposes. ORS 734.570(1) places a $300,000 cap on OIGA's liability for covered claims "[e]xcept for covered claims arising out of workers' compensation policies." In addition, we have assumed that workers' compensation claims are

"claims arising out of an insurance policy" for purposes of ORS 734.510(4)(b)(B) and ORS 734.695.[3] *See Corvallis Aero Service v. Villalobos*, 81 Or App 137, 724 P2d 880 (1986).

We are loath to hold that a workers' compensation policy is an "insurance policy" for purposes of some provisions of the Guaranty Association Act, but not for others, specifically ORS 734,640(1). When a term is used in various parts of the same statute, we must presume, absent clear indications to the contrary, that the legislature intended the same meaning throughout. *Pense v. McCall*, 243 Or 383, 389, 413 P2d 722 (1966); *Cherry Growers v. Emp. Div.*, 25 Or App 645, 649, 550 P2d 1250 (1976). We find no clear evidence of a contrary intent in the OIGA statutes or their legislative history, and, therefore, conclude that workers' compensation benefits, including those received by Bird in this case, are **<132 Or App 356/357>** recoveries obtained pursuant to "claims under insurance policies" under ORS 734.640.

We acknowledge, as Bird emphasizes, that our holding may, in particular cases, frustrate a stated purpose of the OIGA statutes: "to avoid financial loss to claimants or policyholders because of the insolvency of the insurer." ORS 734.520.[4] Under normal circumstances-ie., if Moreland's and Norpac's insurer, Mission, had remained solvent-Bird would have been entitled to retain a portion of the third-party judgment, even if that portion effectively duplicated her workers' compensation benefits, her counsel would have been compensated from that judgment, and the compensation carrier would have had a lien on the balance. ORS 656.593(1)(a), (b) and (d).[5] By requiring a reduction "by the amount of

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[3] ORS 734.510(4)(b)(B) provides:

> "(b) 'Covered claim' does not include:
>
> "* * * * *
>
> "(B) Any amount due any reinsurer, insurer, insurance pool or underwriting association as subrogated recoveries or otherwise."

ORS 734.695 provides:

> "The insured of an insolvent insurer shall not be personally liable for amounts due any reinsurer, insurer, insurance pool or underwriting association as subrogation recoveries or otherwise up to the applicable limits of liability provided by the insurance policy issued by the insolvent insurer."

[4] *Accord Carrier v. Hicks, supra;* in which the court noted the legislature's general intent to

> "maximize[] protection to the insured of an insolvent insurer, up to the OIGA limits, *without intruding on the right of the injured person to recover damages to which he or she legally is entitled* * * *." 316 Or at 351. (Emphasis supplied.)

[5] ORS 656.576 to 656.596 allow a worker who receives a compensable on-the-job injury due to the negligence of a third person to seek damages from that person, and to collect workers' compensation benefits until such damages are actually recovered. ORS 656.593 provides that the proceeds of any damages recovered in such a third-party action

> "(1) * * * shall be subject to a lien of the [workers' compensation insurer] for its share of the proceeds * * * and the total proceeds shall be distributed as follows:
>
> "(a) Costs and attorney fees incurred shall be paid * * *.
>
> "(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.
>
> "(c) The [workers' compensation insurer] shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, [etc.] * * *
>
> "(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. * * *
>
> "(2) The amount retained by the worker * * * shall be in addition to the compensation or other benefits to which such worker * * * [is] entitled under this chapter."

That statutory distribution expresses a legislative intent that both injured workers and workers' compensation insurers benefit from third-party recoveries. *SAIF v. Parker*, 61 Or App 47, 53, 656 P2d 335 (1982).

any recovery" from other insurance, ORS 734.640(3) unambiguously requires a reduction by the full amount of such recovery, precluding such apportionment.[6]

132 Or App 358> We appreciate that our construction of ORS 734,640 to encompass workers' compensation benefits means that plaintiffs in Bird's position may recover less because of an insurer's insolvency. However, given the text and context of the statute, we are unable to read it in a manner that avoids that result.

Bird next argues that, even if both her uninsured motorist and workers' compensation recoveries were obtained pursuant to "claims under an insurance policy," the judgment in her personal injury action was not a "covered claim" subject to ORS 734,640 because Moreland and Norpac were insured by insurers other than the insolvent Mission and they failed to exhaust that coverage. Bird asserts that ORS 734,640(1) requires such exhaustion of other coverage before OIGA can treat a judgment as a "covered claim" and invoke the statutorily prescribed offset.

Bird indiscriminately and improperly conflates two unrelated statutes. ORS 734,510(4) clearly and comprehensively defines "covered claims." Conversely, ORS 734,640(1) is a priority statute, limiting OIGA's obligation to pay "covered claims." That statute requires persons who have such claims to exhaust their remedies against other insurers before they seek a remedy from OIGA; it does not, however, impose any obligations on OIGA, including, for example, any obligation to investigate other insurance before processing a claim. Because Bird's claim fell squarely within ORS 734.510(4)'s definition of "covered claims," OIGA was entitled to treat it as such.

Bird next argues that, regardless of the operation of ORS 734,640, OIGA waived any right it may have had to an offset because it failed to request the offset *before* the entry of final judgment. She relies on ORS 18.580, which allows a **<132 Or App 358/359>** court to deduct certain collateral benefits received by a party awarded damages in a personal injury action "before the entry of final judgment." This argument fails because OIGA's entitlement to offset derives from ORS 734.640, and not, generically, from ORS 18.580. *Hallford v. Smith,* 120 Or App 57, 64, 852 P2d 249 (1993); *State v. Vandepoll,* 118 Or App 193, 198, 846 P2d 1174 (1993). Although OIGA can employ the procedures described at ORS 18.580 to effect its right, it is not obliged to employ those procedures as the exclusive means for doing so.

In a related sense, Bird argues that OIGA cannot formalize its right to a reduction through the procedure it *did* choose to employ, *i.e.,* satisfaction of judgment pursuant to ORS 18.410. She interprets ORS 18.410(2)(a)(C), which requires persons moving for a satisfaction of judgment to specify "the date or dates and amounts of any payments *on the judgment,"* as an indication that a judgment may be satisfied only if the plaintiff has received payments on the judgment. She argues that, because her uninsured motorist and workers' compensation recoveries were not payments "on the judgment" in her personal injury action, those recoveries cannot be deemed to satisfy her judgment against Norpac and Moreland.

We disagree. ORS 18.410 provides a procedure for "obtain[ing] a satisfaction * * * when any [judgment debtor] is unable to obtain a satisfaction." Under ORS 18.400, a satisfaction results "when any judgment is paid *or satisfied."* (Emphasis supplied.) The use of the disjunctive indicates that a judgment may be satisfied by means other than direct payment. Here, because ORS 734.640 allows OIGA to reduce Bird's judgment against Norpac and Moreland by her uninsured motorist and workers' compensation recoveries, the judgment may be deemed satisfied to the extent of those recoveries.[7]

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[6] Conversely, excluding workers' compensation benefits from the operation of ORS 734.640 would subvert another fundamental policy of the OIGA statutes-that OIGA's funds are to be used only as a "last resort" to compensate claimants. *Carrier v. Hicks, supra,* 316 Or at 348-49. ORS 734.510(4)(b)(B) and ORS 734.695 bar AMIC, or any compensation carrier, from imposing a lien against monies OIGA pays to plaintiffs on third-party claims. *See Corvallis Aero Service v. Villalobos, supra.* Consequently, if Bird's judgment were not reduced by the amount of her compensation recovery, she would be entitled to retain not only the claimant's share of the third-party judgment, as per ORS 656.693(1)(a), but also AMIC's putative lien share and could, thus, realize a double recovery *at OIGA's expense* in contravention of the statutory scheme.

[7] A similar "satisfaction by reduction" scheme is described at ORS 18.510(3)(c), where payments made prior to judgment, and therefore, not "on the judgment," may be applied to the judgment in partial satisfaction thereof.

In sum, with respect to Norpac's appeal, we conclude that the trial court erred in denying Norpac's motion to direct satisfaction. Accordingly, we reverse that order.

132 Or App 360> That disposition largely disposes of Bird's appeal of OIGA's declaratory judgment action. In adjudicating Norpac's appeal, we considered and rejected every substantive argument Bird advances against the subsequent judgment. In addition to her substantive arguments, Bird contends that OIGA's claim for declaratory relief was barred either by *res judicata* (claim preclusion) or collateral estoppel (issue preclusion), deriving from the court's prior denial of Norpac's and Moreland's motion to direct satisfaction. Our disposition of Norpac's appeal deprives the prior adjudication of preclusive effect as to Norpac. *See Community Bank v. Vassil,* 280 Or 139, 143-44, 570 P2d 66 (1977). Thus, even if we were to assume, as plaintiff argues, that OIGA and Norpac were in privity so that OIGA should have been bound by the prior denial, the trial court's rejection of Bird's issue preclusion and claim preclusion defenses was not prejudicial.

A different analysis applies to Moreland. As noted, Moreland did not file a timely appeal from the trial court's order denying satisfaction. Accordingly, notwithstanding our reversal on Norpac's appeal, that order was, and is, final and preclusive as to Moreland.

Nonetheless, we do not address plaintiff's preclusion arguments with respect to Moreland because any decision we might render would not "have a practical effect on or concerning the rights of the parties." *Brumnett v. PSRB,* 315 Or 402, 406, 848 P2d 1194 (1993). This is so because, as a matter of law, our holding that the judgment has been properly satisfied as to Norpac in the amount of $90,272.33 also operates to satisfy the joint and several judgment against Moreland to the same extent. *See Starr v. Heckathorne,* 270 Or 238, 527 P2d 401 (1974); *Savelich Logging v. Preston Mill Co.,* 265 Or 456, 509 P2d 1179 (1973). Accordingly, plaintiff's claim and issue preclusion arguments with respect to Moreland, while justiciable, are moot.

Order denying Norpac Foods, Inc., and Donald Moreland's motion to direct satisfaction in CA A65075 is reversed and remanded; the judgment in CA A68732 is affirmed.

Cite as 132 Or App 369 (1995) January 4, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Frances C. Johnson, Claimant.

LEGACY HEALTH SYSTEMS, *Petitioner,*
v.
Frances C. JOHNSON, *Respondent.*
(92-15069; CA A83208)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1994.
Jerald P. Keene argued the cause for petitioner. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C.
Kimberley Chaput argued the cause for respondent. With her on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.
Before Richardson, Chief Judge,* and De Muniz and Leeson, Judges.
PER CURIAM
Affirmed.

* Richardson, C. J., *vice* Rossman, P. J., retired.

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132 Or App 370> Employer seeks review of an order of the Workers' Compensation Board, contending that the Board erred in concluding that claimant is entitled to an award for both scheduled and unscheduled disability for her compensable injury. We have reviewed that Board's order and conclude that it is supported by substantial evidence and that the Board could properly make an award for both scheduled and unscheduled disability.

Employer also asserts that ORS 656.268(4)(g), under which the Board assessed a penalty against employer, is unconstitutional. Employer did not properly raise that argument before the Board, and we will not consider it for the first time on review.

Affirmed.

Cite as 132 Or App 371 (1995) January 4, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Complying Status of Dan J. and Giselle Dana Lane,
and
In the Matter of the Compensation of Marshall K. Birdwell, Claimant.

Dan J. LANE and Giselle Dana Lane, *Petitioners,*
v.
SAIF CORPORATION, Department of Insurance and Finance and Marshall K. Birdwell, *Respondents.*
(92-09931, 92-08414; CA A80625)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1994.
Kenneth L. Kleinsmith argued the cause for petitioners. On the brief were Mildred J. Carmack, William H. Replogle and Schwabe, Williamson & Wyatt.
David L. Runner, Assistant Attorney General, argued the cause for respondents SAIF Corporation and Department of Insurance and Finance. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
No appearance for respondent Marshall K. Birdwell.
Before Richardson, Chief Judge,* and De Muniz and Leeson, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

* Richardson, C. J., *vice* Rossman, P. J., retired.

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132 Or App 372> In this workers' compensation case, the Board determined that petitioners were noncomplying employers and upheld SAIF's acceptance of claimant's head and back injury on behalf of petitioners. The Board did not have the benefit of the Supreme Court's opinion in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 872 P2d 1 (1994), when it issued its order.

SAIF concedes that the Board applied the wrong legal standard and that the case must be remanded to the Board to determine whether petitioners were noncomplying employers with respect to claimant. We accept that concession.

Reversed and remanded for reconsideration.

Cite as 132 Or App 424 (1995) January 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gloria T. Olson, Claimant.

Gloria T. OLSON, *Petitioner,*
v.
SAFEWAY STORES, INC., *Respondent.*
(91-16193; CA A78382)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 29, 1994.
Mike Stebbins argued the cause for petitioner. On the briefs were Karen M. Werner and Stebbins and Coffey.
Kenneth Kleinsmith argued the cause for respondent. With him on the briefs was Meyers & Radler.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P. J.
Reversed and remanded for reconsideration.

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132 Or App 426> Claimant seeks review of an order of the Workers' Compensation Board that affirmed employer's denial of her claims for aggravation and medical services. We reverse.

Claimant injured her right shoulder at work in 1988. She filed a claim for right shoulder strain. Employer never issued a written notice of acceptance as provided in ORS 656.262(6), but paid benefits for the shoulder injury. Before the claim was closed, claimant was diagnosed with tendinitis and, later, with a degenerative shoulder condition. Employer paid for surgery to treat the degenerative condition. In 1989, the claim was closed by a determination order, which awarded temporary disability and unscheduled permanent partial disability (PPD). A second determination order was issued two months later, decreasing the award of permanent disability. Claimant requested a hearing on both orders. In 1990, the parties settled that dispute by entering into a stipulation and order in which the parties agreed that claimant was entitled to receive additional compensation for her shoulder condition.

In 1991, claimant's shoulder condition worsened, and it was learned that she had a rotator cuff tear. She requested authorization for surgery to repair that condition, which employer denied. In November, 1991, employer denied her aggravation claim and her medical services claim. The Board affirmed, holding that the worsening of her shoulder condition and the need for medical treatment were caused in major part by her preexisting degenerative shoulder condition, not by her accepted condition, which was shoulder strain, and therefore was not compensable.

Claimant first assigns error to the Board's finding that employer accepted only the right shoulder strain and not the degenerative shoulder condition. She argues that employer's conduct constituted acceptance of the degenerative condition and, therefore, that that condition is part of the accepted claim. She claims that employer's payment for surgery for the degenerative condition, its failure to appeal two determination orders, which she asserts included awards of compensation for disability caused by the degenerative condition, and the 1990 stipulation and order, which she also **<132 Or App 426/427>** asserts included compensation for the degenerative condition, constituted acceptance of the degenerative condition as a matter of law. Alternatively, she argues that employer's failure to appeal the determination orders and its 1990 stipulation preclude employer from now denying that the degenerative condition is part of the compensable claim.

There is no dispute that employer accepted the claim for shoulder strain, or that claimant's shoulder condition has worsened since the claim was closed. The issue is whether employer's acceptance encompassed the degenerative condition as well as the strain.

Whether a condition has been accepted is a question of fact. *SAIF v. Tull,* 113 Or App 449, 454, 832 P2d 1271 (1992); *see also Taylor v. Masonry Builders, Inc.,* 127 Or App 230, 872 P2d 442, *rev den* 319 Or 281 (1994). The question for our review is whether there is substantial evidence to support the Board's

finding that employer accepted only a right shoulder strain and not the degenerative condition. There is evidence that the claim filed by claimant in 1988 was for a shoulder strain and that she was diagnosed with tendinitis. The record contains the stipulation and order, which recites that employer accepted a claim for tendinitis in the shoulder. The Board's finding that the claim that was accepted was a shoulder strain, and that it did not include the degenerative condition, is reasonable in the light of all the evidence. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). Therefore, the Board's finding is supported by substantial evidence.

Although the basis for claimant's argument Is not free from doubt, it appears that she is asserting that employer's conduct constituted acceptance of the degenerative condition as a matter of law. If that is her argument, she is wrong. Mere payment of compensation does not constitute acceptance. ORS 656.262(9); *Gregg v. SAIF*, 81 Or App 395, 725 P2d 930 (1986). Therefore, employer's payment for treatment of the degenerative condition, including surgery, does not constitute acceptance as a matter of law. Neither does employer's failure to appeal the two determination orders. The determination orders were issued by the Department of Insurance and Finance, not by employer. Their purpose was not to effect an acceptance or denial, but was to make a **<132 Or App 427/428>** determination about the extent of claimant's disability from the accepted shoulder strain and to award compensation in accordance with that determination. The determination orders did not, as a matter of law, constitute acceptance of the degenerative condition.[1]

Claimant also argues that the 1990 stipulation and order constituted acceptance of the degenerative condition. She asserts that employer's agreement to an increase in PPD for the right shoulder condition could only be based on the residuals from the surgery for the degenerative condition. She concludes, therefore, that employer's stipulation "amounted to a written acceptance" of the degenerative condition. Again, we disagree. Even if a stipulation is the equivalent of an acceptance of a claim, the 1990 stipulation says nothing about compensation for the degenerative condition. It says that claimant "filed a claim for a right shoulder condition which has been diagnosed as right shoulder tendinitis," and that "[t]hat claim was accepted and processed through to a Determination Order * * *." It goes on to state an agreement that employer would pay and claimant would accept an additional award of PPD. There is nothing in the order that arguably constitutes acceptance of the degenerative condition; in fact, that condition is nowhere mentioned in the stipulation and order.

If claimant's theory is that employer is barred by its conduct from denying that the degenerative condition is compensable, that argument also fails. Claimant does not rely on issue or claim preclusion, and therefore we do not address whether failure to appeal the determination orders could result in preclusion under *Drews v. EBI Companies*, 310 Or 134, 795 P2d 531 (1990), and *Messmer v. Deluxe Cabinet Works, supra* n 1.[2] Instead, she cites *SAIF v. Forrest*, 68 Or **<132 Or App 428/429>** App 312, 680 P2d 1031 (1984), for the proposition that employer's payment for the shoulder surgery constituted acceptance of the degenerative condition. In that case, the claimant injured his knee. He was awarded compensation based on the referee's finding that the knee condition was work-related. Later, SAIF accepted a claim for aggravation of that condition. After surgery revealed that the knee condition was a result of an off-the-job injury rather than an on-the-job injury, SAIF issued a denial of the aggravation claim on the basis that the knee condition was not related to work. We held that SAIF could not deny the aggravation claim, because the referee's earlier determination that the knee condition was work related had not been appealed. Accordingly, under *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), SAIF could not deny the compensability of that condition.

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[1] Unlike in *Messmer v. Deluxe Cabinet Works*, 130 Or App 254, 881 P2d 180 (1994), the Board did not make a finding that the determination orders awarded compensation for the degenerative condition. Although claimant asserts that the determination orders made an award o.f compensation based in part on disability caused by the degenerative condition, it is not obvious from our review of the determination orders and the evaluators' worksheets that the award included any compensation related to the degenerative condition.

[2] This case is different than *Messmer v. Deluxe Cabinet Works, supra n 1*, because in this case claimant's assignment of error goes to the *Board's* finding that the degenerative condition was not accepted. Neither the Board's order nor claimant's argument addresses claim preclusion.

That case does not assist claimant. Here, there has never been an adjudication that the degenerative condition is compensable. Further, the rule in *Bauman* that an employer may not deny an accepted claim applies only to claims that are specifically accepted under ORS 656,262. *SAIF v. Tull, supra.* Employer in this case has never officially accepted or denied the claim for the degenerative condition. The Board did not err in finding that employer had not accepted a claim for the degenerative condition.

Claimant's next two assignments challenge the Board's application of the major contributing cause standard to her claims for aggravation and for medical services. The Board reasoned that the degenerative condition was a preexisting condition and, therefore, that ORS 656.005(7)(a)(B) applied. It concluded that claimant was not entitled to compensation, because she had not shown that the 1988 on-the-job injury was the major contributing cause of the worsening of her right shoulder condition or of her need for medical treatment.

In *Jocelyn v. Wampler Werth Farms,* 132 Or App 165, __ P2d __ (1994), we held that ORS 656.005(7)(a)(B) does not apply to claims for aggravation under ORS 656,273(1). Claimant need prove only that her worsened condition was caused in material part by the compensable **<132 Or App 429/430>** injury. Similarly, in *Beck v. James River Corp.,* 124 Or App 484, 863 P2d 526 (1993), *rev den* 318 Or 478 (1994), we held that the major contributing cause test of ORS 656,005(7)(a)(B) does not apply to claims for continued need for medical treatment under ORS 656,245. The standard under that statute is also material contributing cause.

The Board erred in applying the major contributing cause test to the aggravation and medical services claims.

Reversed and remanded for reconsideration.

Cite as 132 Or App 436 (1995) January 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Roy A. Phillips, Claimant.

Roy A. PHILLIPS, *Petitioner,*
v.
DEAN's DRYWALL and Liberty Northwest Insurance Corporation, *Respondents.*
(WCB 92-05790; CA A83142)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 28, 1994.
Susan Frank argued the cause for petitioner. With her on the brief was Pozzi, Wilson & Atchison.
Alexander D. Libmann argued the cause for respondents.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P. J.
Reversed and remanded for reconsideration of attorney fees.

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132 Or App 438> Claimant seeks review of an order of the Workers' Compensation Board that awarded him permanent partial disability, but not permanent total disability. He asserts that the Board erred in failing to make an award of permanent total disability and in failing to award a penalty and attorney fees. We remand for the Board to consider the attorney fee request.

Claimant is a sheetrocker who suffered an injury on the job. He has various medical and nonmedical limitations that affect his employability. Employer accepted the claim, and closed it by a notice of closure, in which it awarded claimant temporary disability but no permanent disability compensation. Claimant sought reconsideration from the Department of Insurance and Finance, now called the Department of Consumer and Business Services, which affirmed the notice of closure in all respects. Claimant then sought a hearing. The referee found that claimants disability was not total, but was partial only, and made an award of 16 percent unscheduled disability. On appeal, the Board adopted the referee's findings and conclusions regarding permanent total disability, but increased the unscheduled disability award to 19 percent.

Claimant first argues that the Board erred in failing to find that he is permanently totally disabled under the odd lot doctrine. He asserts that his physical limitations, in addition to nonmedical limitations, leave him unemployable. Claimant relies on reports of vocational experts who determined that claimant is totally disabled. However, the Board adopted the referee's explanation of why the vocational experts' opinions are not persuasive, which is that they are based on an assessment that claimant can perform only light or sedentary work. The Board found, and there is substantial medical evidence to support the finding, that claimant is capable of engaging in medium work. Accordingly, the Board did not err in rejecting the vocational experts' opinions. There is substantial evidence to support the Board's finding that claimant is not totally disabled.

Claimant next challenges the Board's failure to award a penalty under ORS 656.268(4)(g), which provides:

> **132 Or App 439>** "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."

We need not decide whether, as claimant argues, a penalty is available under ORS 656,268(4)(g) for an increase in an award of permanent disability made by the Board rather than by the department, because here the increased award does not meet the threshold requirement that the claimant be found "to be at least 20 percent permanently disabled." The Board awarded 19 percent permanent partial disability. The Board did not err in failing to award claimant a penalty.

Finally, claimant argues that the Board erred in falling to award attorney fees pursuant to ORS 656.382(1) because employer unreasonably resisted the payment of compensation. The Board declined to address whether attorney fees should be awarded, because it found that claimant did not raise the issue at the hearing before the referee. The Board held that it would not address attorney fees for the first time on review.

Claimant argues, correctly, that the issue of attorney fees was raised at the hearing. In his request for hearing, he listed attorney fees as an issue. On the date of the hearing, he hand delivered a letter to the referee in which he argued his entitlement to attorney fees under ORS 656.382(1). The referee did not mention the request for fees or address the issue in any way. Because claimant requested fees and argued for his entitlement to them, the Board erred in failing to consider whether Claimant is entitled to an award of attorney fees under ORS 656.382(1).

Reversed and remanded for reconsideration of attorney fees.

Cite as 132 Or App 455 (1995) January 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jesus Fletes, Deceased, Claimant, and Edwin Hayes, NCE, and Gabriel Alvarez Lopez, Claimant.

Edwin HAYES, *Petitioner,*
v.
SAIF CORPORATION, Estate of Jesus Fletes, Gabriel Alvarez Lopez, *Respondents,*
and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, *Intervenor.*
(92-02935, 92-02586, 92-01344; CA A81345)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 26, 1994.
Adam T. Stamper argued the cause for petitioner. With him on the briefs was Cowling & Heysell.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Roger Ousey argued the cause for respondent Estate of Jesus Fletes. On the brief were Julie Zuver Ellickson and Bischoff & Strooband, P.C.
Bruce D. Smith argued the cause and fled the brief for respondent Gabriel Alvarez Lopez.
Stephanie Striffler, Assistant Attorney General, argued the cause for Intervenor Department of Consumer and Business Services. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Warren, Presiding Judge, and Edmonds and De Muniz, Judges.
EDMONDS, J.
Reversed and remanded.

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132 Or App 458> Edwin Hayes seeks review of an order that declares him to be a subject and noncomplying employer, and assesses a civil penalty against him. ORS 656.740. The Department of Consumer and Business Services (DCBS), formerly the Department of Insurance and Finance, issued an order of noncompliance against Hayes. Hayes sought review before a referee of the Hearings Division. ORS 656.740(3). The referee affirmed the order, and Hayes appealed to the Workers' Compensation Board. The Board dismissed for lack of jurisdiction, ruling that review was directly to this court. Hayes seeks remand to the Board for *de novo* review of the referee's decision or, in the alternative, reversal of the referee's decision. We remand to the Board for *de novo* review.

The referee found that Hayes is a retired individual who operates a small beef-raising business. In 1991, he had 20 head of cattle on land that he either owned or leased. On occasion, he would pay individuals to help him maintain his property or perform work related to his business. Since 1989, he has hired workers to help him haul hay for the cattle. In early September, 1991, he hired a group of men to help him. He did not discuss with the men what he would pay them, but testified that he intended to pay each of them $5 per truckload of hay. Over the course of three days, no fewer than nine truckloads of hay were hauled. On the third day, the work crew was riding on top of the hay loaded on a flat bed truck. The driver of the truck made a sharp turn to avoid a collision and, as a result, the hay and the workers fell off the truck. One worker was killed and another was injured. Later that day, Hayes gave $215 in cash to his tenant to give to the workers. Hayes contends that only $195 of that sum was for labor and the remainder was extra "to buy groceries or whatever" because he felt badly about the accident. DCBS investigated the accident and determined that Hayes was a subject and noncomplying employer, and that the workers (claimants) were subject employees under ORS 656.027.[1] Accordingly, **<132 Or App 458/459>** DCBS issued an order of noncompliance and assessed a penalty against Hayes. Thereafter, SAIF accepted the claims made by claimants.

Upon notification of the director's order, Hayes requested a hearing on that order, as well as a hearing on SAIF's acceptance of the claims. Based on the agreement of the parties, the hearings were consolidated. The only dispute concerned whether the amount of compensation paid to claimants was $200 or more in a 30-day period. At the hearing, Hayes stipulated that the truck accident occurred in the

course and scope of claimants' employment and that, "if [claimants] are subject workers under * * * [ORS 656.027(3)], then the proposed order [of noncompliance] stands, and SAIF's acceptance of the claims also stands."

Hayes argues that the Board erred in refusing to exercise jurisdiction over the appeal of the referee's decision and to review it *de novo*. The Board held that it lacked jurisdiction to review the referee's order, because it determined, based on Hayes' stipulation, that the issue at the hearing before the referee was confined to whether Hayes was a subject employer. As a result, it concluded that the referee's order constituted a final order of DCBS and that review was properly in this court. *See* ORS 656.740(4). Hayes contends that he is entitled to Board review because, at the hearing before the referee, he contested SAIF's acceptance of the claims as well as DCBS's proposed order declaring him to be a noncomplying employer.

ORS 656.740(4)(c) provides:

> "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 thereof shall be as provided for a matter concerning a claim."

132 Or App 460> Our task in interpreting a statute is to discern the intent of the legislature. *PGE v. Bureau of Labor Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). We first examine the text and context of the statute, including other provisions of the same statutory scheme. If the legislature's intent is clear from that inquiry, we need proceed no further, because the text of a statutory provision is the best evidence of the legislature's intent. *State ex rel Juv. Dept. v. Ashley*, 312 Or 169, 174, 818 P2d 1270 (1991).

ORS 656.704(3) provides, in part:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, *matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue.*" (Emphasis supplied.)

Thus, under the statutory scheme, a worker's right to receive compensation or the amount thereof must be "directly in issue" in order to constitute "a matter concerning a claim" under ORS 656.740(4)(c).

We conclude that Hayes' stipulation did not have the effect of precluding the Board's jurisdiction under ORS 656,740(4)(c). Despite the stipulation, claimants' rights to receive compensation remained "directly in issue," because whether claimants were "casual workers" within the meaning of ORS 656.027(3) affected not only Hayes' status as a subject employer, but also claimants' status as subject workers. It follows that the Board had jurisdiction to review the order.

Reversed and remanded.

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[1] ORS 656.027 provides, in part:

> "All workers are subject to this chapter except those nonsubject workers described in the following subsections:
>
> "(3)(a) A worker whose employment is casual and either:
>
> "(A) The employment is not in the course of the trade, business or profession of the employer; or
>
> "(B) The employment is in the course of the trade, business or profession of a nonsubject employer.
>
> "(b) For the purpose of this subsection, 'casual' refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200."

Cite as 132 Or App 483 (1995) January 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rosa V. Watson, Claimant.

TEKTRONIX, INC., *Petitioner,*
v.
Rosa V. WATSON, *Respondent.*
(93-04131; CA A83650)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 17, 1994.
Deborah L. Sather argued the cause for petitioner. With her on the brief was Stoel Rives Boley Jones & Grey.
Robert E. Martin argued the cause and filed the brief for respondent.
Before Richardson, Chief Judge,* and De Muniz and Leeson, Judges.
De MUNIZ, J.
Reversed and remanded for reconsideration.

* Richardson, C. J., *vice* Rossman, P. J., retired.

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132 Or App 485> Employer seeks review of an order of the Workers' Compensation Board. It contends that the Board erred both in failing to give weight to the attending physician's reports for purposes of rating claimant's permanent impairment and in refusing to consider the diagnostic reports of a consulting physician and an independent medical examiner. We reverse and remand for reconsideration.

Claimant has a compensable claim for carpal tunnel syndrome. She was treated with surgery in January and March, 1992. Her attending physician, Dr. Wilson, examined her on July 8, 1992, and noted in his charts that she appeared to be medically stationary "with no significant permanent impairment." On July 29, 1992, the claim was closed by a notice of closure, with no award for permanent partial disability.

Claimant sought reconsideration. Dr. Gritzka was appointed as a medical arbiter. He examined claimant and reported, on February 9, 1993, that she had a 39 percent loss of use or function in her right forearm. The order on reconsideration was issued on March 8, 1993, awarding claimant 39 percent permanent partial disability.

Employer requested a hearing, offering reports of WilSon, claimant's attending physician, Dr. Brown, a consulting physician, and Dr. Button, an independent medical examiner, in support of its view that claimant suffers from no permanent impairment.

We have held that, pursuant to ORS 656.245(3)(b)(B),[1] with the exception of a medical arbiter appointed pursuant to ORS 656.268(7),[2] only the attending physician at **<132 Or App 485/486>** the time of claim closure may make fin dings concerning a worker's impairment. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670, 866 P2d 514 (1994). Reports of independent medical examiners are not

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[1] ORS 656.245(3)(b)(B) provides:

"Except as otherwise provided in this chapter, *only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.*" (Emphasis supplied.)

[2] ORS 656.268(7) provides:

"The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure."

admissible for the purpose of rating impairment unless those findings are ratified by the claimant's attending physician. *See* OAR 436-35-007(8).[3]

When a medical arbiter is appointed, the findings of the arbiter are considered by the department on reconsideration. No subsequent medical evidence is admissible for the purpose of rating the claimant's impairment. ORS 656.268(7). Thus, the record correctly before the referee, the Board and the court in this case includes the reports that claimant's attending physician issued before the medical arbiter's report, the medical arbiter's report, and any report related to impairment that is ratified by the attending physician before the medical arbiter's report.

In affirming the referee, the Board held that, because neither Brown nor Button was claimant's attending physician and there is no indication that Wilson ratified their reports, the reports are not admissible for purposes of rating claimant's impairment. ORS 656.245(3)(b)(B); OAR 436-35-007(8). The Board found that Wilson had "never performed a closing examination nor authored/ratified a report regarding claimant's impairment findings." Thus, although the Board held that Wilson's reports, which had been made before the medical arbiter's .report, were admissible for the purpose of rating claimant's impairment, it concluded, based on the medical arbiter's report, that claimant's permanent impairment is 39 percent.

We agree with the Board that the report of Button's independent medical examination, which was written after the medical arbiter's report, is not admissible either to rate claimant's impairment or to impeach the medical arbiter's impairment rating. ORS 656.268(7).

132 Or App 487> We conclude, however, that the Board erred when it found that Wilson did not ratify findings contained in Brown's report. In his chart note of January 4, 1993, Wilson referred expressly to Brown's report, incorporating Brown's findings. Accordingly, Brown's findings are admissible for purposes of evaluating claimant's impairment.

The only remaining contention is that the Board erroneously "ignored" Wilson's reports for the purpose of rating claimant's impairment. We do not accept that characterization of the Board's action. The Board held, expressly, that Wilson's reports were admissible for purposes of rating impairment. It found, however, that Wilson had never purported to rate claimant's impairment. In his chart note of July 6, 1992, Wilson had expressly noted that claimant had no significant permanent impairment. In a note of January 4, 1993, Wilson said:

> "I believe she is stationary and stable with full range of motion. There is no impairment with regard to the median nerves at this point. The ulnar nerve represents objectively 5% impairment at the right hand."

The Board erred in finding that Wilson's report did not rate claimant's impairment.

Reversed and remanded for reconsideration.

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[3] OAR 436-35-007(8) provides:

> "Impairment findings made by a consulting physician or other medical providers (e.g., occupational or physical therapists) at the time of claim closure may be used to determine 'impairment if the worker's attending physician concurs with the findings as prescribed in OAR 436-10-080."

Cite as 132 Or App 494 (1995) January 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Roger D. Hart, Claimant.

ASPLUNDH TREE EXPERT COMPANY and Crawford & Company, *Petitioners,*
v.
Roger D. HART, *Respondent.*
(90-19506, 90-19507; CA A77409)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 2, 1993.
Margaret H. Leek Leiberan argued the cause for petitioners. With her on the brief were Leiberan & Gazeley, Schuyler T. Wallace and Wallace & Klor.
Michael D. Levelle argued the cause for respondent. With him on the brief was Bennett & Hartman.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed.

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132 Or App 496> Employer seeks review of a Workers' Compensation Board order setting aside a denial of claimant's aggravation claim. We affirm.

On July 7, 1988, claimant compensably injured his lower back. Employer accepted the claim. Following conservative treatment from Dr. Sacamano, his claim was closed on August 29, 1989, by Determination Order awarding him 7 percent unscheduled permanent partial disability (PPD). On July 22, 1990, claimant suffered severe back pain, left leg pain and left leg numbness when he bent over and lifted a 15-pound box at home. He initially sought treatment from Dr. Hazel, who authorized his release from work. Claimant then returned to Sacamano for treatment.

Claimant filed a claim for aggravation of the July 7, 1988, work injury. Employer denied the claim. At the hearing, Hazel opined that claimant suffered a new injury on July 22, 1990, and that the work-related injury of two years earlier did not contribute to claimant's condition. Sacamano testified that, although claimant suffered a new injury on July 22, 1990, both that injury and the previous work-related injury significantly contributed to the worsened condition. He could not, however, say which injury was the major contributing cause of claimant's condition. The referee concluded that, under ORS 656,273(1),[1] claimant has the burden of proving that a non-work injury is not the major contributing cause of claimant's worsened condition, and that claimant had failed to carry that burden. The Board reversed, concluding that ORS 656.273(1) places the burden on the employer to establish that a non-work injury is the major contributing cause of claimant' s condition, and that employer had failed to carry its burden.

132 Or App 497> Employer first assigns error to the Board's conclusion that employer bears the burden of proving that claimant's off-the-job injury is the major contributing cause of his worsened condition. In *Fernandez v. M & M Reforestation,* 124 Or App 38, 42-43, 860 P2d 898 (1993), we held that the Board was correct in allocating the burden of proof in that way. *See also Jocelyn v. Wampler Werth Farms,* 132 Or App 165, 172, __P2d__ (1994). The Board did not err.

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[1] ORS 656.273(1) provides, in part:

"After the last award or arrangement of compensation, an injured Worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

Employer next assigns error to the Board's finding that employer failed to carry its burden of proof. We review that finding for substantial evidence. ORS 656.298(6); ORS 183.482(8). The record presents a conflict of expert opinion on the question whether claimant's worsened condition was caused in major part by his non-work injury. Hazel testified that the July 22, 1990, at-home injury was the major contributing cause of claimant's worsened condition. Sacamano testified that both the work-related injury and the at-home injury significantly contributed to the worsened condition, but that it was not possible to say which was the major cause. The Board was entitled to give more weight to Sacamano's opinion. *Somers v. SAIF,* 77 Or App 259, 263, 712 P2d 179 (1986).

Affirmed.

Cite as 132 Or App 508 (1995) January 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald L. Ledbetter, Claimant.

Ronald L. LEDBETTER, *Petitioner,*
v.
SAIF CORPORATION and Willamette Painting, *Respondents.*
(92-04603; CA A82577)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 16, 1994.
Michael T. Garone argued the cause for petitioner. With him on the brief was Jolles, Bernstein & Garone, P.C.
Steve R. 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 Richardson, Chief Judge,* and De Muniz and Leeson, Judges.
LEESON, J.
Reversed and remanded for reconsideration.

* Richardson, C. J., *vice* Rossman, P. J., retired.

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132 Or App 510> Claimant seeks review of a Workers' Compensation Board order holding that his osteomyelitis condition is not compensable. He contends that SAIF is precluded from denying his current osteomyelitis condition because it stipulated to accepting that condition in 1983. We agree and reverse.

In 1962 or 1963, claimant developed osteomyelitis, an infection of the bone, in his right leg following a motorcycle accident that was not work related. He received treatment for the leg injury and infection until early 1968, at which time he was free of symptoms. On August 12, 1982, claimant fractured his right arm and right leg when he fell from scaffolding while working as a painter. SAIF accepted the claim, but did not specify what was being accepted. In April, 1983, the claim was closed with 20 percent permanent partial disability (PPD) for the arm.

Claimant developed increasing pain in his right thigh, which was diagnosed as "reactivation of chronic osteo-myelitis." In July, 1983, SAIF agreed "to accept the claim for claimant's right thigh condition as an exacerbation of a pre-existing injury." The stipulation specified that

> "claimant preserves the issue of permanent partial disability to be raised again when the claim is next closed as well as any issues relating to any alleged future premature closure of the claim which has been voluntarily reopened."

SAIF began to pay for claimant's antibiotic treatments for the osteomyelitis, and he experienced improvement in the condition by 1985. There is no indication in this record that the claim ever was closed or that the antibiotic treatments ceased.

In 1989, claimant fell while running up some stairs at a friend's home and fractured his right thigh. The fracture was surgically repaired. In 1992, SAIF denied both the compensability of, and responsibility for, claimant's osteomyelitis condition and stopped paying for his antibiotic treatments, on the ground that the condition had returned to its pre-1982 status and that claimant's need for treatment was no longer related to the 1982 injury. The referee upheld SAIF's denial. The Board affirmed, concluding that, because he suffered from a pre-existing condition, claimant had to prove that "the industrial injury is and remains the major contributing cause **<132 Or App 510/511>** of the disability or need for treatment," ORS 656.005(7)(a)(B), in order to establish the continued compensability of the treatments.

Claimant contends that, when SAIF stipulated to the compensability of his osteomyelitis in 1982, the condition itself became compensable, and that treatment related to it is also compensable. SAIF apparently is of the view that its acceptance of the "right thigh condition" did not encompass the osteomyelitis itself, but only the symptoms brought on by the 1982 injury. It maintains that claimant's current need for medical treatment is not related to his 1982 industrial injury, and that the parties acknowledged at the hearing that the only dispute concerns his current need for treatment. Therefore, according to SAIF, because claimant's osteomyelitis is pre-existing, the only issue is whether there is substantial evidence in the record to support the Board's finding that the 1982 fall is not the major contributing cause of claimant's osteomyelitis condition or his need for treatment for that condition.

SAIF is required to compensate claimant "for the specific condition in the notice of acceptance regardless of the cause of that condition." *Georgia-Pacific v. Piwowar,* 305 Or 494, 501, 753 P2d 948 (1988). When SAIF accepted claimant's "right thigh condition" in 1983, it accepted the osteomyelitis. Accordingly, treatment related to that condition is compensable if it meets the requirements of ORS 656.245.

Reversed and remanded for reconsideration.

Cite as 131 Or App 459 (1994) November 23, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Cheryl HUFF, *Appellant,*
v.
GREAT WESTERN SEED CO., a New Jersey corporation, and Lance Dickey, *Respondents.*
(930061; CA A80301)

In Banc*
Appeal from Circuit Court, Linn County.
William O. Lewis, Judge.
Argued and submitted March 29, 1994; resubmitted in banc September 7, 1994.
Mark K. Grider argued the cause and filed the brief for appellant.
Kathy A. Peck argued the cause for respondents. With her on the brief were Janice L. Hirsch and Williams, Zografos, Peck & Atwood, PC.
De MUNIZ, J.
Reversed and remanded.

* Warren, J., not participating.

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131 Or App 461> Plaintiff brought this action against her former employer, Great Western Seed Co., and its general manager, Dickey, alleging that defendants committed unlawful employment practices under ORS 659.410, ORS 659,415 and ORS 659,420,[1] by not reemploying plaintiff after she had suffered a work-related injury and by firing her because she had sought workers' compensation remedies. Defendants moved to dismiss the complaint on the grounds that the action was untimely under the one-year limitation period in ORS 659,121(3). *See* ORCP 21A(9). The trial court granted the motion and entered judgment for defendants. Plaintiff appeals, contending that the trial court erred by allowing the motion to dismiss. We reverse.

After a number of plaintiff's earlier attempts to gain reemployment had failed, defendants allowed her to return to work on January 2, 1992. They fired her on January 9. Plaintiff alleges:

> "At the time of plaintiffs termination, plaintiff was informed that she was being terminated for having a 'bad attitude.' At the time, plaintiff did not view the defendant[s'] action in terminating her as having been the result of her use of the workers' compensation remedies, but on or about January 24, 1992, plaintiff received a copy of a memo signed by defendant Lance Dickey which stated that plaintiff was discharged by defendants for '* * * actively promoting and **<131 Or App 461/462>** advocating fraudulent injury claims in the category of workman's [*sic*] compensation against the SAIF Insurance Co.'"

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[1] ORS 659.410(1) provides:

> "It is an unlawful employment practice for an employer to discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS chapter 656 or of ORS 659.400 to 659.460 or has given testimony under the provisions of such sections."

ORS 659.415(1) provides, in part:

> "A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position."

ORS 659.420(1) provides:

> "A worker who has sustained a compensable injury and is disabled from performing the duties of the worker's former regular employment shall, upon demand, be reemployed by the worker's employer at employment which is available and suitable."

ORS 659,121(3) provides that actions under, *inter alia,* ORS 659,410, ORS 659,415 and ORS 659,420 "shall be commenced within one year of the occurrence of the alleged unlawful employment practice." Plaintiff instituted this action on January 20, 1993, more than one year after her termination, but less than a year after her discovery of Dickey's memorandum, which tied the discharge to her invocation of the workers' compensation system.

Plaintiff relies on *Kraxberger v. Chevron USA, Inc.*, 118 Or App 686, 848 P2d 1242 (1993), and *Cortez v. State of Oregon*, 121 Or App 602, 855 P2d 1154, *rev den* 318 Or 25 (1993). In those cases, we held that the "discovery rule" is applicable to ORS 659.121(3), and, therefore, the limitation period under it does not begin to run until the plaintiff discovers, or reasonably should have discovered, the existence of a claim against the defendant. According to plaintiff, she obtained the necessary knowledge through Dickey's memorandum, and she could not reasonably have discovered the existence of her claim before she discovered the memorandum. Defendants assert, *inter alia,* that *Kraxberger* and *Cortez* support their position that the action is untimely.[2]

In *Kraxberger,* the plaintiff claimed that the defendant employer had violated ORS 659.420 by not reemploying her in an available and suitable position, on her demand, after she suffered a compensable injury. We first concluded that the discovery rule applies to ORS 659.121(3), explaining:

> "ORS 659.121(3) requires that any action claiming violation of ORS 659.420 'shall be commenced within one year of the occurrence of the alleged unlawful employment practice.' Plaintiff's claim, filed in July, 1990, is untimely if the Statute of Limitations began to run before July, 1989. The parties cite no case, and we find none, that addresses the issue of when the Statute of Limitations begins to run under ORS 659.420. To resolve that issue, we must first set out the **<131 Or App 462/463>** substance of the unlawful employment practice defined in that statute.
>
> "The statute provides that an employer commits an unlawful employment practice when it refuses an injured worker's demand for reemployment in work that is suitable and available. ORS 659.420(1). Plaintiff argues that the Statute of Limitations should not begin to run until an injured worker knows or should know that suitable work is available after the employer has refused the worker's demand. We agree. Without that knowledge, an injured worker would have no reason to bring an action alleging an unlawful employment practice. *See Williams v. Waterway Terminals Co.*, 298 Or 506, 693 P2d 1290 (1985).
>
> "* * * * *
>
> "The Statute of Limitations begins to run when a worker who has made a demand in accordance with the administrative scheme knows or should know that work is available and suitable." 118 Or App at 690-91. (Footnotes omitted.)

We nevertheless concluded that the plaintiff's claim was time-barred, because she was aware of the existence of an available and suitable position more than one year before she brought her action.

In *Cortez,* the plaintiff claimed that the defendant employer refused to promote him because of race, in violation of ORS 659,030(1)(a).[3] We again applied the discovery rule, but also again held that the claim was not timely. Although the plaintiff knew more than one year before initiating suit that he had been refused promotion for racially motivated reasons, he contended that the unlawful practice did not occur until the defendant hired another person to fill the position that the plaintiff had sought. We disagreed and concluded that, because the unlawful practice was the earlier discriminatory refusal itself, the action was untimely.

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[2] Although plaintiff's complaint sets forth only one claim, a number of unlawful employment practices, which took place at different times, are alleged. For purposes of this appeal from the dismissal of the entire action, the parties' arguments correctly focus on whether the motion was properly allowed with respect to the most recent of the alleged unlawful practices. By addressing that question, we imply no view as to the timeliness of the action as it relates to any earlier event.

[3] Under ORS 659.030(1)(a), it is an unlawful employment practice for an employer, *inter alia,* to discriminate in hiring on the basis of race or other enumerated statuses. ORS 659.121 applies to actions brought to redress violations of ORS 659.030.

Defendants argue that *Kraxberger* and *Cortez* favor their position, because, in each case, we held that the plaintiff's discovery of a particular event, rather than the plaintiff's discovery of the employer's wrongful motive, triggered **<131 Or App 463/464>** the running of the statute. Here, defendants reason, the relevant event was plaintiff's discharge, of which she was aware when it happened, and her later discovery of the memorandum revealing defendants' motive was irrelevant.

Cortez and *Kraxberger* do not assist defendants. In this case, like those, the threshold question is *what* the plaintiff had to discover in order to be aware of the existence of a claim. In *Kraxberger,* the employer's failure to offer the available and suitable position was a *per se* unlawful employment practice under ORS 659.420, without regard for the employer's motive. *See Palmer v. Central Oregon Irrigation Dist.*, 91 Or App 132, 136, 754 P2d 601, *rev den* 306 Or 413 (1988). There was and could have been no issue about the discovery of the employer's motive in *Kraxberger,* because motive is not relevant to a claim under ORS 659.420.

Conversely, under ORS 659.030(1)(a), the statute involved in *Cortez,* the employer's discriminatory motive is an essential component of the alleged unlawful employment practice. However, the plaintiff there had discovered "both the employment decision and * * * that the refusal to promote him was racially motivated" more than one year before the action was brought. 121 Or App at 605. In other words, at the time of the decision not to promote him, the plaintiff in *Cortez* had the requisite knowledge of the employer's discriminatory motive to make him aware that an unlawful practice had occurred, while plaintiff alleges here that, at the time she was fired, she did not have the corresponding knowledge.

Like *Cortez* and unlike *Kraxberger,* the employer's *act* here was not, in itself, an unlawful employment practice. Under ORS 659.410, there must be a discriminatory motive in order for a violation to occur; moreover, an employer is free to discharge an employee, *at least* for cause, notwithstanding - but not because of - the employee's involvement with the workers' compensation system. *See Vaughn v. Pacific Northwest Bell Telephone* 289 Or 73, 611 P2d 281 (1980). Defendants' discharge of plaintiff could be an actionable violation of ORS 659.410 only if they acted with a discriminatory motive, and not if they fired plaintiff solely for the reason she alleges they gave her at the time of the discharge.

131 Or App 465> Taking plaintiff's allegations as true, as we do for purposes of reviewing the granting of the motion to dismiss, all that she knew on January 9, 1992, was that she was fired and that the stated explanation was her perceived "bad attitude." According to plaintiff's allegations, it was not until she received Dickey's memorandum on January 24 that she gained any information linking the firing and defendants' motive for it to her involvement with the workers' compensation system. She brought her action less than one year thereafter. Whether she in fact knew or should have known that she had a claim sooner than that is a question for the trier of fact. *Peterson v. Mult. Co. Sch. Dist. No. 1,* 64 Or App 81, 85, 668 P2d 385, *rev den* 295 Or 773 (1983). The complaint does not show on its face that the action is barred by the Statute of Limitations. *See Munsey v. Plumbers' Local #51,* 85 Or App 396, 399, 736 P2d 615 (1987).

The trial court erred by granting the motion to dismiss.

Reversed and remanded.

Cite as 320 Or 383 (1994) December 2, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Joan E. Hathaway, Claimant.

Joan E. HATHAWAY, *Petitioner on Review,*
v.
HEALTH FUTURE ENTERPRISES and SAIF Corporation, *Respondents on Review.*
(WCB 90-21435; CA A72995; SC S41202)

In Banc
On review from the Court of Appeals*
Argued and submitted September 9, 1994.
Robert Wollheim, of Welch, Bruun, Green & Wollheim, Portland, argued the cause for petitioner on review. With him on the petition was J. David Kryger, of Emmons, Kropp, Kryger, Alexander, Egan & Allen, P.C., Albany.
Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Donald M. Hooton, Portland, filed a brief on behalf of *amicus curiae* Oregon Workers' Compensation Attorneys.
DURHAM, J.
The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

* Judicial review from the Workers' Compensation Board. 125 Or App 549,865 P2d 503 (1993).

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320 Or 385> The issue in this case is whether the Workers' Compensation Board (Board) erred in dismissing claimant's request for a hearing regarding insurer's refusal to pay for palliative medical care. The Court of Appeals held that the Board did not err, because ORS 656.245(1)(b) and ORS 656.704(3) grant to the director of the Department of Insurance and Finance[1] exclusive authority to resolve a dispute over an insurer's refusal to pay for palliative care. Therefore, according to the court, the Board had no authority to resolve the dispute. *Hathaway v. Health Future Enterprises,* 125 Or App 549, 553, 865 P2d 503 (1993). We allowed review to address the jurisdictional issue. We affirm the decision of the Court of Appeals, but for a different reason.

In October 1988, claimant suffered a compensable injury. In February 1989, the claim was closed. In September 1990, claimant's attending physician, Dr. Ouellette, recommended palliative chiropractic treatment.[2] Insurer disapproved the treatment. Ouellette did not request approval of the treatment from the director. Claimant requested a hearing before the Board's Hearings Division. A referee set aside insurer's refusal. The Board overruled the referee and concluded that, because the director's jurisdiction is exclusive, it had no jurisdiction over the dispute. The Court of Appeals affirmed.

On review, the parties dispute the meaning of three statutes.[3] ORS 656.283(1) provides:

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[1] The Department of Insurance and Finance is now known as the Department of Consumer and Business Services. Or Laws 1993, ch 744, § 10.

[2] ORS chapter 656 does not define "palliative care." The parties raise no question about whether the treatment recommended by Ouellette was palliative care. Given the nature of the treatment, as described in the record, the parties' characterization of the treatment as palliative care is reasonable. For that reason, we have no occasion to decide the meaning or scope of the phrase "palliative care" in ORS 656.245(1)(b).

[3] Claimant also asserts that the Board's order violates Article I, sections 10 and 20, of the Oregon Constitution and the Fourteenth Amendment to the Constitution of the United States. She acknowledges that she did not preserve those arguments before the Board or the Court of Appeals, but contends that they concern errors of law that are apparent on the face of the record. We do not agree that claimant's constitutional arguments concern alleged errors that, if they are errors at all, would be ones that are apparent on the face of the record. We, therefore, decline to address them. *See Ailes v. Portland Meadows, Inc.,* 312 Or 376, 381,823 P2d 956 (1991) (in order to be "apparent," the asserted error must be "obvious, not reasonably in dispute").

Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a <320 Or 385/386> hearing on *any question concerning a claim."* (Emphasis added.)

ORS 656.704(3) provides:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, *matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue.* However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." (Emphasis added.)

ORS 656.245(1) provides:

> "(1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability.
>
> "(b) Notwithstanding paragraph (a) of this subsection, after the worker has become medically stationary, palliative care is not compensable, except when provided to a worker who has been determined to have permanent total disability, when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device. If the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment. The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment.
>
> "(c) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related <320 Or 386/387> services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. A pharmacist or dispensing physician shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide such medical services continues for the life of the worker."

Claimant admits that the palliative care recommended by her doctor is not covered by any of the exceptions to noncompensability described in the first sentence of ORS 656.245(1)(b). She argues that the second sentence of that statute *requires* her doctor to request approval of palliative care from the insurer but that, in contrast, the third sentence merely *permits* her doctor to request approval from the director after the insurer declines to approve the care. From the permissive wording of the third sentence, she infers that a claimant may seek approval of palliative care either through a doctor's request for approval to the insurer and the director or through a request for a hearing under ORS 656.283(1).

We first address whether claimant's request for a hearing on insurer's disapproval of palliative care is a "question concerning a claim" under ORS 656.283(1), that is, whether it is a "matter[] in which a worker's right to receive compensation, or the amount thereof, [is] directly in issue" within the meaning of the first sentence of ORS 656.704(3).[4] If not, then we need not address insurer's alternative argument, *viz.*, that the last sentence of ORS 656.704(3) excludes a dispute over a disapproval of noncompensable palliative care from the Board's authority.

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[4] We assume, as do the parties, that the phrases "question concerning a claim" in ORS 656.283(1), and "matters concerning a claim" in ORS 656.704(3) are synonymous.

We turn to the text and context of the statutes in question. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993) (stating method for statutory interpretation). ORS 656.283(1) entitles a claimant to request a hearing before a referee on "any question concerning a claim." ORS 656.005(6) provides:

> "'Claim' means a written request for *compensation* from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." (Emphasis added.)

320 Or 388> ORS 656.005(8) provides:

> "'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter."

We look to ORS 656.245(1) to determine whether a request for palliative care seeks "compensation," that is, a "medical service[], provided * * * pursuant to this chapter," within the meaning of ORS 656.005(8). ORS 656.245(1)(a) obligates an insurer, under the conditions specified in that statute, to provide medical services, including all "compensable medical services" listed in ORS 656.245(1)(c), for every compensable injury. However, that obligation is subject to the exception stated in the first sentence of ORS 656.245(1)(b), *viz.*, that "palliative care is not compensable." That exception is itself subject to three exceptions for palliative care that is provided to a worker with permanent total disability or that is necessary to monitor prescription medication or a prosthetic device. None of those three exceptions is relevant here. Under our reading of the first sentence of subsection (1)(b), the palliative care requested by claimant is not a compensable medical service under ORS 656.245(1)(a) and, thus, is not "compensation" under ORS 656.005(8).

The second sentence of ORS 656.245(1)(b) creates a procedure whereby an insurer or the director, at the request of the worker's attending physician, nonetheless may approve "palliative care which would otherwise not be compensable under this paragraph." Under that sentence, palliative care for which a physician seeks approval is not a compensable medical service unless the insurer or the director grants approval. That sentence does not suggest that the creation of an approval procedure modifies the predicate fact, stated in the first sentence of subsection (1)(b) that palliative care is not compensable. Only if the insurer or the director grants approval can the worker claim that palliative care that is otherwise noncompensable is a "medical service" provided "pursuant to this chapter" within the meaning of ORS 656.005(8).

Claimant argues that an ambiguity arises from the term "may" in the third sentence of ORS 656.245(1)(b):

> **320 Or 389>** "If approval is not granted, the attending physician *may* request approval from the director for such treatment." (Emphasis added.)

We disagree. The legislature's use of the permissive term "may" in describing the physician's procedural right to request director approval is a recognition that the right of the physician to make the request does not create any duty on the physician to do so. So understood, the sentence does not alter the fact that the subject of the physician's request - if it is made - is noncompensable palliative care. Claimant's reading of the third sentence would make palliative care a compensable medical service, in contradiction of the first sentence in ORS 656.245(1)(b). Her reading also would render the approval procedure described in the second and third sentences of that subsection duplicative or useless. She does not explain those contradictions. We also agree with insurer's contention that the terminology in the approval procedure, whereunder a physician may "request approval" and an insurer or the director may "grant approval" of palliative care, reflects a legislative intention not to treat a request for palliative care as a "claim" under ORS 656.005(6) and ORS 656.283(1) that an insurer must "accept" or "deny" under ORS 656.262(6).[5] In view of those textual obstacles, we are not persuaded by claimant's argument that,

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[5] ORS 656.262(6) provides, in part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim."

in this context, the term "may" plausibly can be interpreted to create, by implication, a right to request a hearing under ORS 656.283(1) regarding noncompensable palliative care.

Claimant also argues that the legislature's choice to mention only "physicians," not "claimants," in describing the approval procedure in the second and third sentences in ORS 656.245(1)(b), signifies a legislative intent to permit a claimant to invoke the Board's hearing procedure under ORS 656.283(1) in order to obtain approval of palliative care. We disagree. The legislature's choice not to include claimants in the approval procedure does not alter the noncompensability of the palliative care to which the approval procedure applies. **<320 Or 389/390>** In that context, the reference in the second and third sentences of ORS 656.245(1)(b) to the attending physician's procedural options does not indicate that disapproval of a request for noncompensable palliative care is a "question concerning a claim" under ORS 656.283(1).

We have examined the other subsections of ORS 656.245 but find nothing that casts doubt on our reading of ORS 656.245(1)(b). We also have examined ORS 656.327, which addresses the director's review of medical treatment disputes. That statute, however, relates only to a dispute over medical treatment that a worker *is receiving,* not a proposal for *future* medical treatment. *Martin v. City of Albany,* 320 Or 175, 188, 880 P2d 926 (1994). Neither ORS 656.327, nor any other statute to which the parties have directed our attention, creates any ambiguity about the meaning of ORS 656.245(1), ORS 656.704(3), or ORS 656.283(1) in this context.

We conclude that claimant's request for a hearing regarding insurer's disapproval of noncompensable palliative care is not a "matter[] in which a worker's right to receive compensation, or the amount thereof, [is] directly in issue," within the meaning of ORS 656.704(3), because noncompensable palliative care is not "compensation" within the meaning of ORS 656.005(8). For that reason, claimant's request for a hearing did not relate to a "question concerning a claim" that the Board was authorized to resolve under ORS 656.283(1). It follows that the Board and the Court of Appeals correctly determined that the Board had no authority to consider the claim. The Board did not err in dismissing claimant's request for a hearing.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

Cite as 320 Or 391 (1994) December 2, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Rexi L. Nicholson, Claimant.

Rexi L. NICHOLSON, *Petitioner on Review,*
v.
SALEM AREA TRANSIT and SAIF Corporation, *Respondents on Review.*
(WCB 91-03460; CA A76237; SC S41208)

In Banc
On review from the Court of Appeals*
Argued and submitted September 9, 1994.

Robert Wollheim, of Welch, Bruun, Green & Wollheim, Portland, argued the cause for petitioner on review. With him on the petition was Gary D. Allen, of Emmons, Kropp, Kryger, Alexander, Egan & Allen, P.C., Albany.

Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

DURHAM, J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

* Judicial review from the Workers' Compensation Board. 126 Or App 172,866 P2d 525 (1994).

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320 Or App 393> The issue in this case is whether the Workers' Compensation Board (Board) erred in dismissing claimant's request for a hearing regarding insurer's refusal to approve palliative medical care under ORS 656,245(1)(b)[1] The Court of Appeals affirmed the Board's conclusion that the palliative care dispute was not a "question concerning a claim," under ORS 656,283(1),[2] because the approval procedure for palliative care in ORS 656,245(1)(b) was the exclusive procedure for obtaining that care. Therefore, according to the court, under the last sentence of ORS 656.704(3),[3] the Board had no jurisdiction over the dispute. *Nicholson v. Salem Area Transit,* 126 Or App 172, 173, 866 P2d 525 (1994) (citing *Hathaway v. Health Future Enterprises,* 125 Or App 549, 865 P2d 503 (1993), *aff'd,* 320 Or 383, ___P2d___ (1994)). We allowed review to address the jurisdictional issue. As in *Hathaway,* we affirm the decision of the Court of Appeals, but for a different reason.

In 1985, claimant suffered a work-related back and neck strain. Insurer accepted the claim, and it

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[1] ORS 656.245(1)(b) provides:

"Notwithstanding paragraph (a) of this subsection, after the worker has become medically stationary, palliative care is not compensable, except when provided to a worker who has been determined to have permanent total disability, when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device. If the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment. The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment."

[2] ORS 656.283(1) provides:

"Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim."

[3] ORS 656.704(3) provides:

"For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise

was closed by a <320 Or 393/394> determination order in November 1986. In July 1990, Dr. Stringham, claimant's attending physician, recommended to insurer that claimant receive treatment from a chiropractic physician.[4] According to the Board,

> "[t]he treatment recommended by Dr. Stringham was for palliative care, i.e., manual manipulation and electrical stimulation. The treatment modality was recommended by Dr. Stringham to maintain claimant's level of functioning, control pain, Keep claimant from being severely symptomatic and allow claimant to work full time. The requested treatment is not required to monitor administration of prescription medicine[,] to maintain claimant in a medically stationary status or to monitor the status of a prosthetic device * * *"

In September 1990, insurer disapproved Stringham's recommendation. In January 1991, Stringham requested that the director of the Department of Insurance and Finance[5] approve the treatment. In March 1991, the director issued an order denying the request. Claimant requested a hearing before the Board under ORS 656.283(1). The Board held that it had no jurisdiction over the dispute, and the Court of Appeals affirmed.[6]

In *Hathaway v. Health Future Enterprises, supra,* 320 Or at 390, this court held that a request for a hearing regarding noncompensable palliative care is not a "question concerning a claim" under ORS 656.283(1), because it does not concern "compensation":

> "We conclude that claimant's request for a hearing regarding insurer's disapproval of noncompensable palliative care is not a 'matter[] in which a worker's right to receive compensation, or the amount thereof, [is] directly in issue,' within the <320 Or 394/395> meaning of ORS 656.704(3), because noncompensable palliative care is not 'compensation' within the meaning of ORS 656.005(8)[7] For that reason, claimant's request for a hearing did not relate to a 'question concerning a claim' that the Board was authorized to resolve under ORS 656.283(1). It follows that the Board and e Court of Appeals correctly determined that the Board had no authority to consider the claim."

The facts in this case are similar to those in *Hathaway.* Claimant agrees that her request, like that in *Hathaway,* does not concern palliative care that is covered by an exception to the rule of noncompensability stated in the first sentence of ORS 656.245(1)(b). In each case, the attending physician requested that the insurer approve palliative care, and the insurer declined.

One procedural matter distinguishes this case from *Hathaway.* In *Hathaway,* after the insurer disapproved the physician's request, the claimant requested a board hearing under ORS 656.283(1). In this case, after insurer declined approval, the physician requested approval by the director, and the director refused to approve the care.

Claimant argues that her physician satisfied the requirements of the approval procedure described in the second and third sentences of ORS 656,245(1)(b). She also argues that the legislature's use of the permissive term "may" in the third sentence of ORS 656.245(1)(b) indicates a legislative intent to permit claimant to use other procedural avenues, such as ORS 656,283(1), to obtain approval of

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[4] Because the parties do not dispute that the treatment recommended by Stringham was "palliative care," we have no occasion to decide the meaning or scope of the phrase "palliative care" in ORS 656.245(1)(b). *See Hathaway v. Health Future Enterprises, supra,* 320 Or at 385 n 2 (same).

[5] The Department of Insurance and Finance is now known as the Department of Consumer and Business Services. Or Laws 1993, ch 744, § 10.

[6] The Board declined to address the constitutionality of ORS 656.245(1)(b), because no party had raised that question. Claimant argued to the Court of Appeals and also argues to this court that ORS 656.245(1)(b) is unconstitutional and that we should address that issue as an error apparent on the face of the record. *See Ailes v. Portland Meadows, Inc.,* 312 Or 376, 381,823 P2d 956 (1991) (stating standards for review of unpreserved error). We decline claimant's invitation.

[7] ORS 656.005(8) provides:

> "'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter."

noncompensable palliative care, at least where, as here, the physician first exhausts the statutory approval procedure. We do not agree.

In *Hathaway,* we rejected the argument that the term "may" in this context signifies a legislative intention to permit the Board to address claims for palliative care under ORS 656,283(1):

> "The legislature's use of the permissive term 'may' in describing the physician's procedural right to request director approval is a recognition that the fight of the physician to **<320 Or 395/396>** make the request does not create any duty on the physician to do so. So understood, the sentence does not alter the fact that the subject of the physician's request - if it is made - is noncompensable palliative care. Claimant's reading of the third sentence would make palliative care a compensable medical service, in contradiction of the first sentence in ORS 656.245(1)(b). Her reading also would render the approval procedure described in the second and third sentences of that subsection duplicative or useless. She does not explain those contradictions. We also agree with insurer's contention that the terminology in the approval procedure, whereunder a physician may 'request approval' and an insurer or the director may 'grant approval' of palliative care, reflects a legislative intention not to treat a request for palliative care as a 'claim' under ORS 656.005(6) and ORS 656.283(1) that an insurer must 'accept' or 'deny' under ORS 656.262(6).[5] In view of those textual obstacles, we are not persuaded by claimant's argument that, in this context, the term 'may' plausibly can be interpreted to create, by implication, a right to request a hearing under ORS 656.283(1) regarding non-compensable palliative care.

> "[5] ORS 656.262(6) provides, in part:
>
> "'Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim.'" 320 Or at 389.

The physician's exhaustion of the approval procedure does not lead us to a different conclusion. The fact remains that the subject of the physician's request is noncompensable palliative care. Nothing in the text suggests that disapproval by the director changes the noncompensable character of the requested care.

Claimant also argues that the Board erred, because the director violated the obligation in ORS 656.245(1)(b) to "appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment" recommended by Stringham. She contends that that procedural error renders the director's order invalid. Claimant's argument misses the point. Nothing in ORS chapter 656 authorizes the Board to review, for procedural error, a director's order that disapproves noncompensable palliative care, or to treat a request for palliative care as a question concerning a claim under ORS 656.283(1) **<320 Or App 396/397>** if, as claimant asserts, the director's order is "invalid" due to procedural error.[8] Because the director's arguable error in failing to appoint a panel of physicians, as required by ORS 656,245(1)(b), does not make the request for noncompensable palliative care a question concerning a claim under ORS 656.283(1), the Board correctly dismissed the request for a hearing.

Hathaway disposes of claimant's remaining arguments. We find no error.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

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[8] Although we do not decide the question here, ORS 656.704(2) may play a role in the determination of whether a claimant has a remedy for procedural error by the director in disapproving palliative care. It provides, in part:

> "Actions and orders of the director and the conduct of hearings and other proceedings pursuant to this chapter, and judicial review thereof, regarding all matters other than those concerning a claim under this chapter, are subject only to ORS 183.310 to 183,550 and such procedural rules as the director may prescribe."

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