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A compilation of the decisions of the Oregon Workers' Compensation Board and the opinions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law.

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MARTHA M. CHAMBERLAIN, Claimant
Doblie & Francesconi, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-09945
April 3, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Pferdner's order which: (1) Upheld a Determination Order which found claimant medically stationary on November 24, 1981; (2) upheld the employer's denial of an aggravation claim dated September 30, 1982; (3) upheld the employer's oral denial at hearing of an aggravation claim; and (4) declined to award a penalty and associated attorney's fee for the employer's alleged failure to process the second aggravation claim. The employer cross-requests review of that portion of the Referee's order awarding interim compensation for the period September 7, 1982 to September 30, 1982, and imposing a penalty and associated attorney's fee for failure to pay interim compensation.

The Board affirms that portion of the Referee's order which found that claimant was medically stationary on November 24, 1981.

The Board also affirms that portion of the Referee's order which upheld the employer's denial of claimant's aggravation claim dated September 30, 1982. We agree with the Referee that claimant has failed to prove by a preponderance of the evidence that her condition worsened. We also agree with the Referee that claimant was entitled to interim compensation pending the employer's denial. Accordingly, we affirm that portion of the Referee's order awarding claimant interim compensation and an associated penalty and attorney's fee relative to the period of September 7, 1982 to September 30, 1982.

The Board also affirms that portion of the Referee's order which upheld the denial made by the employer at hearing of claimant's aggravation claim dated April 4, 1983. We agree with the Referee that claimant has failed to prove by a preponderance of the evidence that her condition worsened.

We also affirm that portion of the Referee's order which declined to award a penalty and associated attorney's fee for the employer's alleged failure to process claimant's aggravation claim dated April 4, 1983. However, we differ with the Referee's reasoning. The employer did not have an obligation to accept or deny the aggravation claim until 60 days after it was made. ORS 656.273(6), 656.262(6). The employer denied the aggravation claim at hearing on April 22, 1983, well within the 60 day period. Accordingly, no penalties can be assessed for an alleged failure to respond to the aggravation claim.

ORDER

The Referee's order dated June 1, 1983 is affirmed. Claimant's attorney is awarded $150 for services on Board review, to be paid by the employer.

WAYLAND A. PORTER, Claimant
Evohl F. Malagon, Claimant's Attorney
Wiswall, et al., Defense Attorneys
Minturn, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 82-11772 & 82-09211
April 3, 1984
Order on Reconsideration

EBI Companies requests reconsideration of our October 13, 1983 Order on Review which affirmed Referee Nichols' order finding that claimant had suffered a new injury to his shoulder and neck while EBI was on the risk, rather than an aggravation of a 1977 shoulder and neck injury that had occurred while the SAIF Corporation was on the risk. 35 Van Natta 2034 (1983). We abated our order to allow sufficient time for a response and for further consideration of EBI's contentions.

Claimant suffered an injury in February 1977 when he fell out of his log truck onto his right shoulder and neck. As a result, he underwent surgery for a torn rotator cuff and anterior impingement syndrome. Claimant twice had his injury claim reopened on an aggravation basis -- once in February 1978 and once in May 1979 -- resulting in increased awards of time loss and permanent disability benefits. Thereafter, claimant did not seek medical treatment again until July of 1982. Claimant had been able to drive a dump truck and a log truck for different employers in that interim without seeking medical treatment. In February 1982 claimant began working for EBI's insured, Carters, Inc., driving a short log truck known as a mule train. The cab of the truck was poorly balanced with the load causing a very rough and bouncy ride. Driving the mule train caused claimant's condition to gradually worsen until he sought medical treatment again on June 14, 1982. At that time his doctor advised him to stop driving truck. There was not one specific injurious event in driving the mule train that caused claimant's worsening. Rather, it was caused by successive micro-traumas over a four to five month period at Carters, Inc. The rough bouncing while driving the mule train was an identifiable activity that caused a change in claimant's neck and shoulder injury.

The medical evidence relates claimant's worsened condition to both an aggravation and a new injury. Claimant's testimony is inconclusive, as he testifies to experiencing about the same complaints, yet testifies that his condition gradually worsened due to driving the mule train.

In Boise Cascade v. Starbuck, 296 Or 238 (1984), the Supreme Court indicated that in a situation such as this in which there is a compensable injury at an earlier employment and then exposure at a later employment, the later employer is responsible if the exposure at that employment actually contributed to the disability.

In our capacity as finder of facts, we agree with the Referee's finding that there is sufficient evidence to conclude that claimant's employment while EBI was on the risk actually contributed to claimant's disability. In addition to the fact that the medical evidence, while equivocal, will support such a finding, we considered the two year gap in medical treatment immediately before claimant began working for EBI's insured, the identifiable trauma-producing activity of driving the mule train log truck and the need for claimant to again seek medical treatment based on his worsened condition. Of these factors, no

single one, in and of itself, would convince us that the later employment actually contributed to the disability; however, when considered together these facts are sufficient to convince us that the later employment actually did contribute to claimant's disabling condition.

ORDER

On reconsideration of the Order on Review dated October 13, 1983, we adhere to that order which hereby is reaffirmed and republished.

Board Member Barnes Concurring:

In its motion for reconsideration, EBI expresses some frustration in understanding the factors that this Board utilizes in deciding whether a claimant has suffered an aggravation or a new injury in employer/insurer responsibility cases. EBI states, for example, that every reason we gave in Harry K. Agner, 35 Van Natta 781 (1983), for finding an aggravation is equally applicable and relevant in this factually-similar case in which we find a new injury.

Unlike my Board colleagues, I am willing to respond to EBI's expressed frustration. The principal problem is that recent appellate court doctrines in this area, although characterized by a facial simplicity, prove to be very difficult in application. Our typical employer/insurer responsibility cases present records just like the record in this case in which the doctors take no position and/or take conflicting positions on the question of aggravation versus new injury. In short, I think every member of this Board shares the frustration EBI has expressed.

Given decisional standards that can break down rapidly in application, and given the high level of resulting frustration experienced by the decision makers, the ultimate response to EBI should be that lawyers who practice in this area should not pay too much attention to our expressions of policy -- in Agner or in any other case -- when the pattern of our decisions cannot be reconciled with any consistent policy. The Supreme Court has stated that the law governing employer/insurer responsibility is intended to spread "liability fairly among employers by the law of averages." Bracke v. Baza'r, 293 Or 239, 248 (1982). Although I doubt it is exactly what the court had in mind, the total randomness of the results being reached in this area is consistent only with the law of averages, no other form of law.

I strongly believe and seriously suggest that the Oregon workers compensation system would be much improved if questions of employer/insurer responsibility were taken completely out of the usual Referee/Board/Court of Appeals/Supreme Court litigation system and placed in binding arbitration between the potentially responsible entities. I have repeatedly suggested that the Board should sponsor legislation to create the arbitration alternative because I think the Board is in the best position to be aware of and to document the dismal failure of the current approach to responsibility litigation. My Board colleagues have previously expressed opposition based on the reasoning that resolution of all contested workers compensation issues should be centralized in a

single agency. There is certainly some merit to that position, but the Legislature has already created some exceptions to it. By virtue of the amendment to ORS 656.388(2) by Oregon Laws 1983, chapter 568, section 3, attorney fee awards at the Court of Appeals and Supreme Court level in workers compensation cases can be reviewed at the circuit court level, which, to say the least, is certainly unusual. Even more relevant, by virtue of the amendment to ORS 656.289(4) by Oregon Laws 1983, chapter 809, section 3, disputes between a health insurer and a workers compensation insurer about responsibility for medical bills following a disputed claim settlement "shall be settled among the parties by arbitration." It seems to me that it would be a small additional step to provide for responsibility arbitration between two workers compensation insurers.

DAWN G. MELLIS, Claimant
Pozzi, et al., Claimant's Attorneys
Breathouwer & Gilman, Defense Attorneys

WCB 83-00058
April 4, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Leahy's order which overturned its denial of claimant's claim for a fractured hip. The only issue is whether claimant was acting within the course of her employment when her injury occurred.

We find the facts to be as follows: Claimant is a paralegal with a law firm which has its offices on the fourteenth floor of the Standard Plaza, an office building in downtown Portland. Claimant works in the probate section of the law firm. Claimant is paid on a salary basis rather than an hourly basis. She, like the associates in the firm, is expected to bill a certain number of hours each year. The firm does not require her to be in the office during any particular hours. However, customarily, claimant works from 8 am until 5 pm with an hour off for lunch between noon and 1 pm. Claimant normally takes a bus to her home during the noon hour. Occasionally, claimant works after 5 pm or on weekends in order to complete her work.

The Standard Plaza is an office building owned by Standard Insurance Company. The employer leases space from Standard Insurance. On the third floor of the building is a cafeteria known as Tiffany's. The cafeteria is frequented mainly by building tenants but is open to the general public. Employes of the law firm occasionally take breaks and eat lunch in the cafeteria. Although the law firm has a lunchroom, it does not object to employes taking breaks in the cafeteria on the third floor.

On November 17, 1982 claimant did not arrive at work until 9:30 because she had personal business to attend to at home. She worked through the normal lunch hour and ate an apple at her desk. At about 2 o'clock she started working on a large file. She reviewed the file for about 15 minutes and realized that she would have to spend the rest of the afternoon working on that file. She then decided to go down to the cafeteria before starting work in earnest on the file. The cafeteria food services were closed at that hour, but some pre-packaged food was available. Claimant purchased and ate a small salad. About 15 minutes after arriving

in the cafeteria, claimant got up to return to her office. She became entangled in some chairs, fell and broke her hip.

Claimant filed a workers' compensation claim, and the insurer denied the claim on the basis that claimant was not acting within the course of her employment when she was injured. The Referee found that claimant was acting within the course of her employment and overturned the denial. He reasoned that, because claimant's activity was contemplated by the employer, was acquiesced in by the employer and was partly for the benefit of the employer, it was within the course of her employment. We disagree and reverse.

The Court of Appeals has set forth the following factors to be considered in determining whether an injury arises out of and in the course of employment:

> "(a) Whether the activity was for the benefit of the employer...
>
> "(b) Whether the activity was contemplated by the employer and employee either at the time of hiring or later...
>
> "(c) Whether the activity was an ordinary risk of, and incidental to, the employment...
>
> "(d) Whether the employee was paid for the activity...
>
> "(e) Whether the activity was on the employer's premises...
>
> "(f) Whether the activity was directed by or acquiesced in by the employer...
>
> "(g) Whether the employee was on a personal mission of his own..." Jordan v. Western Electric, 1 Or App 441, 443-44 (1970).

Since the Jordan decision, the Supreme Court has adopted the unitary work-connection approach to determining the course issue. Rogers v. SAIF, 289 Or 633 (1980). The Supreme Court said the ultimate inquiry is whether "the relationship between the injury and the employment is sufficient that the injury should be compensable." 289 Or at 642.

In Halfman v. SAIF, 49 Or App 23 (1980), the Court of Appeals considered the various factors enumerated in Jordan as helpful in applying the unitary work-connection inquiry. The Court of Appeals in both Jordan and Halfman found injuries incurred during coffee breaks compensable.

In Jordan, the claimant was working a night shift during which the company-owned cafeteria was closed. Vending machines were available, but the common practice was for workers to take breaks at a nearby restaurant. Claimant accompanied a supervisor to the nearby restaurant and was injured slipping on a curb during the return trip. The court thought it important that this was a paid coffee break, that the foreman accompanied claimant and thereby approved of his activity, that this was a common practice and that

the employer benefited because claimant was refreshed by the coffee break.

In Halfman, the claimant was an attendant at a collection center for Goodwill Industries. The employer did not provide either eating and drinking facilities or toilet facilities. Claimant took a break just before his regular lunch period in order to use the facilities at a nearby gas station. Claimant was struck by an automobile after using the gas station facilities. The court thought it important that using the off-premises facilities benefited the employer because claimant was refreshed and because the employer was relieved of the cost of providing such facilities. The court noted that such off-premises trips were obviously contemplated by the employer. The court explained its holding:

> "The basis of the personal comfort doctrine is that certain activities by employes are expected and necessary and the conduct of these activities is not a departure from the employment relationship. [Citations omitted.]
>
> "Claimant was not on the employer's premises when he was injured....Although on-premises injuries are more often found to be compensable because of the control exercised over the premises by the employer, where, as here, the employer has created the necessity for the employe to go off premises for basic necessities that are certain to arise during the day, we do not consider the fact that the injury did not occur on the employer's premises to be of great significance." Halfman v. SAIF, 49 Or App at 29.

We now apply the factors enumerated in Jordan to this case. Claimant's rest and refreshment in the cafeteria was arguably for the benefit of both the employer and claimant. It seems likely that the employer contemplated that claimant would take occasional breaks and lunch periods. We do not believe that eating in a public cafeteria can be considered an ordinary risk of or incidental to claimant's employment, especially when the employer provided a lunch room. We find that, because claimant was a salaried employee whose hours were not fixed by the employer, she was not paid for her time in the cafeteria. We find that the cafeteria was a public place and was not part of the employer's premises. Claimant's trip to the cafeteria was not directed by the employer, but was presumably acquiesced in by the employer. Claimant was on a mission for her own benefit which may incidentally have benefited her employer. An analysis of all these factors does not conclusively establish whether claimant's injury arose out of and in the course of her employment.

What we find most convincing is that the employer maintained no control over claimant and that whatever benefit the employer derived from claimant's trip to the cafeteria was incidental. We do not believe that these facts are sufficient to provide the necessary work-connection to make this injury compensable. Accordingly, we reverse the Referee.

ORDER

The Referee's order dated October 11, 1983 is reversed, and the insurer's denial dated December 22, 1982 is reinstated and affirmed.

JERRY J. MEOLA, Claimant
Elton T. Lafky, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-09459
April 4, 1984
Order on Review (Remanding)

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Howell's order which set aside its September 29, 1980 denial of further benefits for claimant's left shoulder injury. SAIF alternatively requests that this case be remanded to the Hearings Division for the taking of further evidence. We decide that remand is appropriate in this case and, therefore, do not reach the merits of the claim.

Claimant dislocated his shoulder on August 5, 1980 when he fell from a ladder at work. Claimant sought immediate medical treatment at a hospital emergency room and was referred to Dr. Stevens, orthopedic surgeon.

On August 6, 1980 Dr. Stevens wrote to SAIF, stating in part:

> "[Claimant] was in to see me today because of an injury to the left shoulder that occurred yesterday in a fall at work from a ladder. He fell onto the outer side of the shoulder. Since then it has been quite painful, and he thinks it may have slipped out again transiently in the course of the fall. He has been having some trouble for about 6 months now since a recreational injury that involved the left shoulder. Subsequently about 10 different times he thinks the shoulder has 'slipped out.'
>
> "Apparently this happens when he plays basketball, either over the head shooting or dribbling out in front of him or when he waterskis with direct pull on the shoulder."

Claimant's shoulder pain and weakness did not resolve over the next few days as hoped. Dr. Stevens finally recommended a surgical correction of the subluxation condition.

On September 24, 1980, after reviewing Dr. Stevens' reports which included a history of a preexisting and underlying shoulder instability, Dr. Norton opined that claimant's current condition was due to the preexisting condition and not to claimant's fall from the ladder at work. Based on Dr. Norton's report, SAIF issued its denial of further benefits.

At hearing, claimant alleged for the first time that Dr. Stevens had mixed up his prior shoulder history with that of his older brother whom Dr. Stevens had also treated for a left shoulder subluxation condition. Claimant testified that he had no problems with his left shoulder prior to his August 5, 1980 fall at work,

except for an incident in 1975 when he was involved in a car accident resulting in temporary pain in his whole left side. The Referee found claimant's testimony credible despite the absence of corroboration from his brother or other witnesses or any attempt to correct Dr. Stevens' erroneous history. The Referee concluded that claimant's left shoulder difficulty began with the traumatic injury of August 5, 1980 and that the subsequent problems were all due to that injury.

After the Referee's order was issued, Dr. Norton sent a copy of that order to Dr. Stevens so that he could correct his records regarding the two brothers. Dr. Stevens responded by writing Dr. Norton a letter that differs considerably from claimant's theory about his versus his brother's respective medical histories. It is this report from Dr. Stevens which SAIF requests be admitted into evidence on remand.

SAIF had no pre-hearing notice that claimant would testify that Dr. Stevens had confused his medical history with that of his brother, and thus had no reason pre-hearing to inquire further about this matter. Subsequent inquiry has produced Dr. Stevens' subsequent report which is inconsistent with claimant's sworn hearing testimony. In exercising our discretion, see Bailey v. SAIF, 296 Or 41 (1983), regarding whether to remand because a hearing record has been "improperly, incompletely or insufficiently developed," ORS 656.295(5), one significant consideration is whether there is a colorable showing of possibly fraudulent testimony. We do not at this point mean to suggest how the conflict between claimant and Dr. Stevens should be resolved; but we conclude that it is now appropriate to remand this matter for the introduction of further evidence and, in light of the additional evidence, a ruling on that conflict.

ORDER

The Referee's order dated September 1, 1983 is vacated and this case is remanded to the Hearings Division for further proceedings in accordance with this order.

LORRIE L. WIDMAN, Claimant
Harrington, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-04271
April 4, 1984
Order on Remand

On review of the Board's order dated December 7, 1982, the Court of Appeals reversed and remanded for acceptance of this claim and for a "determination of extent of disability."

It appears that this claim was processed to closure under the terms of the Referee's order of December 8, 1981, which set aside the insurer's denial; that a Determination Order was entered on March 1, 1982; and that claimant thereafter requested a hearing raising as issues additional medical care and treatment, extent of temporary and permanent disability. See generally ORS 656.313(1); SAIF v. Maddox, 295 Or 448 (1983). Claimant's hearing request presently is pending in the Hearings Division (WCB Case No. 82-03825); the issue of extent of disability presently is not properly before us.

Now, therefore, the above-noted Board order is vacated, and this claim is remanded to the insurer for acceptance, further processing and the payment of benefits in accordance with law.

IT IS SO ORDERED.

CHESTER A. CLARK, Claimant
Doblie & Francesconi, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-10864
April 6, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee McCullough's order which awarded claimant permanent total disability benefits and temporary disability benefits from September 14, 1981 to November 13, 1981. Prior to hearing, claimant had received scheduled permanent disability awards totalling 50% (75°) of his left leg. The employer contends that claimant is not entitled to permanent total disability or to the temporary disability benefits awarded. We reverse the permanent total disability award but affirm the temporary disability award.

We make the following findings of fact. Claimant is 43 years old. In 1974, while working in a mill, claimant suffered a left hip injury which was found to be compensable. In May 1975 claimant underwent surgery which involved a Thompson prosthetic replacement for his left hip. In November 1981 claimant had further left hip surgery involving a total hip replacement. His claim was last closed again by a Determination Order dated November 24, 1982. Claimant requested a hearing on that Determination Order, contending that he was permanently and totally disabled.

Claimant was examined and evaluated at the Callahan Center in March and April 1983. The medical and vocational reports from the Callahan Center indicate that claimant is limited to light bench-type work. The Callahan Center reports also state that claimant is interested in and has demonstrated an ability to perform electronic or mechanical bench work assembly jobs, and that he has good tolerance for standing at a bench when allowed to change positions as needed.

Thereafter, a vocational rehabilitation counselor began assisting claimant in finding an on-the-job training position involving light bench-type work. Tentative arrangements were eventually made for claimant to be hired by Sunrise Industries to be trained on the job in appliance repair, with wages subsidized through the vocational program, and with continued employment by Sunrise after completion of the training. At the time of hearing, claimant was awaiting approval of the training program by Field Services Division. Because the arrangements had been made with Sunrise, claimant's vocational counselor conducted no formal labor market survey.

Prior to the Sunrise training arrangements, claimant and his vocational counselor visited another potential training site, at which time claimant relied heavily on his cane and demonstrated little interest in the training program. Claimant's vocational counselor testified that he did not observe claimant using his cane at home before or after the training site visit. Claimant's vocational counselor further testified that the first training site people were not interested in training claimant because of his heavy leaning on his cane and his lack of interest in the program.

When asked if claimant could sell his services in the labor

market as a whole, claimant's vocational counselor testified that taking into account the record, his experience working with claimant and the industry, and claimant's attitude and presentation, claimant could not sell his services. Claimant's vocational counselor also testified that light bench work jobs were within claimant's physical, mental and other capabilities given an appropriate period of time to acquire familiarity with the component parts. The Referee stated:

> "I construe this to mean more than just a few hours or a few days of orientation at the new job. Rather, I believe that [the vocational counselor] meant that claimant could do these bench work jobs after he is trained to do them and that he feels that claimant is capable of succeeding in such training."

Based particularly on the vocational evidence and the Callahan Center reports, the Referee concluded that claimant is "presently" not employable in the general labor market, although he may become so in the future with training.

First, we cannot agree with the Referee's conclusion that the vocational counselor meant claimant needed more than a few hours or days of orientation at a new job in order to be employable. The witness did not make such a statement, and the record does not support such an interpretation. We interpret the vocational counselor's testimony as a whole to mean that claimant could perform some bench work after he acquires familiarity with the component parts, and other bench work, such as appliance repair, after training. We cannot distinguish between the "acquiring familiarity" that the counselor mentioned and the orientation everyone experiences when starting any new job. Although claimant cannot perform appliance repair work without training, we are not convinced that claimant cannot perform other light bench work that only requires job orientation as opposed to a training program. We do not interpret Gettman v. SAIF, 289 Or 609 (1980), to require a finding that a claimant cannot perform suitable and gainful work when some orientation is needed in order for the claimant to perform a new job.

Second, we disagree with the Referee's interpretation of the vocational counselor's testimony regarding claimant's ability to sell his services in the entire labor market. The vocational counselor opined that claimant was not employable considering, among other things, his "attitude and presentation." We find that this qualifying phrase, combined with claimant's actions at the time of the visit to the first potential training site, indicates that his status is a result of his lack of motivation, rather than just physical and vocational factors.

Based on the factors discussed above and the record as a whole we find that claimant has not proven he is unable to perform any suitable and gainful work. Therefore, we reverse the award of permanent total disability and rate claimant's permanent partial disability. Since claimant's last left hip surgery involved the acetabulum, claimant is entitled to a rating of unscheduled permanent disability as well as a rating of scheduled disability for loss of use of his left leg. Cf. Woodman v. Georgia-Pacific Corp., 289 Or 551 (1980).

Considering claimant's impairment, age, education, work experience, adaptability, labor market findings and other relevant factors, we find that an award of 60% (192°) unscheduled permanent disability adequately compensates claimant for his loss of earning capacity due to this injury. Further, we affirm the previous scheduled awards totalling 50% (75°) permanent disability for loss of use of the left leg.

After the review process was completed, but before this order was prepared in final form and mailed, we received a request from the employer dated March 26, 1984 to remand this case to the Referee for the introduction of additional evidence. Since we completed the review process before that motion arrived, we decline to consider it with the understanding that, in the event of an appeal, the Court of Appeals has authority to consider additional evidence pursuant to ORS 656.298(6).

ORDER

The Referee's order dated August 30, 1983 is affirmed in part and reversed in part. The portion of the Referee's order which awarded permanent total disability benefits is reversed, and in lieu of all prior awards, claimant is awarded 60% (192°) unscheduled permanent partial disability and 50% (75°) scheduled permanent partial disability for loss of use of his left leg. The remainder of the Referee's order is affirmed.

LEIA D'LYN, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-00864 & 82-03225
April 6, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Danner's order which set aside two denials issued by SAIF, one on behalf of "D" Plus Properties and the other on behalf of Willister Court. The Referee found that claimant had a compensable occupational disease as a result of her concurrent work activities for these two employers, and that both employers were thus responsible for providing compensation. SAIF contends that the Referee erred in finding that claimant, as sole proprietor of "D" Plus Properties, specifically elected workers' compensation coverage as required by ORS 656.128. SAIF also argues that the Referee erred in concluding that claimant sustained a compensable occupational disease with respect to Willister Court. Claimant contends that she is entitled to a larger attorney's fee than that awarded by the Referee.

Claimant is a licensed real estate broker. In May 1981 claimant began working for Willister Court as a resident apartment manager. Claimant's duties as resident manager included renting and cleaning apartments in the 27-unit complex, collecting rent receipts, keeping ledgers and doing the banking. Claimant's supervisor was JoAnn Davis.

Since claimant had a real estate broker's license and Ms. Davis was a licensed sales agent, claimant and Ms. Davis decided to go into the apartment management business together. A new business entity was formed under the assumed business name of "D" Plus Properties. Since claimant was a broker and Ms. Davis was a

sales agent, this new business relationship technically put claimant in the position of being Ms. Davis' employer, although Ms. Davis was still claimant's supervisor at Willister Court where claimant also continued working.

On approximately November 3, 1981 claimant telephoned the SAIF Corporation's district office in Portland for the purpose of obtaining workers' compensation coverage for "D" Plus Properties. Claimant informed a SAIF employe that she wished to obtain workers' compensation coverage for herself as a real estate broker and for Ms. Davis as a sales agent. Claimant was informed that a fee of $60 would be required for opening the account, that a deposit of $154 would be needed for insurance coverage of herself as a sole proprietor, and that $71 would be needed for Ms. Davis, for a total fee of $285. On November 6, 1981 claimant completed a SAIF Corporation application for workers' compensation insurance. Claimant checked the box on the application indicating that "D" Plus Properties was a sole proprietorship. The total estimated payroll for the next twelve months was listed as $22,000. The top portion of the application contained notations from a SAIF employe. A SAIF internal memorandum dated December 28, 1981 states that these notations indicated that the estimated payroll was intended to be for a personal election and one employe. Testimony at the hearing from a SAIF representative was to the effect that the notations on the application indicated that the $22,000 estimated payroll were broken down for personal election coverage and one employe.

Claimant completed the application and mailed it to SAIF along with a check in the required amount of $285. Claimant's application was received by SAIF on November 10, 1981 and SAIF deposited claimant's check in its account. In a letter addressed to claimant and dated November 18, 1981, SAIF indicated that workers' compensation coverage was effective as of November 12, 1981. The letter also stated that the coverage did not include owners or partners. Claimant testified that she did not recall receiving that letter. On November 24, 1981 SAIF sent claimant another letter containing information concerning her insurance coverage. This letter stated that individual proprietors are personally covered only if their names "appear as a payroll description above." The payroll description referred to in the letter stated, "Real Estate Agency-Agent/Salespersons."

On December 3, 1981 claimant was hospitalized. The admitting report states that claimant was brought to the hospital in a "very distraught" state and was incoherent, agitated and frightened. An acute psychotic episode was diagnosed. Dr. Ball related claimant's condition to her employment. Claimant eventually stabilized and was discharged from the hospital on December 16, 1981.

On December 8, 1981 claimant filed an occupational disease claim with SAIF, alleging that she suffered psychological difficulties as a result of her employment with "D" Plus Properties. SAIF denied this claim on December 16, 1981 on the grounds that claimant had no personal election for workers' compensation in effect at the time of her hospitalization.

Claimant thereafter moved to Roseburg where she was examined and treated by Dr. Beem, who related the following history in his report of March 30, 1982:

> "It was on November 2, 1981 that [Ms. Davis] . . . decided to go to work for [claimant] as a sales person . . . . This left [claimant] in a position of being the broker over a salesperson who was [also] the apartment owner's representative and [claimant's] boss. * * * It was on November 23, that [claimant] rented out two units at Willister Court as resident manager but since she was the broker handling the apartments she used her brokers name but deposited the money in JoAnn Davis' account as was proper in that JoAnn Davis was the manager. On November 24th [claimant] changed her DBA name for her brokerage. She went to the bank and informed them . . . but the bank claimed her brand new client trust account which she had opened in the name of "D" Plus Properties was overdrawn $20.00. This frightened [claimant] and she felt it destroyed her feelings of security since as a broker she was fully responsible for this account and for the accurate and proper handling of all funds entrusted to it . . . [Claimant] began to worry and rehash over and over whether the business maneuver she had gone thru had been done properly and whether or not she had done something wrong. She worried that both she and JoAnn might lose their licenses. She continued to get more and more preoccupied in the matter."

Dr. Beem went on to relate events that took place immediately prior to claimant's hospitalization. These events included demands from the owners of Willister Court for changes in the property management contract and demands that Ms. Davis be bonded. The ultimate event occurred on December 1, 1981, when the owners of Willister Court informed claimant that they were giving the account to another broker. Dr. Beem diagnosed claimant as suffering from post traumatic stress disorder secondary to job-related stress.

On April 2, 1982 SAIF, on behalf of Willister Court, denied that claimant's stress disorder was a result of her work activities with Willister Court.

On October 19, 1982 Dr. Beem reported that he was unable to state that claimant's work activities from November through December 1981 with Willister Court were the major cause of claimant's condition. He also reported that he was unable to state that her work activities with "D" Plus Properties were the major cause of her condition. However, Dr. Beem did state that:

> "I <u>am</u> able to state that [claimant's] work activities for both [Willister Court] and for "D" Plus Properties <u>combined</u> during November 1981 through December 1981, within

> reasonable medical probability, constitute the major contributing factor to cause [claimant's] psychiatric condition and need for medical care and treatment from December 3, 1981 and thereafter."

The matter proceeded to hearing on November 18, 1982. Counsel for SAIF stipulated that if workers' compensation coverage for claimant existed under the policy issued to "D" Plus Properties, claimant did sustain a compensable occupational disease as against that employer. SAIF expressly denied that claimant had sustained a compensable claim with respect to Willister Court. The Referee concluded that SAIF was estopped from denying that claimant was insured under the "D" Plus Properties account. Based on Dr. Beem's October 19, 1982 report, the Referee concluded that claimant suffered from a compensable occupational disease in relation to her employment with "D" Plus Properties and Williver Court. Based on Colwell v. Trotman, 47 Or App 855 (1980), the Referee found both employers liable, set aside both denials and awarded claimant's attorney a fee of $600 in relation to each denial.

ORS 656.027(7) provides that sole proprietors are not subject workers. However, ORS 656.128(1) provides an option whereby sole proprietors may elect to be covered as subject workers:

> "Any person who is a sole proprietor, or a member of a partnership, may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon the insurer may accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of computation under this chapter." (Emphasis added.)

SAIF argues that the application for workers' compensation insurance which claimant completed was not sufficient under the statute, and that claimant was required to file a special application if she desired to make a personal election. SAIF also argues that its letter of November 24, 1981 adequately informed claimant that she had no coverage in effect.

We agree with the Referee that claimant was a subject worker of "D" Plus Properties at the time of her December 1981 hospitalization. However, we do not base our decision on the doctrine of equitable estoppel because we find that claimant and "D" Plus Properties in fact had workers' compensation coverage in effect at the time of her hospitalization.

Claimant argues, and we agree, that although ORS 656.128(1) requires that a sole proprietor make a written application for workers' compensation coverage, there is nothing in the statute which requires that any specific type of form, such as SAIF's special personal election form, be utilized. Claimant did complete a written application for workers' compensation insurance. That application contained notations from a SAIF employe indicating that SAIF's charges and the estimated payroll were intended to be for a personal election and one employe.

SAIF's internal memorandum dated December 28, 1981 is a virtual admission that the application was intended as a personal election. Claimant's check in the amount of $285, which was cashed by SAIF, was the exact amount which would have been necessary for a personal election and one employe in relation to the estimated payroll of "D" Plus Properties. We conclude that claimant's written application for workers' compensation insurance together with the notations written on the top of that application by a SAIF employe constitute a sufficient written application pursuant to ORS 656.128(1). We also conclude that SAIF accepted that application when it cashed claimant's check in the appropriate amount.

With regard to SAIF's argument that claimant was informed by letter of November 24, 1981 that the insurance did not include sole proprietors, we note that claimant testified as follows:

> "I got the letter back from [SAIF], and I just glanced at it and I looked down at the bottom and it says, 'Individual proprietors or partners are personally covered only if the names appear as a payroll description above.' So I looked above and it said 'Real estate agency,' it said 'Agent' and it said 'Salesperson.' So I figured if Joann was a salesperson, then I must be the agent. I thought, 'Well, that's taken care of.' And I really believed that I was -- my name was the agent, if they called her the salesperson. * * * * "

In view of the communications between SAIF and claimant which preceded her receipt of this letter, we find that claimant's interpretation of the November 24, 1981 letter was entirely reasonable.

We next address the question of compensability. SAIF argues that claimant failed to establish that her work activities for Willister Court were the major cause of her psychological difficulties. SAIF contends that the Referee's reliance on Colwell v. Trotman, supra, was inappropriate, as the evidence in the current case indicates that claimant's work activities for Willister Court and "D" Plus Properties were very dissimilar.

In Davidson Baking v. Industrial Indemnity, 20 Or App 508, 515 (1975), the court concluded that the cost of a compensable condition that had been caused by two employers could not be apportioned between those employers. See also Cutright v. Amer. Ship Dismantler, 6 Or App 62 (1971). However, the court in Colwell concluded that the cost of a compensable condition could be apportioned between two employers in a situation involving concurrent and comparable employment. We are uncertain what the ultimate effect of these decisions is. Apparently the general rule is that there is no apportionment subject to some very limited exceptions. However, it is not necessary for us to determine the exact scope of these decisions because we conclude that claimant's work exposure at "D" Plus Properties alone, was the major cause of her psychological difficulties.

Although Dr. Beem concludes that claimant's combined employment activities with Willister Court and "D" Plus Properties throughout November and December 1981 were the major cause of claimant's psychological condition, that appears to be more of a legal than medical conclusion on his part; and we are convinced that Dr. Beem's reports combined with the non-medical evidence result in the conclusion that claimant's employment activities with "D" Plus Properties were the actual major cause of her condition.

Claimant had never experienced psychological difficulties of any kind prior to her employment with Willister Court in 1981. Claimant experienced no psychological difficulties subsequent to her employment with Willister Court and prior to the formation of "D" Plus Properties in November 1981. Although claimant continued to be employed by Willister Court after the formation of "D" Plus Properties thereafter, a chain of events took place which eventually culminated in claimant's hospitalization in December 1981. A reading of Dr. Beem's report of March 30, 1982 is convincing that all of these events were more related to claimant's activities with "D" Plus Properties than they were to her employment with Willister Court.

It was the formation of "D" Plus Properties that put claimant in a state of confusion in regard to her business relationship with Ms. Davis. When claimant was informed by her bank that the "D" Plus Properties' client trust account was overdrawn, she became frightened, and she began to lose her feelings of security because she was responsible for the accurate handling of funds entrusted to the account. Claimant thereafter began to worry that she may have made a mistake in the formation of her business and worried that she might lose her broker's license. Further difficulties occurred in relation to contractual negotiations between the owners of Willister Court and claimant in relation to "D" Plus Properties taking over the property management function for Willister Court. The final event before claimant's hospitalization occurred when the owners of Willister Court informed claimant that the account was to go to a different broker.

It follows that the $1,200 attorney fee awarded by the Referee is payable solely by SAIF as insurer for "D" Plus Properties. In regard to claimant's argument that she is entitled to a greater attorney fee than that awarded by the Referee, we disagree. All things considered, we find that $1,200 is an adequate fee for the efforts expended and results obtained. OAR 438-47-010.

ORDER

The Referee's order dated January 21, 1983 is affirmed in part and reversed in part. Those portions of the order which found claimant's occupational disease claim compensable against both Willister Court and "D" Plus Properties are reversed. The denial issued by SAIF on April 2, 1982 on behalf of Willister Court is reinstated and affirmed. Those portions of the Referee's order which set aside SAIF's denial issued on December 16, 1981 on behalf of "D" Plus Properties are affirmed, and SAIF as insurer for "D" Plus Properties is ordered to accept the claim in its entirety and to process it in accordance with ORS 656.268. SAIF, as insurer for "D" Plus Properties is, therefore, responsible for

paying the entire $1,200 attorney's fee awarded by the Referee. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $700 for services on Board review, to be paid by the SAIF Corporation as insurer for "D" Plus Properties.

ADAM J. GABEL, Claimant
Roll & Westmoreland, Claimant's Attorneys
Rankin, et al., Attorneys
Schwabe, et al., Attorneys
Roberts, et al., Attorneys
Moscato & Byerly, Attorneys
Mitchell, et al., Attorneys
Richard Pearce, Attorney

WCB 81-02817, 81-03932, 81-04989, 81-04990, 81-09226, 81-10240 & 81-10404
April 6, 1984
Order on Reconsideration

Claimant's attorney requests that we reconsider our Order on Review dated March 16, 1984 and award him an attorney's fee. We have reconsidered our order, and we adhere to it.

Claimant sustained a hearing loss while working for 30 years for the same employer. During those 30 years, the employer obtained workers' compensation insurance from six different insurers. During the last years of claimant's work, the employer was self-insured. Claimant filed occupational disease claims against all six insurers and the employer in its self-insured capacity. Some of the insurers denied both compensability and responsibility. Others denied only responsibility. The Referee found the claim compensable and assigned responsibility to the self-insured employer.

The self-insured employer requested review of the Referee's order. Claimant filed a cross-request for review which did not specify what issues the cross-request raised. One of the other insurers then moved to dismiss the request for review and the cross-request for review on the ground that the attorneys of record, and not the parties, had been served with the request for review. The self-insured employer responded with a legal memorandum, arguing that service on attorneys of record was sufficient. Claimant's attorney filed a two-sentence letter joining the self-insured employer's memorandum. The Board then denied the motion to dismiss.

We thought before, and we continue to think, that the only issue raised by the briefs of the employer and the insurers was the issue of employer/insurer responsibility. Only claimant's brief addresses the issue of compensability. Claimant's brief also argues that the Referee's finding on responsibility should be upheld. In our Order on Review we concluded that the Referee had erroneously assigned responsibility to the self-insured employer; we assigned responsibility to SAFECO, one of the insurers.

Claimant's attorney urges in his motion for reconsideration:

> "I request that the Board reconsider this matter and amend its Order on Review to allow award of attorney's fees because of work done in research in response to the earlier Motion to Dismiss this case, as well as because of research and work done in preparing and filing Claimant's appeal brief

with the Board. Finally, had Claimant not cross-appealed against the Employer the Board now finds responsible, the Claimant could conceivably been left without a remedy because of failure to join a party. Claimant's attorney was clearly instrumental in bringing about the present finding of compensability."

As previously indicated, we do not believe that compensability was at issue before the Board. Claimant's attorney is not entitled to a fee for prevailing on a non-issue. Had claimant's position on the responsibility issue prevailed, he may have been entitled to an attorney's fee. Robert Heilman, 34 Van Natta 1487 (1982). However, that position did not prevail, so claimant is entitled to no attorney's fee on the responsibility issue. We do not understand how it was to claimant's advantage to cross-request review of an order which was totally favorable. Had the self-insured employer failed to request review or had the motion to dismiss been granted, claimant would have been left with a finding that his hearing loss is compensable. Furthermore, even if it was in some unknown way to claimant's advantage to prevail on the motion to dismiss, we do not find any indication of claimant's attorney's "research in response to the earlier motion to dismiss" in the two-sentence letter in which he joins the self-insured employer's response.

ORDER

On reconsideration, the Board adheres to the Order on Review dated March 16, 1984, which hereby is readopted and republished.

WILLIAM J. HAMILTON, Claimant
Breathouwer & Gilman, Claimant's Attorneys
Velure, et al., Defense Attorneys

WCB n/a
April 6, 1984
Order Denying Approval of Stipulated Settlement for Distribution of Third Party Recovery

The claimant and industrial insurer have entered into a stipulation by the terms of which a $50,000 judgment obtained by claimant against a third party defendant is distributed between these two parties. A partial distribution has been made, whereby claimant's attorney's fee and the costs of litigation have been paid; claimant has received his statutory minimum percentage of the remaining balance; an amount equal to the industrial insurer's actual claim costs for compensation paid to date (approximately $12,855) has been placed in trust; and a remaining balance of approximately $11,850 has been paid to claimant. See ORS 656.593(1).

The stipulation which has been proffered to the Board provides that the sum presently being held in trust, which represents the amount of the industrial insurer's claim costs, shall be paid to claimant, and that:

"In exchange for its waiver of its right to recover payments made in claimant's workers' compensation claim, claimant hereby agrees that [the insurer] shall have and receive a credit in the amount of [the

> insurer's lien] as and against any future workers' compensation benefits to which claimant might otherwise be entitled, incurred or to become payable until November 23, 1986."

The claim was initially closed on November 23, 1981; hence, claimant's aggravation rights will expire on November 23, 1986.

In requesting Board approval of their stipulation, the parties rely upon our prior approval of a similar stipulated distribution in Lonnie G. Miller, 31 Van Natta 103 (1981). The parties' agreement in Miller differed slightly from the agreement in this case, for the reason that out of the proceeds of claimant's third party recovery, the industrial insurer was reimbursed for its actual claim costs, pursuant to ORS 656.593(1)(c), and the remaining balance, ORS 656.593(1)(d), was paid to claimant. The insurer in that case apparently anticipated future claim costs, which would comprise a portion of its lien if it was established to a reasonable certainty that such future claim costs would be incurred. See LeRoy R. Schlecht, 32 Van Natta 261 (1981), rev'd in part on other grounds 60 Or App 449 (1982). In Miller the insurer waived its potential lien for future claim costs and paid the remaining balance of the third party recovery to claimant, in consideration for which the parties agreed:

> "[The insurer] shall have and receive a credit in the amount of [the remaining balance] as and against any future workers' compensation benefits to which claimant might otherwise be entitled, incurred or to become payable within the next 12 succeeding months after execution of this agreement . . . ." 31 Van Natta at 103.

The Board complimented the parties for avoiding the difficult issue of whether and to what extent the industrial insurer would incur future claim expenditures and stated its approval of the settlement approach utilized by the parties in that case. We also commented about the use of setoffs in workers' compensation settlements.

> "[W]e have recently refused to approve stipulated settlements in which the parties agreed to a setoff or credit of amounts then to be paid against any future workers' compensation benefits, including medical services and time loss. We presently and generally intend to refuse approval of a bargain in which a worker relinquishes future rights to medical services and time loss. On the other hand, in one case we did approve a stipulated settlement which contained a setoff for any future award of increased permanent disability based on representations about unique circumstances in that case.

"Despite our general concerns about setoffs, we will approve the setoff negotiated by the parties in this case because: (1) There is not now pending any workers' compensation litigation involving these parties; (2) the worker is not trading the right to receive future workers' compensation benefits for present receipt of workers' compensation benefits, but instead is trading the right to receive future workers' compensation benefits for present receipt of something else, i.e., a larger share of the third party settlement than he might otherwise be entitled to receive; and (3) the possibility of a setoff is limited in duration to 12 months, which seems like an eminently reasonable period." 31 Van Natta at 104.

The obvious differences between the parties' agreement in this case and the agreement in Miller is, for one thing, the apparent fact that the insurer in this case makes no claim for future claim expenditures, and the "balance" which is being paid to claimant represents the insurer's lien for actual claim expenditures; and that the period during which the setoff is in effect is for a substantially longer period, in excess of two and a half years from the present date and, significantly, for the remainder of the period during which claimant has aggravation rights pursuant to ORS 656.273. However, it is not for reasons arising from the factual distinctions between the agreement in Miller and the parties' agreement now before us that we decline to approve this agreement. It is for the reason that we now have grave doubts concerning the propriety of the parties' arrangement in Miller and our approval of that agreement. In view of these doubts, we decline to approve the stipulation presented in this case.

Shortly after approving the stipulation in Miller, we decided Robert A. Parker, 33 Van Natta 259 (1981), in which we held that an industrial insurer is required to make a determination of its reasonably to be expected future claim costs pursuant to ORS 656.593(1)(c); and that in the event that the insurer fails to make such a claim against the proceeds of a third party recovery, the insurer is responsible for future claim costs just as if there had been no third party recovery. Our decision was affirmed in SAIF v. Parker, 61 Or App 47 (1982).

The issue in Parker arose in the following context. The claimant had settled a third party action and, in effecting a distribution of the proceeds, claimant and the SAIF Corporation entered into an arrangement whereby SAIF was reimbursed for its claim costs paid to date but did not retain any amount in satisfaction of a possible claim for reasonably to be expected future claim expenditures. Instead, SAIF followed what was, at the time, its standard policy in effecting distribution of the proceeds of a third party recovery and paid the remaining balance in its entirety to the claimant with the "understanding" that claimant would be responsible for future expeditures that otherwise would have been SAIF's responsibility in connection with claimant's workers' compensation claim. As stated in our order:

> "The fact that claimant did not share SAIF's 'understanding' came to light less than a week later when claimant submitted a bill to SAIF for $18.50 for medical services in connection with his industrial injury. SAIF's refusal to pay that bill gave rise to this request for hearing." 32 Van Natta at 259.

We affirmed the Referee's order holding SAIF responsible for payment of claimant's medical expense, borrowing liberally from the Referee's well-reasoned order in stating the reasons for our holding:

> "'One of the purposes of the workers' compensation law is to insure that a claimant will receive continued and adequate medical care, reasonable and necessary because of his industrial injury. This is the purpose of ORS 656.245. Simply because the Fund does not wish to encumber itself with additional bookkeeping, it is not relieved of its duty to ascertain that such provisions are made.
>
> "'In this particular case, claimant sustained a very serious injury, and it is reasonable and logical to anticipate continued medical treatment. While it is true that in this particular case claimant received a large settlement, and substantial funds beyond the amount paid to him or on his behalf by the Fund, that is not to say that the claimant would always have this money, with which to pay future medical expenses. * * *
>
> * * *
>
> "There is no statutory authority for the Fund's position that the payment of the balance to claimant operates as a bar to further compensation in the claim." 32 Van Natta at 260-61.

On review the Court of Appeals affirmed, stating in part:

> "Under the statutory scheme, neither a worker's election to pursue a third-party recovery nor the worker's receipt of his share of the proceeds recovered absolves the carrier of its duty to provide continued medical services.
>
> * * *
>
> "As we view the statutory scheme, its primary function and purpose is to shift to the wrongdoer, at least in part, the cost of compensating the injured worker, giving both the paying agency and the worker some

> benefit from the third-party claim recovery. It would not be consistent with that scheme to terminate the worker's right to have paid his medical expenses incurred after the recovery; neither would it be consistent with the remedial purpose of the Act to make the worker whole." 61 Or App at 51, 53.

In determining the effect of SAIF's failure to claim a portion of the proceeds in satisfaction of its lien for anticipated future expenditures, the court stated:

> "The statutory scheme appears to limit the paying agency's right to reimbursement to the retained fund; there is no provision permitting the paying agency to claim reimbursement from the worker any other way. Accordingly, if the paying agency pays over the fund, it also gives up its right to reimbursement for those future expenses." 61 Or App at 55.

It may be that Parker is of limited relevance to this case, which involves the question of whether the parties' stipulation should be approved. Parker focused primarily on the effect of the industrial insurer's failure to claim a lien for anticipated future expenditures; and in this case, the insurer apparently makes no claim for future claim costs. Nevertheless there is an essential similarity between the proposed stipulation in this case and the "agreement" or "understanding" between the parties in Parker, which lends support to our conclusion that the stipulation in question is not subject to approval.

Generally a person may waive any right or remedy to which the person is legally entitled, including constitutional rights. However, this general principle, in the context of claims for workers' compensation benefits, must be considered in light of the principles and policies underlying the Workers' Compensation Act, with particular reference to ORS 656.236(1), the statutory prohibition against a worker's release of his or her rights under the Act. See also ORS 656.289(4). We recently have refused to approve several stipulated settlement agreements where we have found that the proffered stipulation constitutes a release and, therefore, violates ORS 656.236(1). Walter E. Ginn, 36 Van Natta 1 (1984); Warren C. Bacon, 35 Van Natta 1694 (1983); Donald T. Campbell, 35 Van Natta 1622 (1983); Duane E. Maddy, 35 Van Natta 1629 (1983); Arnold Androes, 35 Van Natta 1619 (1983). In Bacon we stated:

> "Although the parties may believe that their agreement represents a reasonable disposition of this compensable industrial injury claim, in ORS 656.236(1) the legislature has prohibited some private dispositions of workers' compensation claims regardless of reasonableness." 35 Van Natta at 1697.

None of the cases discussed above involve distribution of the

proceeds of a third party recovery; however, as we previously indicated in Lonnie G. Miller, supra, 31 Van Natta at 104, considerations involving the release of rights under the Workers' Compensation Act can and do arise in the context of settlement of disputes arising under ORS 656.593.

The question, therefore, is whether the proffered agreement in this case constitutes a release of the claimant's rights under the Workers' Compensation Act and, therefore, violates ORS 656.236(1). We find that it does, although only to a limited extent. The statute states: "No release . . . of any rights. . . is valid." This is subject to the exception for cases in which there is a bona fide dispute concerning compensability of a claim, stated in ORS 656.289(4). That exception to the general prohibition against releases is not involved in this case. Therefore, although the agreement may be considered a limited release, it is nevertheless prohibited by the statute.

The practical effect of this agreement is to provide that the industrial insurer waives its lien against the proceeds of claimant's third party recovery in its entirety by paying to claimant that sum which equals the insurer's lien for actual claim costs. In consideration for this waiver, claimant agrees that until November 23, 1986, the date upon which claimant's aggravation rights expire, the insurer shall not be liable for any possible costs incurred by claimant in connection with his compensable injury claim, up to the amount of the insurer's lien for claim costs. As the court observed in Parker, it is explicitly stated in ORS 656.593(2) that the amount retained by the claimant out of the proceeds of the third party recovery is in addition to the compensation or other benefits to which the claimant is entitled under the Act. 61 Or App at 64. See also ORS 656.580(1).

In conclusion, we hold that the parties' stipulated distribution of the proceeds of claimant's third party recovery will not be approved because it is in violation of the statutory prohibition against releases. ORS 656.236(1). To the extent that our decision today is inconsistent with our prior decision in Lonnie G. Miller, 31 Van Natta 103 (1981), Miller is overruled.

ORDER

The parties' stipulation distributing the proceeds of claimant's third party recovery is not approved.

CONNIE J. DISHON, Claimant
Dwight Ronald Gerber, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 83-01483
April 10, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Referee Seifert's order which set aside its denial of claimant's occupational disease claim. The insurer contends that claimant has not proven that her work activities worsened her underlying condition. We agree and reverse.

We make the following findings of fact. Claimant began

meat wrapper. She did not seek medical treatment at that time. She had prior left shoulder problems related to a fall from a horse when she was 13 years old. Also, in 1975, claimant had received treatment for her left shoulder related to her work activities at that time. Claimant first sought treatment for her current left shoulder problems on November 4, 1982. She indicated to her doctor that she had suffered increased shoulder pain when she had reached out to grab her son at home.

Although the parties argue about whether the at-home incident was the actual cause of claimant's shoulder problems and whether claimant had complained about her shoulder pain to her supervisor before the at-home incident, we find it unnecessary to resolve those questions. Drs. Degge and Freeman are the only doctors in the record who specifically address whether claimant's work worsened her preexisting shoulder condition as opposed to a worsening of symptoms. Dr. Degge, who claimant saw at the request of the insurer, opined:

> "This patient apparently sustained a separation of the left acromioclavicular joint in a fall from a horse at 13 years of age. She had gradual increasing symptoms of deterioration in the joint over the years, apparently aggravated by her work carrying meat trays on a repetitive basis over several months."

We understand Dr. Degge to say that claimant's work aggravated her symptoms rather than her underlying condition.

Dr. Freeman, claimant's treating doctor, stated that although her work as a meat wrapper did not cause her left shoulder condition, her work activity aggravated her left shoulder symptoms. Considering these doctors' opinions, we are unable to find that claimant's work activity caused a worsening of her underlying condition. Therefore, we find her occupational disease claim not compensable.

ORDER

The Referee's order dated October 19, 1983 is reversed. The insurer's denial dated February 4, 1983 is reinstated and affirmed.

CHARLES B. DREW, Claimant
David Force, Claimant's Attorney
Keith Skelton, Defense Attorney

WCB 81-08571
April 10, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Quillinan's order which set aside its denial of claimant's occupational disease claim for his asthma condition.

As a preliminary matter, claimant moves to strike the employer's brief because the employer's brief includes as attachments two articles from medical journals written by Dr. Bardana, claimant's chief medical expert. Much of the employer's brief is aimed at impeaching Dr. Bardana's testimony through

motion to strike, Dr. Bardana was deposed after the hearing in this matter. The employer had every opportunity to impeach the doctor at the deposition.

The Board has no authority to consider evidence which was not part of the record submitted to it. ORS 656.295(5); Thomas C. Whittle, 36 Van Natta 343 (March 29, 1984). We can only remand to the Referee in order to receive the medical journal articles into evidence, but we see no basis here for doing so. We have thus not considered the medical journal articles attached to the employer's brief in our review of this case. Claimant's motion to strike is granted to this extent.

On the merits, we reverse. Claimant is a 50 year old mill worker who has operated an edge gluer machine for the past several years. Claimant has noncompensable chronic obstructive pulmonary disease and preexisting asthma. He alleges that his occupational exposure to the atmosphere in the mill is the major cause of a worsening of his asthma.

The experts are in disagreement. Dr. Patterson, the employer's consultant, examined claimant on September 21, 1981. Dr. Patterson took a detailed history from claimant, consulted previous studies done on claimant, examined claimant and performed further testing. Dr. Patterson summarized the conditions in the mill as he understood them. He said the air contained irritants which could have irritated claimant's asthma. Dr. Patterson opined: "Mr. Drew was made worse in terms of his breathing these exposures at work, just as he was made worse by inhalations of perfumes and other nonspecific dusts and fumes away from the workplace."

On May 24, 1982 Dr. Bardana examined claimant. Dr. Bardana also took a detailed history from claimant, consulted previous studies, examined claimant and conducted his own tests. Dr. Bardana opined:

> "[H]e does have non-occupational asthma significantly altered by occupational exposures. The latter are heterogenous and varied. They include wood dusts, wood and glue smoke and glue fumes. The 1,1,1-trichloroethane is one component of the latter fumes. Levels in the plant were at the upper level of PEL (350 ppm is maximum). Vapors are known irritants to mucous membranes. Methylene chloride is another known irritant whose federal standard is 500 ppm . . . However, NIOSH has recommended a time-weighted average limit of 75 ppm. Levels in the plant (measurement technique not known) was 200 ppm. Both these irritants associated with other stated factors could easily have worsened [claimant's] asthmatic state."

On July 19, 1982 Dr. Patterson wrote a second report in which he responded to Dr. Bardana's report. Dr. Patterson challenged Dr. Bardana's interpretation of some of the testing. More important, he noted that he and Dr. Bardana had apparently been furnished with different data concerning concentrations of the two chemicals associated with the gluing process:

"Available for my review was the report from Environmental Health Sciences of July 9th . . . These levels seem quite low. Perhaps Dr. Bardana had different information.

* * *

"I don't disagree with Dr. Bardana's contention that simply because Mr. Drew has a nonoccupational asthma that it couldn't be made worse by the workplace. I felt what objective evidence we had at hand failed to support such a contention."

On August 9, 1982 Dr. Bardana responded. He disagreed with Dr. Patterson concerning the interpretation of previous tests. However, he conceded that he had erred concerning the concentration of the two chemicals associated with the gluing.

"Finally, the analysis of plant exposures . . . in my initial report represents error on my part. After searching my file exhaustively, I feel I must have used data on the 'Fuller Co. material safety sheet' as levels detected in the plant. These data represent maximum limits . . . and not levels in his plant . . . In any event, both materials are potential irritants to the lung. Most importantly, the pine wood dust/vapors may have contained colophony pine fumes which have been implicated in asthmatic syndromes in woodworkers." (Emphasis in original.)

Dr. Bardana maintained his opinion that claimant's "exposures at his work site represented more than a casual irritant."

Following the hearing in this matter, Dr. Bardana was deposed. Dr. Bardana admitted at deposition that he did not know the concentrations of dust to which claimant was exposed at work. Dr. Bardana also admitted that he did not know the concentrations of glue to which claimant was exposed. He said he based his conclusion on the history concerning work exposure which was related to him by claimant.

The Referee characterized Dr. Patterson's position as being that work exposure and off work exposure contributed equally to the worsening of claimant's asthma. We think Dr. Patterson's position can more accurately be summarized as being that he is unconvinced that claimant's work exposure was the major cause of any worsening of claimant's asthma. The Referee apparently deferred to Dr. Bardana's contrary opinion because she concluded that claimant's work exposure was the major cause of the worsening of his asthma.

We find Dr. Patterson more persuasive than Dr. Bardana. Dr. Patterson's reports are thorough, consistent and well reasoned. Dr. Bardana's first report contains a major factual error. Furthermore, upon learning his error, Dr. Bardana admitted that he has no data to support his conclusion, yet continued to opine that claimant's work exposure to whatever glue and dust to which he was

actually exposed was the major cause of the worsening of the asthma.

We find that claimant has failed to prove by a preponderance of the evidence that his on the job exposure was the major cause of the worsening of his asthma.

ORDER

The Referee's order dated June 14, 1983 is reversed. The employer's denial dated September 10, 1981 is reinstated and affirmed.

JOHN C. HALE, Claimant
David Jensen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB TP-83005
April 10, 1984
Third Party Distribution Order

This case arises under ORS 656.593, which provides for Board resolution of any dispute concerning the proper distribution of the proceeds of a third party recovery. The issue in this case is the amount of an attorney's fee which claimant's attorney is entitled to retain from the proceeds of the third party recovery. Specifically, claimant's attorney seeks Board approval of a fee equal to 40% of the gross recovery obtained in claimant's behalf.

ORS 656.593(1) provides that the proceeds of a third party recovery are to be distributed according to a certain formula. Subsection (1)(a) provides:

> "Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the board for such actions."

OAR 438-47-095, the Board's administrative rule governing recovery of an attorney's fee out of the proceeds of a third party recovery, provides:

> "In third party claims, as outlined in ORS 656.593, the attorney's fees shall in no event exceed 33-1/3 percent of the gross recovery obtained by the claimant."

We have construed this administrative rule, in light of the general principles governing attorney fees in workers' compensation proceedings, with particular reference to OAR 438-47-010(2), to allow the Board to authorize payment of a fee in excess of 33-1/3%, where the claimant's attorney makes a satisfactory showing that such an extraordinary fee is warranted, and that it is consistent with the retainer agreement entered into between the attorney and client. Leonard F. Kisor, 35 Van Natta 282, 285 (1983). See also John Galanopoulos, 34 Van Natta 615 (1982), 35 Van Natta 548 (1983).

There is no question concerning the retainer agreement entered into between claimant and his attorney; it is clear that, under the terms of the agreement, claimant's attorney would be entitled to recover 40% of the gross recovery obtained in claimant's behalf, in view of the fact that this case proceeded to

trial. The only issue, therefore, is whether counsel's services were "extraordinary" within the meaning of OAR 438-47-010(2). In making this determination, some guidance is offered by the facts presented in Kisor and Galanopoulos, in which we authorized an attorney's fee equal to 40% of the gross recovery obtained by claimant.

Kisor involved federal district court litigation in the State of Washington, initiated by a deceased worker's widow, against various asbestos manufacturers whose products allegedly caused the worker's death as a consequence of mesothelioma. Portland counsel necessarily associated local counsel in Seattle, Washington. The third-party action named approximately 30 defendants, and obviously involved complex issues of proximate causation. Similar cases of this nature were cited by claimant's attorneys in support of their claim for an extraordinary fee. It was indicated that those cases had involved approximately 78,000 pages of documentary materials. In determining that it was appropriate to interpret OAR 438-47-095 in such a manner as to allow recovery of a fee in excess of 33-1/3% in certain cases, we stated:

> "Attorney fees exceeding the limitations contained in the administrative rules are commonly awarded in workers' compensation proceedings where the attorney has made a satisfactory showing of extraordinary services, generally based upon favorable resolution of a claim involving unusually complicated legal, medical or other factual issues, where there has been a justified expenditure of an extraordinary amount of the attorney's time.
>
> " * * * In fact civil litigation often entails a greater investment of attorney resources than does the usual proceeding in workers' compensation claims, simply by virtue of the procedural differences, including motion practice and discovery. This is particularly true in cases involving complex litigation, such as the products liability case involved in this instance." 35 Van Natta at 284-85.

In Galanopoulos, we initially, in an interim order, concluded that OAR 438-47-095 precluded allowance of any fee in excess of one-third of a third party recovery. By the time we issued our final third party distribution order in Galanopoulos, we had reconsidered this interpretation in Kisor. We determined that, in view of the complicated nature of the litigation in Galanopoulos, a malpractice action against a podiatrist which involved extensive medical research and investigative work on the part of claimant's attorney, substantial efforts in trial preparation and five days in trial, an extraordinary fee in the amount of 40% of the gross recovery was warranted. 35 Van Natta at 554. We also considered the apparently excellent result obtained in claimant's behalf.

In this case, by comparison, we are unable to conclude that

counsel has rendered "extraordinary services" such as to warrant departure from the 33-1/3% provision of OAR 438-47-095. The factors which weigh in favor of allowing counsel a fee in excess of one-third of claimant's third party recovery are counsel's expenditure of over 200 hours in representing claimant, which included two or three trips to California for purposes of investigation and deposition; a three-day trial; the third party's apparent contention that claimant was solely liable for the accident which resulted in his injuries; the protracted discovery proceedings characteristic of federal court litigation; counsel's apparent expertise in federal court tort litigation; and the fact that it was necessary, in view of claimant's financial position, for counsel to advance substantial out-of-pocket costs. In addition, the contingent nature of such litigation is always a factor to be considered in adequately compensating claimants'/plaintiffs' attorneys. In spite of these various factors, however, which make counsel's claim for a fee in excess of one-third extremely colorable, we are unable to conclude that the efforts expended and the results obtained in claimant's behalf warrant departure from the general limitation upon recovery of an attorney's fee out of the proceeds of a third party recovery.

We hold that claimant's attorney is entitled to be paid and retain 33-1/3% of the total proceeds of claimant's third party recovery. To the extent that this order requires an adjustment in the distribution previously effected pursuant to ORS 656.593(1), claimant's attorney shall make appropriate reimbursement to claimant and the SAIF Corporation.

IT IS SO ORDERED.

CLARENCE C. MARTIN, Claimant
St. Andrew Legal Clinic, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-08201
April 10, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Neal's Order on Remand which affirmed the SAIF Corporation's denial of claimant's condition as of August 1, 1980 and which declined to award a penalty and associated attorney's fee for unreasonable delay in the payment of compensation. Claimant also argues that because SAIF concedes that the Determination Order of May 20, 1980 was unaffected by the August 1, 1980 denial, he is entitled to an award for permanent disability.

The Board affirms those portions of the Referee's order which upheld SAIF's denial and which declined to award a penalty and associated attorney's fee for unreasonable delay in the payment of compensation.

However, we disagree with the Referee's treatment of the issues raised concerning the Determination Order of May 20, 1980. In order to clarify this issue, we begin with a recitation of the material facts.

Claimant compensably injured his sacroiliac on February 3, 1975. The claim was apparently closed as nondisabling. In January 1980 claimant filed an aggravation claim which was accepted by SAIF and processed to closure. A Determination Order

issued May 20, 1980, which awarded claimant temporary disability but no permanent disability. On May 27, 1980 claimant filed another aggravation claim. On August 1, 1980 SAIF denied the second aggravation claim stating:

> "Medical reports now indicate that your injury of 1975 is medically stationary, and that your current problems are not related to that injury. We see no relationship between your current condition and your original industrial injury of February 3, 1975."

Claimant requested a hearing to protest both the denial and the Determination Order.

Because SAIF has conceded that the denial did not in any way affect the Determination Order, the Referee should have decided whether the Determination Order was correct in failing to grant claimant an award for permanent disability. We now make that decision. ORS 656.214(5) provides that a claimant is entitled to unscheduled permanent partial disability for "permanent loss of earning capacity due to the compensable injury." While it is apparent that claimant has significant loss of earning capacity, the overwhelming evidence in this case indicates that none of this loss of earning capacity is due to the compensable injury. Accordingly, we find that the Determination Order of May 20, 1980 should be affirmed.

ORDER

The Referee's Order on Remand dated September 15, 1983 is modified to specifically provide that the Determination Order of May 20, 1980 is affirmed. Except as modified, the Referee's order is affirmed in its entirety.

PATRICIA M. ANDERSON, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-07388
April 12, 1984
Amended Order on Reconsideration

The insurer moves the Board to amend our Order on Reconsideration dated March 14, 1984. In our Order on Review dated November 30, 1983 we stated:

> "The Referee also ordered the insurer to pay claimant's attorney $3,518, representing $2,490 in attorney fees and $1,028 in advanced expenses. Since we reversed the finding of compensability, we likewise reverse the award of attorney's fees. We note, however, that the advanced expenses would not have been recoverable if claimant had prevailed on the compensability question. It is well settled that a claimant's litigation costs are not compensable." (Emphasis supplied.)

Our March 14, 1984 Order on Reconsideration vacated our Order on Review and affirmed those portions of the Referee's order which set aside the insurer's denial of February 18, 1982. In doing so,

however, we said nothing about that portion of the Referee's order which awarded claimant's attorney litigation costs. The insurer states:

> "The hypothetical posed by the Board now having become a reality, the insurer/employer requests that the Board follow through and modify its 'affirmance' of the Referee's Opinion and Order so as to reverse that portion awarding nonrecoverable litigation costs."

The insurer is correct. As we stated in John A. Mayer, 7 Van Natta 278 (1971):

> "There is no basis in either law or Board regulation to impose hearing costs incurred by one party upon the other party."

See also Richard Stinson, 29 Van Natta 469 (1980); Clara Peoples, 31 Van Natta 134 (1981); Daniel Bell, 34 Van Natta 100 (1982); Charles L. Wray, 34 Van Natta 1742 (1982). We, therefore, amend our Order on Reconsideration dated March 14, 1984 to reverse those portions of the Referee's order which awarded claimant's attorney litigation costs in the amount of $1,028.

IT IS SO ORDERED.

JACK S. CARROLL, Claimant
Pozzi, et al., Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 83-00006
April 13, 1984
Order Vacating Order on Review and Briefing Schedule

The Board issued its Order on Review herein on March 30, 1984, in which we noted that neither party had filed a brief in this employer-initiated proceeding. We now are in receipt of the employer's motion indicating that, due to a failure in office procedures, counsel was not aware that a briefing schedule had been established. Claimant has responded, requesting that, in the event the proceeding on review is reinstated, claimant be allowed an opportunity to file a brief in support of his cross-request for review.

Now, therefore, the above-referenced Order on Review dated March 30, 1984, is vacated and held for naught, and this proceeding on review is reinstated. The parties shall submit their briefs in accordance with the following. Employer/appellant has 20 days or until May 3, 1984 within which to file a brief. Claimant/respondent has 20 days from receipt of the employer's brief to file a brief. The Board will accept a reply brief from the employer if it is received within 10 days of claimant's brief. On June 4, 1984, the Board will proceed to docket this case for review on the basis of the file then developed.

All extensions require prior approval. Extensions of time for filing briefs will be granted only on written motion and only for good cause.

IT IS SO ORDERED.

DENNIS P. CUMMINGS, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 81-06478 & 81-07564
April 13, 1984
Order on Reconsideration

The Board issued its Order on Review herein on March 16, 1984. Claimant has requested reconsideration of that order insofar as it fails to award a reasonable attorney's fee pursuant to ORS 656.382(2). On reconsideration, we decline to award counsel a fee and, therefore, adhere to our prior order.

This case involves a difficult issue concerning the proper interpretation and application of ORS 656.029, which, in turn, determines the issue of which employer is responsible for payment of claimant's compensation.

In August of 1981, the Compliance Division entered an order pursuant to ORS 656.307, designating the SAIF Corporation, the insurer for the subject employer Gold Coast Realty, as the agent responsible for payment of claimant's compensation. By an order dated April 20, 1982, the Referee determined that claimant was a subject worker of Gold Coast Realty at the time of his injury, by operation of ORS 656.029 and, therefore, ordered SAIF to continue processing claimant's injury claim as the insurer for Gold Coast Realty. The Referee also set aside a denial issued by SAIF as the processing agent for the alleged noncomplying employer Russ Bruegger, dba Bruegger & Co. Signs; and awarded claimant's attorney $500 for services at hearing.

SAIF/Gold Coast Realty requested review contending that the Referee erroneously interpreted and applied ORS 656.029. Claimant submitted a respondent's brief contending: (1) That the Board lacked jurisdiction to adjudicate this dispute between two employers and the State of Oregon; and (2) that Gold Coast Realty is the responsible employer according to law.

We disagreed with the Referee's interpretation and application of ORS 656.029. We reinstated and affirmed the denial issued by SAIF in behalf of Gold Coast Realty; and we set aside the denial issued by SAIF as the processing agent for the alleged noncomplying employer, remanding the claim to SAIF for processing pursuant to ORS 656.054(1). Although we did not expressly address claimant's juridictional argument, it is implicit in our order that it was rejected.

Claimant's request for reconsideration refers to the Referee's award of a $500 attorney's fee and states: "The Board has now compounded the initial niggardliness of the Referee with respect to the award of an attorney's fee by awarding no fee whatsoever for the efforts of counsel on review."

It is true, as counsel states, that, under the terms of the Board's Order on Review, claimant's compensation has been neither diminished nor affected. This fact, however, is not due so much to the efforts of counsel as it is to the fact that, at least since entry of the .307 order in August 1981, claimant's entitlement to compensation from some paying agent has not been in issue. Considering this fact, counsel's entitlement to a fee for services at hearing is governed by OAR 438-47-090(1), which provides in pertinent part that, "the attorney will receive no fee unless he/she actively and meaningfully participates at the

hearing in behalf and in defense of claimant's rights." No party to this proceeding, including claimant, took issue with the Referee's award of a $500 attorney's fee. Only on reconsideration, in seeking a fee for services on Board review, does claimant now express discontent with the Referee's award. Presumably, counsel did not consider this a viable issue for purposes of Board review.

We have adopted the standard of OAR 438-47-090, "active and meaningful participation," as the standard for determining an attorney's entitlement to a fee on Board review where the only issue on review is employer/insurer responsibility. Robert Heilman, 34 Van Natta 1487 (1982). In Heilman, we concluded that at the Board level, "active and meaningful participation . . . means arguing a position that is adverse to one of the potentially responsible employers or insurers." 34 Van Natta at 1488. See also Wayne A. Dettwyler, 35 Van Natta 1599, 1602 (1983). Of course, in order to meaningfully participate on Board review, for purposes of an attorney's entitlement to a fee, it is necessary that the position advocated by claimant be the prevailing position on review. See Adam J. Gabel, WCB Case Nos. 81-02817, 81-03932, 81-04989, 81-04990, 81-09226, 81-10240, 81-10404, 36 Van Natta 575 (April 6, 1984).

Applying these standards to claimant's participation on review in this case, we find that, as indicated, claimant advanced two arguments on review. The jurisdictional argument was rejected. The Board also disagreed with the position taken by claimant concerning the employer responsibility issue, as determined by our interpretation and application of ORS 656.029. In sum, although claimant's attorney actively participated on Board review, his participation was less than meaningful, for purposes of entitlement to a fee on Board review.

For the foregoing reasons, we decline to award claimant's attorney a fee for services on Board review. Accordingly, we decline to modify our prior order.

ORDER

On reconsideration of the Order on Review dated March 16, 1984, the Board adheres to its prior order, which hereby is readopted and republished.

BILL B. DAMERON, Claimant
William Mansfield, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Horne & Tenenbaum, Defense Attorneys
Frohnmayer, et al., Defense Attorneys

WCB 81-06138, 81-06139 & 81-06140
April 13, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer, Peter Kiewit & Sons (hereinafter "PKS"), requests review of Referee Mongrain's order which set aside its denial of claimant's aggravation claim and thereby determined that it was the employer responsible for payment of compensation for claimant's low back condition, presently diagnosed as arachnoiditis. Responsibility is the only issue on review. We reverse based upon our finding that claimant's most recent employer, Hoffman Construction (hereinafter "Hoffman"), is the employer responsible for payment of claimant's compensation.

By an Own Motion Order dated October 21, 1982, the Board referred to the Hearings Division claimant's request for own motion relief in connection with a 1974 injury sustained by claimant while employed by Umpqua River Navigation Company (hereinafter "Umpqua"), insured by Wausau Insurance Companies. The Referee conducted a consolidated hearing and, in addition to issuing an appealable order in connection with claimant's 1980 injury with PKS and 1981 employment with Hoffman, separately recommended that the Board decline to exercise its discretionary own motion authority, in view of his finding that a more recent employer was responsible for claimant's condition. We have this day issued a separate Own Motion Order in Own Motion No. 82-0287M, declining to exercise our own motion authority in view of our determination concerning employer responsibility.

We agree with and adopt the Referee's statement of the pertinent facts. We deem it appropriate to set forth in full the Referee's factual findings:

> "The claimant, 51 years old at the time of hearing, experienced a compensable low back injury on March 21, 1974 while employed by [Umpqua] as an iron worker, following which he was subjected to three surgical procedures, developed arachnoiditis and was granted a permanent disability award of 40 percent unscheduled disability.
>
> "Shortly prior to his final award of permanent disability the claimant complained primarily of pain in his right hip and thigh extending into the calf and ankle, in addition to pain in the right big toe and secondary weakness and lack of coordination of the right foot, especially the ankle. At that time he was working for [PKS] in a primarily supervisory capacity which allowed him to limit his lifting to function basically in accordance with medically imposed 'light duty' restrictions. Despite the frequent occurrence of pain the claimant's overall symptoms remained stable

until February 27, 1980, when he raised up and struck his low back at the site of the previous surgery. Thereafter, although he did not miss any time from work the claimant experienced progressive burning pain in his legs and in July 1980 he filed a workers' compensation claim and consulted Dr. Mario Campagna, the neurosurgeon who had performed the three surgeries on his back. The claim was accepted as a nondisabling injury. Dr. Campagna diagnosed a lumbar sprain, provided some conservative treatment and in November 1980 declared the claimant medically stationary and suffering from minimal disability as a result of the February 1980 accident. In December 1980 the claimant complained to Dr. Michael Narus, a neurologist, of increased bilateral leg weakness in addition to the burning pain. The claimant was also involved in an automobile accident in December 1980, but there is no evidence he injured his back in that accident.

"The claimant commenced employment at [Hoffman] in January 1981. His duties at Hoffman were not strictly supervisory and he was required to intermittently lift weights of 60 to 90 pounds and do a good deal of bending and twisting, all of which caused him increased pain. He also jumped off trucks occasionally when loading them and experienced increased pain on those occasions. In March 1981 the claimant was hospitalized by Dr. Narus because of his back and leg pain-weakness, at which time the continuing presence of significant arachnoiditis was diagnosed. On May 11, 1980 Scott Wetzel Services [in behalf of PKS] issued a denial stating that the claimant's 'present condition' had been caused by his present work and was not an aggravation.

"A few weeks after his discharge from the hospital the claimant returned to work for another employer at non-supervisory iron work, and from then to the end of the year he worked for several employers carrying out various duties, some 'light,' and experienced more pain and a progressive worsening of symptoms. The State Accident Insurance Fund issued a denial on August 21, 1981 stating that it had been unable to substantiate that the claimant's back condition was the direct result of his work activities at [Hoffman] between January and March, 1981.

* * *

> "Dr. Campagna reported in October 1981 that in December 1980 the claimant had recovered sufficiently to permit him to do unlimited physical activity."

The Referee found no reason to question claimant's credibility.

In determining that PKS was the responsible employer, the Referee first analyzed the evidence of the causal relationship between claimant's current condition and his work activity at Hoffman, the most recent in this series of employers with which claimant filed a claim. First he determined that there was no persuasive evidence that, while employed by Hoffman, claimant sustained a specific incident identifiable as a traumatic injury. We agree with this evaluation of the evidence concerning the presence or absence of an "accidental injury" during claimant's employment with Hoffman. The Referee's analysis continues:

> "Accordingly, it seems appropriate to conclude that any responsibility of Hoffman must be determined on the basis of work activity having caused a worsening of the condition and therefore an occupational disease. Weller v. Union Carbide, 288 Or 27 (1979). In order to establish that, the evidence must prove the work was the major contributing cause of the worsening. SAIF v. Gygi, 55 Or App 570 (1982). Considering all the problems the claimant experienced prior to his employment at Hoffman, and also considering the lack of medical opinion stating or implying that the Hoffman work was the major contributing cause of the claimant's worsened condition, an occupational disease has not been [proven]. Therefore, the Fund's denial [in behalf of Hoffman] must be approved."

The Referee then scrutinized the evidence concerning the continuing relationship between claimant's 1980 injury with PKS and his current claim for compensation. He determined that this compensable injury was a material contributing factor to claimant's low back condition and the ensuing disability; therefore, he overturned the denial issued in behalf of PKS and assigned responsibility to that employer, remanding the claimant's aggravation claim for acceptance and payment of benefits according to law.

Since the date of the Referee's order, there has been a good deal of activity in the appellate courts in the area of employer/insurer responsibility. Less than two months after the Referee's order issued, the Court of Appeals decided Boise Cascade Corp. v. Starbuck, 61 Or App 631 (1983). If the Court of Appeals' approach to the responsibility issue presented in this case represented the most recent direction from the appellate court, we would be strongly inclined to agree with the Referee's analysis and resulting conclusion. However, the Supreme Court has more recently spoken on their review of Starbuck, 296 Or 238 (1984); and we

believe that the Supreme Court's decision requires a slightly different approach to analyzing the responsibility issue presented in this case; and the difference is outcome determinative.

In Starbuck the Referee found persuasive evidence of a new injury sustained during claimant's employment in 1979. The Board reversed, finding no evidence of an injury, "new or otherwise," during claimant's more recent employment.

> Claimant unequivocally testified there was no injury, trauma or onset of significantly increased symptoms at that job; rather, claimant's story was one of generally constant and gradually worsening back symptoms throughout 1978 and into 1979 following his accepted back injury claim while working at BC [Boise Cascade, the first employer]." Terry L. Starbuck, 34 Van Natta 81, 82 (1982).

Starbuck was procedurally very complicated and, at the Referee and Board levels at least, involved issues of compensability and not merely responsibility. In any event, in order to determine which employer was liable for claimant's compensation, it is clear that the Board focused on the presence or absence of a trauma during claimant's more recent employment. Finding none, we eliminated the possibility of a compensable new injury claim.

Although it is not entirely clear, it appears as though employer responsibility was the only issue brought before the Court of Appeals. The court went to great length to distinguish the rule of Smith v. Ed's Pancake House, 27 Or App 361 (1976), from the "could have" rule of Inkley v. Forest Fiber Products Co., 288 Or 337 (1980), and Bracke v. Baza'r, 293 Or 239 (1982), in response to the argument that claimant's more recent employer should be found liable for claimant's compensation because claimant engaged in work activity during that employment which could have caused claimant's compensable condition. The Court of Appeals concluded that, although the Supreme Court's opinion in Bracke created some confusion, two different rules applied in cases involving alleged successive industrial injuries on the one hand (the rule of Smith); and, on the other hand, cases involving employer/insurer responsibility for an occupational disease claim where the claimant alleges successive employment exposures.

On review the Supreme Court considered its prior decisions concerning the last injurious exposure rule, noting that its prior decisions applying "the rule" arose in the context of occupational disease cases. After quoting at length a portion of its decision in Bracke, the court stated:

> "The opinion states that the last injurious exposure rule applies to cases of occupational disease as well as injury cases. 293 Or at 248. The Bracke opinion also makes clear that the rule has a dual function: It assigns liability between employers; and it eases the claimant's burden of proof by relieving the worker of the burden of proving specific causation as to one of several potentially liable employers.

"When, as here, the evidence shows that a disability is caused solely by an injury occurring during an earlier employment, there is no reason to apply the rule. As in Bracke, the finding that the earlier employment caused the disability obviates the need for the rule. By summarizing the results of our previous decisions applying the rule, the inapplicability of the rule in this case is apparent.

* * *

"(3) In a successive injury context, if an on-the-job compensable injury and a later off-the-job injury materially contribute to a disability, the last injurious exposure rule does not operate to free the employer from responsibility to pay disability benefits. Grable v. Weyerhaeuser Company, [291 Or 387, 402 (1981)] is such a case. Compare, Peterson v. Eugene F. Burrill Lumber, [294 Or 537, 543 (1983)] (rule does not apply under successive injury theory unless evidence shows a second injury materially contributes to disability).

"(4) In the situation where a compensable injury at one employment contributes to a disability occurring during a later employment involving work conditions capable of causing the disability, but which did not contribute to the disability, the first employer is liable. In Bracke, the disability was caused by and arose during the first employment. Even though the conditions of the later employment were capable of causing the disability, the later employer was not liable because that employment did not contribute to the disability. In the case at bar, as well, the later employment did not contribute to the disability; responsibility is properly placed upon the employer whose employment caused the disability.

"The last injurious exposure rule is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not. Once a worker proves that the disability is work-related, he or she need not prove that any one employment caused the disability. The rule accomplishes that and makes liable the last employer whose conditions of employment might have caused the disability. However, the rule does not prevent a worker from proving that an earlier employment caused

> the disability; nor does it prevent an employer from proving that the claimant's disability was caused by a different employment or that the disability did not arise from any work-related injury.
>
> * * *
>
> "True, there is evidence in this case that straining and lifting at the later employment concurred with the first injury to cause the disability. Had the trier of fact made that finding, the second employer would be liable. But the trier of fact (in this case, the Court of Appeals) concluded otherwise, and we are bound by that finding." 296 Or at 242-45.

Whereas the Court of Appeals understood that it was necessary, as a threshold matter, to determine whether the claim was one for occupational disease or injury, 61 Or App at 640, see also United Pac. Reliance Inc. v. Banks, 64 Or App 644, 648 (1983); Donald Drake Co. v. Lundmark, 63 Or App 261, 263 (1983), it is apparent that under the Supreme Court's formulation of the rule, in cases which are factually similar to Starbuck, the occupational disease/injury distinction becomes less critical in assigning responsibility for payment of compensation. The factual similarity between this case and Starbuck lies in the presence of an accidental injury during a previous employment, which has continued to be causally related to symptomatology experienced by claimant during later employment, the absence, during the later employment, of an identifiable traumatic incident or episode during the more recent employment which can be realistically characterized as "an injury," and work activity during the later employment which may have contributed to claimant's disability.

Where this factual pattern is presented, the responsibility determination is not resolved by answering the legal question: Has claimant sustained an accidental injury, or is claimant suffering from an occupational disease? Once it is determined that the condition is otherwise compensable (and there is no serious contention to the contrary in this case), the primary inquiry is the causal relationship between the work activity performed for the various employers involved and the condition giving rise to the claim for compensation. The fact that there may be no incident or episode during the most recent employment which can be identified as an "injury" is of less significance than the presence or absence of evidence establishing a materially causal connection between claimant's most recent work activity and the current claim for compensation. We understand Starbuck to require evidence of an actual, material contribution to claimant's disabling condition in cases which fall into the same factual category, in order to relieve an employer potentially responsible for payment of compensation pursuant to ORS 656.273 and "shift" liability for payment of the claim to a more recent employer or insurer. See Robert R. Burns, 36 Van Natta 181 (February 29, 1984). Compare, Donald R. Bailey, 36 Van Natta 74 (January 31, 1984) (no evidence of any actual contribution to claimant's condition resulting from most recent employment).

In cases presenting this factual pattern, in order to "shift"

liability to a more recent employer/insurer, we believe it is consistent with fairness and the proportional allocation of liability among employers, as discussed in Bracke v. Baza'r, 293 Or 239, 249-50 (1982), to require not merely evidence of a recurrence or exacerbation of symptoms, but to require persuasive evidence of a worsening of the claimant's underlying condition. Cf. Starbuck, 296 Or at 244: "The last injurious exposure rule is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not."

Turning to the evidence in this case, evaluated in light of the applicable rule of law, we find persuasive evidence that claimant's work activity during his employment with Hoffman materially contributed to his condition, diagnosed as arachnoiditis. We specifically find that this work activity contributed not merely to an increase in the symptoms of this pathology, but that, in fact, it caused a worsening of that underlying condition. We are particularly persuaded by the statements authored by Dr. Narus, concerning the etiology of claimant's current condition and the nature of arachnoiditis:

> "There is no doubt in my mind as to the etiology and cause of Mr. Dameron's back pain. As has been noted for some time in my medical records, the patient first injured his back in November of 1973 while working for Umpqua Construction Company. He subsequently had three back surgeries. His pain was at a tolerable level until he aggravated his back pain while working on the Applegate Dam for the Peter Kiewit Company. He was admitted to Rogue Valley Hospital in March of 1981, and investigations there revealed nearly complete block of the spinal canal due to arachnoiditis. Surgical consultation was obtained, and it was felt that the patient was not a candidate for surgery. Ultimately the patient began working for the Hoffman Construction Company as a common laborer, and this exacerbated the aggravation of the original injury. There is no doubt in my mind whatsoever that the patient has a permanent arachnoiditis which will result in chronic and constant life long back pain. The arachnoiditis is due to the trauma from his injuries and the multiple surgeries."

Although Dr. Narus' reference to an exacerbation of "the aggravation of the original injury" is slightly confusing when read in context with his later statements, it is fairly clear that he is ofthe opinion that claimant's employment with Hoffman worsened his underlying condition. In a subsequent report Dr. Narus stated:

> "Arachnoiditis is primarily an inflammation of the arachnoid meningeal coverings of the spinal cord and nerves in the low back. If this chronic inflammation persists, significant scar tissue can result. This is what was found on Mr. Dameron's CT scan, and myelogram.

"It is my opinion that the significant increase in pain, in this particular case, reflects an aggravation of the underlying pathophysiology involved in the arachnoiditis in this particular case. It is my opinion that the arachnoiditis was aggravated resulting in an increased amount of scar tissue or a decompensation of already marginally functional neurological tissue. This subsequently results in the increased pain.

"There is no question that the post operative arachnoiditis in Mr. Dameron's case had been tolerable, but that it was clearly aggravated by a blow to his back while working for Peter Kiewit Company, and further aggravated by the heavy lifting done while working for the Hoffman Construction Company."

Our finding that claimant's work activity for Hoffman actually and materially contributed to claimant's arachnoiditis results in the conclusion that the SAIF Corporation, as insurer for Hoffman, is responsible for payment of claimant's compensation. It is true that claimant engaged in work activity subsequent to his employment with Hoffman, which was similar to the work claimant performed for Hoffman; however, there is no persuasive evidence that this subsequent work activity contributed, materially or otherwise, to claimant's disabling condition.

ORDER

The Referee's order dated December 5, 1982 is reversed in part. That portion of the order which set aside the denial dated May 11, 1981, issued by Scott Wetzel Services in behalf of Peter Kiewit & Sons, is reversed, and that denial is reinstated and affirmed. That portion of the order which upheld the denial dated August 21, 1981 issued by the SAIF Corporation in behalf of Hoffman Construction is reversed. SAIF's denial is set aside, and this claim is remanded to the SAIF Corporation for acceptance and payment of benefits in accordance with law. The remainder of the Referee's order is affirmed. SAIF shall reimburse Peter Kiewit & Sons for compensation paid to claimant under the terms of the Referee's order. The attorney's fee awarded by the Referee shall be paid by SAIF.

JEFFERSON DAVIS, Claimant
Evohl F. Malagon, Claimant's Attorney
Thorp, et al., Attorneys
Roberts, et al., Defense Attorneys
Luvaas, et al., Defense Attorneys
Miller, et al., Defense Attorneys
Moscato, et al., Defense Attorneys

WCB 81-10466, 82-02086, 82-08340, & 82-08341
April 13, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Home Insurance Company requests review of Referee Howell's order which assigned it responsibility for payment of claimant's compensation on the basis of a finding that claimant's most recent work activity for the employer in December 1981 and January 1982, during which period Home Insurance Company ("Home") provided coverage, independently contributed to claimant's disability and need for further disc surgery. Home contends that either Truck Insurance Exchange or EBI Companies, which previously provided the employer's coverage, is the responsible party.

By an Order dated October 22, 1982, as amended by Order of October 28, 1982, the Board referred claimant's request for own motion relief in connection with a 1975 injury insured by North Pacific Insurance Company, to the Hearings Division for consolidation with claimant's hearing requests pending herein. The Referee conducted a consolidated hearing and, in addition to issuing his order, made a separate own motion recommendation to the Board, whereby he recommended that, in view of his finding that Home is responsible for payment of claimant's compensation, the Board decline to exercise its own motion authority. We have this day issued a separate own motion order in Own Motion No. 82-0261M, in which we have adopted the Referee's recommendation.

We affirm the Referee's order assigning responsibility to Home. We do so based upon our finding that claimant's work activity during the period of time that Home provided coverage for the employer actually and materially contributed to claimant's disabling condition. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Bill B. Dameron, (WCB Case Nos. 81-06138, 81-06139, 81-06140), 36 Van Natta 592 (decided this date). In view of this finding and conclusion, it is unnecessary to address Home's contention that EBI Companies should be assigned responsibility for payment of claimant's compensation on the basis of Bauman v. SAIF, 295 Or 788 (1983).

Claimant's attorney actively and meaningfully participated on Board review with regard to the issue of insurer responsibility and in support of the Referee's order assigning responsibility to Home. Therefore, it is appropriate to award claimant's attorney a reasonable fee for services on Board review. Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated December 15, 1982 is affirmed. Claimant's attorney is awarded $675 for services on Board review.

JOE HOLMES, JR., Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 81-0034M
April 13, 1984
Own Motion Order

Claimant's attorney has requested that the Board direct SAIF Corporation to pay him the additional $500 attorney fee granted by its April 22, 1983 order.

On December 30, 1983 the Board ordered claimant's claim be opened and allowed his attorney a fee out of claimant's compensation not to exceed $750. We amended that fee to a maximum of $1,200 by order of April 22, 1983. At that time, claimant's claim remained in an open status. SAIF Corporation's Legal Division date stamped this order on April 21, 1983; however, the own motion section of SAIF did not receive the order until May 11, 1983. In the meantime, claimant's last compensation payment had already been paid as of approximately May 2, 1983. When the own motion section of SAIF received our April 22nd order on May 11th, it was determined that no further amounts were due claimant and, therefore, no compensation out of which to deduct the attorney's fee.

It is apparent that had SAIF's own motion section received our order from its Legal Division in a timely manner, rather than 20 days later, claimant's attorney may have received an additional attorney fee. We feel it is regrettable that claimant's attorney did not receive the remainder of his fee from SAIF; however, since any portion of claimant's compensation due his attorney has been paid directly to claimant, claimant's attorney will of necessity have to look to his claimant for payment thereof.

IT IS SO ORDERED.

SHARON A. JONES, Claimant
Evohl Malagon, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 82-02227
April 17, 1984
Order on Reconsideration

On March 20, 1984, the Board entered its Order of Dismissal herein, dismissing the insurer's request and the claimant's cross-request for review of the Referee's orders dated April 29, 1983 and June 21, 1983. Claimant has moved the Board for reconsideration of its order insofar as it fails to award a reasonable attorney's fee pursuant to ORS 656.382(2).

The insurer's request for review was received July 18, 1983. Claimant's cross-request was received July 26, 1983. Both requests were acknowledged, and a copy of the transcript of the proceedings before the Referee subsequently was forwarded to both parties, together with a briefing schedule. By letter of March 2, 1984, the insurer advised the Board that it no longer wished to proceed with review of the Referee's order; therefore, dismissal was requested. After receipt of the insurer's letter, and by letter of March 9, 1984, claimant requested that her cross-request be dismissed. The Board entered its order accordingly.

Under the circumstances presented herein, we find it appropriate to award claimant's attorney a reasonable attorney's fee for services on Board review. SAIF v. Bond, 64 Or App 505 (1983); see also SAIF v. Muehlhauser, 64 Or App 724 (1983). We modify our prior order.

ORDER

On reconsideration of the Order of Dismissal entered herein on March 20, 1984, we modify that order to award claimant's attorney $150 for services on Board review, to be paid by the insurer. Except as modified, we adhere to our prior order, which hereby is republished.

EUGENE A. PAGE, Claimant
Olson Law Firm, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 80-05763 & 80-07722
April 17, 1984
Order on Reconsideration

Claimant has requested that we reconsider our Order on Review dated March 23, 1984. Specifically, claimant requests that we consider his disabling pain and consequently increase his award of unscheduled disability. The Board considered claimant's disabling pain in its decision on extent of disability reflected in the Order on Review. Accordingly, on reconsideration we adhere to our previous order.

ORDER

On reconsideration of the Order on Review dated March 23, 1984, the Board adheres to its prior order, which hereby is readopted and republished.

HOWARD DEAN, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-02503
April 18, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Seymour's order which set aside the June 16, 1983 order of the Workers' Compensation Department which authorized SAIF to suspend claimant's compensation as of June 9, 1983; ordered SAIF to pay claimant temporary total disability benefits from June 9, 1983 until closure; and ordered SAIF to pay claimant a penalty in the amount of 15% of the temporary total disability made payable by his order. SAIF contends that the Referee erred on all counts.

Claimant sustained a compensable injury to his neck, left shoulder and left arm on November 15, 1979. A Determination Order eventually issued on August 18, 1982 terminating claimant's time loss compensation as of June 30, 1982. In a prior proceeding (WCB Case No. 82-05128), Referee Baker set aside the Determination Order as premature and ordered SAIF to reinstate time loss benefits. SAIF requested Board review. Pursuant to that Referee's order, SAIF reinstated claimant's time loss benefits pending review. On May 27, 1983 SAIF notified claimant that it was requesting the Workers' Compensation Department to suspend claimant's temporary total disability payments pursuant to OAR 436-54-286 for claimant's alleged refusal to undergo Pain Center therapy. On June 16, 1983 the Department issued an order suspending claimant's compensation as of June 9, 1983. Claimant's request for hearing led to this proceeding.

A hearing before Referee Seymour was held on August 11, 1983. After noting that claimant was receiving temporary

disability benefits pursuant to Referee Baker's order, Referee Seymour concluded that the Department's June 16, 1983 suspension order improperly terminated those benefits. Temporary disability benefits were ordered reinstated as of June 9, 1983.

In the meantime, Referee Baker's order in WCB Case No. 82-05128 was proceeding to Board review. On March 7, 1984 we issued an Order on Review which reversed those portions of Referee Baker's order which found the August 18, 1982 Determination Order premature. The Determination Order, which as noted above terminated claimant's time loss benefits as of June 30, 1982, was reinstated and WCB Case No. 82-05128 was remanded for a determination of the extent of claimant's permanent disability. Howard Dean, 36 Van Natta 213 (March 7, 1984).

We conclude that our decision in the prior case renders this case moot. The issues in this case were based entirely on the time loss benefits that claimant was receiving pursuant to Referee Baker's order. Since we subsequently concluded in our March 7, 1984 Order on Review that claimant was not entitled to those benefits, it follows that the Department's suspension order and Referee Seymour's order are moot because there were no benefits to suspend or reinstate.

ORDER

The Referee's order dated September 9, 1983 is vacated and claimant's request for hearing in this case is dismissed as moot.

MANUEL F. JIMINEZ, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-05383
April 18, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Brown's order which set aside its backup denial. SAIF requests that the Board remand the case to the Referee for further evidence in light of Bauman v. SAIF, 295 Or 788 (1983).

SAIF has not tendered or stated it has any evidence that would bring its denial within the "fraud, misrepresentation or other illegal activity" exception to the general rule forbidding backup denials. It merely states:

> "The SAIF Corporation believes that the present case is an exception to the general 'Bauman' rule, and that this matter should be remanded to the Referee for at least a showing of fraud, misrepresentation or other illegal activity."

The mere assertion of belief on SAIF's part that this case is an exception without any indication that SAIF actually possesses some evidence which would allow it to issue a backup denial is insufficient. We decline to remand, and we affirm the Referee's order.

ORDER

The Referee's order dated September 12, 1983 is affirmed. Claimant's attorney is awarded $300 for services on Board review, to be paid by the SAIF Corporation.

STEVEN LUNDMARK, Claimant
Miller, Nash, Yerke, et al., Claimant's Attorneys
Mitchell, Lang & Smith, Defense Attorneys

WCB 80-04474 & 80-03297
April 18, 1984
Order on Remand

On review of the Board's Order dated July 29, 1981, the Court of Appeals reversed the Board's Order and remanded with instructions that the Referee's Order dated August 28, 1980 be reinstated.

Now, therefore, the above-noted Board Order is vacated and the above-noted Referee's Order is republished and affirmed.

IT IS SO ORDERED.

CLAUDE LYON, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-11497
April 18, 1984
Order on Remand

On review of the Board's order dated March 25, 1983, the Court of Appeals remanded that portion of the order which held that claimant was not entitled to enrollment in an intensive pain center program.

Now, therefore, that portion of the above-noted Board order which held that claimant is not entitled to enrollment in a pain center program is vacated. The SAIF Corporation's denial dated December 8, 1981 is set aside, and this claim for compensation pursuant to ORS 656.245 is remanded to the SAIF Corporation for processing in accordance with the order of the court.

IT IS SO ORDERED.

DORA McFALL, Claimant
Pozzi, et al., Claimant's Attorneys
Annala, et al., Defense Attorneys

WCB 82-03984
April 18, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer, Diamond Fruit Growers (Diamond), requests review of Referee Galton's order which awarded claimant benefits for permanent total disability. The main issue for review is the extent of claimant's disability.

The Referee's order contains an excellent summary of the facts which we adopt as our own.

The Referee concluded that claimant had established permanent total disability from a medical standpoint alone. He also concluded that, if claimant was not permanently and totally disabled from a medical standpoint alone, her physical condition when combined with the relevant social/vocational considerations resulted in a finding of permanent total disability, and that it was not necessary for claimant to comply with the seek-work requirements of ORS 656.206(3).

The employer argues that claimant is not entitled to an award of permanent total disability because: (1) Claimant unreasonably failed to follow medical advice to minimize her disability; (2) claimant failed to comply with the requirements of ORS 656.206(3);

and (3) claimant is not permanently and totally disabled from a medical standpoint alone or when the relevant social/vocational factors are considered in conjunction with her physical condition.

A case factually similar to the current claim was presented in Clemons v. Roseburg Lumber Co., 34 Or App 135 (1978). In Clemons, the claimant sustained a compensable injury to her right arm and shoulder. Corrective surgery was recommended, but claimant refused to submit to surgery. The claim was closed with an award of partial disability, and a hearing was held on the issue of extent of disability. The Referee and Board found that, although claimant's disability exceeded that awarded by the Determination Order, the award of permanent disability could not be increased due to claimant's refusal to mitigate her injury. The court stated:

> "There are two threads running through our cases dealing with the effects upon compensation of unreasonable refusal to submit to medical treatment which might promote recovery and expedite reintegration into the labor market; one relating to proof and the other to restoration. The first emphasizes the burden upon the worker to prove the extent of disability. Refusal of a diagnostic procedure such as a myelogram is regarded as a weakness in the claimant's burden of proof. * * * The other line of cases treats refusal of available treatment as a negative factor in determining extent of compensable incapacity." (Citations omitted.) 34 Or App at 138-39.

The court in Clemons went on to state that the test for determining whether a permanent disability award should be adjusted because of a claimant's refusal to submit to recommended treatment is whether the refusal is reasonable, and set forth the factors upon which to base a determination of reasonableness. 34 Or App at 139. The court concluded that the claimant's refusal to undergo a transaxillary rib resection was reasonable, and that her benefits should not have been reduced due to this refusal.

In Nelson v. EBI Companies, 296 Or 246 (1984), the Supreme Court indicated its agreement with the concept that a claimant who has suffered an injury has a duty to minimize his or her damages in workers' compensation cases, and that an unreasonable failure to follow needed medical advice is a form of lack of minimization. Although the Supreme Court agreed with the test set forth in Clemons, it found that the employer/insurer has the burden of proof to persuade the trier of fact that the worker unreasonably failed to follow medical advice or otherwise mitigate damages. The question in this case thus is: Has the employer established by a preponderance that claimant unreasonably failed to mitigate her damages by refusing to follow medical advice? We believe that it has.

Claimant's condition has been variously described as acute tenosynovitis, Sudeck's atrophy, fibrous ankylosis, osteoporosis,

and left upper extremity causalgia secondary to deQuervain's tenosynovitis. The condition first appeared in 1977. Virtually all of the examiners found functional overlay to be a signficant problem. Since the time claimant filed her claim in 1977, her condition has undergone a steady deterioration. Although the numerous physicians who have examined claimant may have offered somewhat different diagnoses for her condition, they are unanimous in their opinions as to the appropriate mode of treatment.

Dr. Schwartz reported on March 29, 1979 that the best form of treatment for claimant's arm was simply to use her arm. Dr. Langston felt that claimant's condition should be treated with a gauntlet and a return to work. The physicians at the Callahan Center reported that claimant needed to be encouraged to carry out an active exercise program and that strength and range of motion would "undoubtedly improve under an exercise program." Dr. Dow reported on October 10, 1978, that:

> "This patient remains a very difficult problem because of she and her husband's attitude toward her illness. They protested practically anything that is done for her aggravates her difficulty . . . . Otherwise, until she and her husband change their attitude to one of some positive attitude toward efforts at improving her condition, I think her difficulty will continue to have a serious downhill course with all the complications which do arise from the entity known as Sudeck's atrophy . . . . It will require exercise and use, both of which will generate the pain over a temporary time but will eventually give relief if the patient is willing to endure the discomfort of the treatment."

Despite her apparent disinterest, claimant was evaluated at the Northwest Pain Center. Dr. Seres reported that claimant's major problem appeared to be secondary to disuse of her left upper extremity, and that increased mobility of the shoulder and elbow would be an important part of any theory directed at her pain problem. Dr. Seres also reported that: "There appears to be a significant reluctance both on the part of the patient and her husband to accept a more active approach to her problem." In a multidisciplinary summary dated February 15, 1979, the Pain Center examiners reported that a significant amount of claimant's disability was related to disuse and related changes. It was felt that improvement could be accomplished with progressive exercises, but that it was claimant's basic desire to be left alone. That being the case, claimant was not admitted to the Pain Center.

Dr. Burton, a psychiatrist, reported on January 4, 1982 that claimant's arm condition was basically serving two functions. Dr. Burton felt that the arm condition served as a mechanism to maintain claimant's tight family group by serving as a locus for the projection of blame. Dr. Burton also felt that the arm served the function of providing secondary gain in the form of continued compensation payments which served to reinforce claimant's

continued disability. Dr. Burton proposed that claimant, with the involvement of her family, undergo a therapeutic treatment program. The doctor felt that such a program had a good potential for success if claimant and her family would cooperate.

However, on February 26, 1982 Dr. Burton reported that claimant and her husband had refused to pursue any form of psychotherapy. The only reason given for this refusal was: "We don't believe in psychiatrists." Dr. Burton concluded that claimant and her husband found the secondary gain factors more important than the inconvenience of her arm symptomatology.

The reasonableness inquiry from Clemons focuses on the questions of whether an ordinarily prudent and reasonable person (taking into account the worker's perspective) would submit to the recommended treatment, considering the claimant's physical and psychological condition, the degree of pain accompanying and following the treatment, the risks posed by the treatment, and the likelihood that it would significantly reduce the worker's disability. Clemons, supra, 34 Or App at 135. We think that there is little question but that an ordinarily prudent and reasonable person would submit to the treatments recommended in this case. Although there is a degree of pain which would initially be involved in that treatment, there is a degree of pain associated with virtually any form of medical treatment, and we basically understand the physicians' unanimous position in this case to be, "no pain, no gain." The trade-off for some initial pain claimant might undergo in the early stages of her treatment is a probable significant reduction in her disability. Additionally, the risks posed by the treatment in this case appear to be extremely minimal. No surgery has been proposed. The physicians are only asking claimant to undergo conservative treatment which appears to consist of physical and possibly psychiatric therapy, and nearly all of the physicians who have examined claimant agreed that the likelihood for reduction of disability ranges from good to substantial.

We do not think that it is asking too much of claimant to undergo physical and/or psychiatric therapy considering what we understand to be the potential likelihood that claimant's disability would likely be reduced by a reasonable degree. However, claimant has consistently refused to undergo any of the recommended treatment, and there is no good excuse offered for this refusal. Balancing all of the factors set forth in Clemons, we conclude that the employer has met its burden under Nelson, and has established that claimant's refusal to undergo recommended treatment was unreasonable, and that an award of permanent total disability under such circumstances cannot be justified. Claimant's previous awards of 95% scheduled disability and 70% unscheduled disability are more than sufficient.

We also conclude that, even if claimant's refusal to minimize her injury was not unreasonable, claimant's failure to comply with ORS 656.206(3) would also preclude an award of permanent total disability. Unlike the Referee, we do not find that claimant is permanently and totally disabled from a physical standpoint alone, or when her physical condition is considered in combination with the relevant social/vocational factors. Thus, we do not believe that it would have been a useless gesture for claimant to comply with the requirements of ORS 656.206(3). Claimant has made no

attempts whatsoever to seek employment since the time she filed her claim in 1977. Claimant's only restrictions involve her left arm, and to a lesser extent, her left shoulder. Claimant has no other physical limitations. There is evidence in the record which indicates that claimant engages in a number of activities in her home. (See, for example, Dr. Quan's report of March 10, 1981.) Dr. Burton was of the opinion that claimant could perform work compatible with her physical disability, as were Orthopaedic Consultants, as were the examiners at the Callahan Center. Although claimant does have some social/vocational impediments to employment, we do not feel that they are so severe that she should be excused from the seek-work requirements of the statute.

Our conclusion that claimant is not permanently and totally disabled makes it unnecessary for us to address the issue raised by the employer concerning an offset for claimant's prior award.

ORDER

The Referee's order dated June 21, 1983 is reversed.

PATRICIA A. REES, Claimant
Ackerman, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-04763
April 18, 1984
Order of Dismissal

The employer has requested review of Referee's order dated March 13, 1984. The request for review was filed with the Board on April 13, 1984, more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The employer request for review is hereby dismissed as being untimely filed.

RALPH W. VANHOOF, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys
Gilah Tenenbaum, Defense Attorney

WCB 82-08659 & 82-08458
April 18, 1984
Order on Reconsideration

Claimant requests reconsideration of our Order on Review dated March 23, 1984. Claimant contends that he is entitled to an attorney fee for his successful defense of the Referee's order on the appeal by Wausau Insurance Company. Claimant is correct. As the only issue raised by Wausau, however, was employer/insurer responsibility, a moderate attorney fee only is warranted.

ORDER

On reconsideration of our Order on Review dated March 23, 1984, claimant's attorney is awarded an attorney's fee of $450 for services on Board review, to be paid by Wausau Insurance Company. We adhere to our former order in all other respects.

This matter is before us on the SAIF Corporation's petition for resolution of a dispute concerning the proper distribution of the proceeds of a third party recovery obtained by claimant. ORS 656.593(1). The issue is whether claimant may claim, as costs pursuant to ORS 656.593(1)(a), medical expenses incurred in California which have not been paid by SAIF.

Claimant was injured on November 2, 1979, in a motor vehicle accident in Salem, Oregon, while acting within the course of his employment. He filed a workers' compensation claim with his employer, insured by SAIF, and also elected to pursue a civil action against the allegedly negligent third party. ORS 656.154, 656.578. The third party civil action proceeded to trial in February 1983, and claimant was awarded approximately $9,700 in damages by a jury verdict. The court allowed costs and disbursements of approximately $523, pursuant to the cost bill filed by claimant.

SAIF's lien as of the time the dispute was submitted to the Board for resolution exceeded $5,500. In addition to the costs allowed by the court, SAIF agreed that claimant should retain out of the proceeds of the third party recovery the additional sum of approximately $1,330 as costs. This sum represents additional litigation expenses incurred by claimant, primarily related to expert medical evidence.

The factual background relative to claimant's out-of-state medical expenses is as follows. After his injury, claimant commenced treatment with an Oregon chiropractor. Subsequently, claimant either moved to California to reside with his parents or went for a visit and began to experience back problems. In any event, while in California, claimant treated with a chiropractor, Dr. Ward. It appears that Dr. Ward is certified under California law as a "Spinal Column Stressologist," and the treatment he provided claimant is described as "coccygeal-meningeal stress fixation syndrome treatment." This is characterized in literature apparently made available through Dr. Ward's office as "a newly developed, scientific, highly specialized procedure [which] is not routine in nature." Further description indicates:

> "It requires proper examination, objective evaluation, and it may involve two or three persons to aid in performing the treatment. The treatment involves an intra-rectal manual, manipulative breakdown of the stress fixations and/or fusion at the sacral-coccygeal articulation."

In March of 1980, claimant informed SAIF by telephone about his treatment with Dr. Ward. By letter of March 27, 1980 SAIF stated it would not recognize or authorize Dr. Ward's treatment. That letter notified claimant that, while he was in California, his treating physician would be a Dr. Turek, an M.D., and that a medical exam had been arranged for the following month. The March 1980 letter to claimant is the only evidence of SAIF's

notification to claimant or Dr. Ward concerning its refusal to pay for Dr. Ward's treatments.

Claimant incurred approximately $2,160 in chiropractic costs through treatment with Dr. Ward. SAIF's stated reason for refusing to pay for these treatments is the fact that Dr. Ward is not an Oregon chiropractor. See generally ORS 656.245; Mogliotti v. Reynolds Metals Co., 67 Or App 142 (1984); Rivers v. SAIF, 45 Or App 1105 (1980); Anita Gilliam, 35 Van Natta 377 (1983).

Claimant contends that it is inequitable to require that he pay for Dr. Ward's treatments out of his share of the proceeds of the third party recovery, particularly since this treatment is "obviously related" to his industrial injury. Claimant contends that SAIF's refusal to pay for this treatment is based upon "an artificial exclusion" in the workers' compensation law. But see ORS 656.245(3).

We fail to see what claimant's position has to do with the precise issue before us. For present purposes, it matters not whether Dr. Ward's treatment was related or unrelated, reasonable or unreasonable. Those issues could and should have been raised by requesting a hearing on SAIF's March 1980 denial of Dr. Ward's treatment.

The precise issue before us is whether, by any stretch of the imagination, the bills for Dr. Ward's treatment can now be taken into account at the time of third party distribution as "costs" within the meaning of ORS 656.593(1)(a), which states that, from any damages recovered from a third party, "Costs and attorney fees shall [first] be paid . . ." (Emphasis added.) It is clear to us that "costs" in this statute means litigation expense associated with the judicial process of prosecuting a third party action. SAIF has already agreed to reimburse claimant for litigation costs which were not recoverable as part of claimant's cost bill in the judicial proceedings, primarily expert witness fees. To extend the definition of "costs" as proposed by claimant to include Dr. Ward's treatment -- which had nothing to do with the actual judicial proceedings -- would go far beyond the scope of what the legislature could have intended that term to mean.

Accordingly, we conclude that claimant is not entitled to be paid those expenses incurred as a result of out-of-state chiropractic treatment as "costs" within the meaning of ORS 656.593(1)(a).

ORDER

Claimant's third party recovery shall be distributed in accordance with the statutory distribution formula and in a manner consistent with this order.

JOHN J. O'HALLORAN, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80- 05999 & 81-08748
April 19, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Leahy's orders which, in effect, affirmed Determination Orders dated June 16, 1980 and November 21, 1980 which awarded claimant no compensation for permanent disability as a result of his industrial injuries of May 11, 1979 and December 20, 1979. Claimant contends that he is permanently and totally disabled as a result of prior industrial injuries and either or both of his 1979 industrial injuries; or, in the alternative, that he is entitled to an award of permanent partial disability, scheduled and unscheduled.

We adopt the Referee's findings of fact and affirm his conclusion that claimant is not entitled to an award of permanent partial disability. The medical consensus is that, as a result of his head injuries, claimant suffers from a post concussion syndrome, i.e., recurrent headaches, ringing in the left ear (tinnitus), a dull ache in the left side of the head, and a sense of imbalance, giddiness, or dysequilibrium, particularly noticeable at heights. Dr. Korn, who examined claimant in connection with an evaluation for the tinnitus and putative hearing loss, stated his impression that this sense of lost balance, particularly in high places, "represents a modest emotional over-lay relating to working 'high steel.'" The record suggests that this sense of dysequilibrium is a permanent residual of claimant's head injuries, but there is a dearth of medical evidence regarding the degree of permanent impairment, if any, which is or may be attributable to this mild dysequilibrium.

Dr. Coull stated that the combination of what he diagnosed as peripheral neuropathy in the lower extremities, which is unrelated to claimant's 1979 injuries, and the diagnosed post concussion syndrome, "would severely impair [claimant's] ability to work at heights because of impaired postural reflexes. On the other hand, from a neurological standpoint, he does not appear to be disabled for other sorts of ground work."

In February 1981 Dr. Reimer reported:

> "This gentleman is working full-time, currently at the Bonneville Power Expansion. He is an iron worker, though he currently has a job which keeps him on the ground, which he finds safe in view of his on-going symptoms.
>
> "* * * In spite of these symptoms, he continues to work full-time, and he does not feel that it interferes with his employment as long as he remains on the ground level."

Claimant's primary treating physician, Dr. Thompson, reported to counsel for Texstar Construction (December 1979 accident) by letter dated March 30, 1982, obviously in response to an inquiry

concerning the relative responsibility of claimant's two employers for the consequences of the two accidents:

> "It is impossible to say which accident caused his later troubles, as they both caused similar symptoms and these symptoms continued through both accidents and were similar. The symptoms were of the subjective type and it was impossible to judge them from an objective point of view as to whether they were worse or better as time went on or which accident was responsible for the residual effects."

The opinions of Drs. Coull, Reimer and Thompson are the medical opinions most relevant to the issue of permanent impairment attributable to the symptoms of mild dysequilibrium. Dr. Thompson identifies the subjectivity of these symptoms, which is supported to some extent by Dr. Korn's reference to a "modest emotional over-lay;" Dr. Reimer refers to claimant's "feeling" that he no longer is capable of working at heights, without verifying objective impairment in this regard; and Dr. Coull, who has identified "impaired postural reflexes," seems to link this medical problem, and the consequential effect upon claimant's ability to work at heights, primarily with the diagnosis of "peripheral polyneuropathy primarily involving sensory modalities distally in the lower extremities," the etiology of which remains obscure, but which is not related to claimant's industrial injuries. In view of this void in the record, concerning medical verification of impairment resulting from the symptoms of mild dysequilibrium, we find that claimant has failed to establish that he is entitled to an award of unscheduled permanent disability for this component of the diagnosed post concussion syndrome.

We face a similar problem concerning the tinnitus, or ringing, in claimant's left ear. The tinnitus does not appear to result in any impairment based upon the medical evidence of record. Claimant's testimony supports this conclusion as well. The most that claimant could say of the tinnitus was that it is annoying. Dr. Korn, who evaluated claimant specifically for tinnitus and hearing loss, does not even mention the residual effects associated with the tinnitus, other than to state that it is permanent. Although permanent, we must be able to find that this condition results in impairment. There is no such evidence.

There is evidence of a permanent hearing loss, the extent of which has been evaluated by Dr. Korn, who unequivocally relates this hearing loss to neuro-sensory damage resulting from the May 1979 head trauma. Our problem in accepting this evidence as persuasive is in the fact that, prior to his examination by Dr. Korn, claimant had been examined by Drs. Thompson and Reimer on several occasions, and neither physician identified any hearing loss problem. Indeed, in his June 4, 1979 report of his initial examination of claimant, Dr. Reimer specifically noted that claimant did not complain of hearing loss; and when Dr. Reimer reexamined claimant on May 19, 1980, his examination revealed no hearing abnormality. The complaints related by claimant at that time included his headaches and buzzing sensation in the head. Claimant testified that he experienced a hearing problem after his initial head trauma, but we are unable to understand why, if this

is so, physicians' reports more contemporaneous with the events in question did not document this complaint, and, in fact, record a history to the contrary. Given this state of the record, although we do not question the diagnosis of hearing loss by Dr. Korn, we simply do not find persuasive his conclusion that this hearing loss is a result of claimant's head trauma.

The headaches, which also comprise part of the symptomatology associated with the diagnosis of post concussion syndrome, do not appear to be disabling. The apparently increasing difficulties claimant has experienced with his lower extremities subsequent to his head trauma are clearly not related to either one of these claims for injuries sustained in 1979.

With regard to claimant's contention that he is entitled to an award for permanent and total disability, we affirm and adopt the portions of the Referee's order finding to the contrary.

ORDER

The Referee's orders dated January 6, 1983 and January 13, 1983 are affirmed.

SYLVIA J. ROBERTS, Claimant
D. Richard Hammersley, Claimant's Attorney
John Snarskis, Defense Attorney
Roberts, et al., Defense Attorney

WCB 82-11651 & 82-11028
April 19, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

United Pacific Reliance Insurance Company requests review of Referee Mulder's order which set aside its denial of claimant's aggravation claim and upheld the denial issued by Industrial Indemnity of claimant's alternative new injury claim. The issue is employer/insurer responsibility. Industrial Indemnity has also raised an issue relative to compensability, but we find it has no merit.

Claimant was employed by Opti-Craft, which was insured by United Pacific, when she sustained a compensable low back injury on March 2, 1979. Claimant underwent bilateral L4-5 laminectomy with disc excision on June 13, 1979. The claim was closed by Determination Order dated December 20, 1980 which awarded claimant 15% (48°) unscheduled permanent partial disability. This was later increased to 25% (80°) permanent partial disability by a Referee's order dated September 9, 1980.

In July 1981 claimant went to work for Ford Industries, insured by Industrial Indemnity, as an electronics assembler. While lifting some boxes on July 20, 1982, claimant experienced what she described as a sudden and severe pain which encircled her chest. More specifically, claimant experienced pain in her mid-back, but after a few days the mid-back pain began to recede, and claimant began to notice pain in the area of her previous back surgery. Claimant's condition was initially diagnosed as a dorsal and lumbosacral strain with degenerative joint disease.

On October 25, 1982 Industrial Indemnity, as insurer for Ford Industries, issued a partial denial, which stated that claimant's July 1982 "upper back strain" was accepted, but that her lower back condition was denied. On December 3, 1982 United Pacific denied claimant's aggravation claim.

With regard to the question of responsibility for claimant's low back condition, Dr. Thompson stated that in his opinion, claimant's current complaints were referrable to her prior injury and subsequent surgery rather than to her July 1982 incident, and that he did not believe the July 1982 incident "significantly" aggravated claimant's condition.

Dr. Dinneen reported on October 8, 1982 that: "It would seem to me appropriate to consider each incident contributing about 15 percent to this problem." (It is possible that Dr. Dinneen actually meant to state that each incident contributed 50 percent to claimant's current condition.)

Claimant apparently received no medical treatment and took no medication for her back condition from March 1980, when Dr. Duff performed a closing examination in relation to claimant's 1979 injury, until the July 1982 incident.

The Referee concluded that claimant sustained an aggravation of her 1979 injury rather than a new injury which would be the responsibility of Industrial Indemnity. We disagree.

Subsequent to the Referee's decision in this case, the Supreme Court issued its decision in Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The question under Starbuck is whether the incident at claimant's second employment contributed to her current disability. 296 Or at 244-45. If it did not, responsibility remains with United Pacific; if it did, responsibility shifts to Industrial Indemnity. We find that the July 1982 incident did contribute to claimant's current disability, and that Industrial Indemnity is thus responsible.

There are several factors which support our conclusion that claimant sustained a new injury in July 1982. Although it is true that claimant received an award of 25% disability as a result of her 1979 injury, it nevertheless would appear that claimant substantially recovered from the 1979 injury and related surgery. Claimant told investigators from both United Pacific and Industrial Indemnity that:

> "Since the surgery I had no problem with it you know after the initial period of . . . . when it healed and ever since I've worked at Ford Industry, I've had absolutely no trouble with my back whatsoever, I mean I could do everything that I did before it got hurt you know the first time . . . ."

and:

> "It was perfect, there was not a doggone thing wrong with it.
>
> * * *
>
> "I could do just about, you know, anything and everything."

Claimant related basically the same history to all of the physicians who examined her following the July 1982 incident. The fact that claimant experienced no continuing symptoms, took no

medication and sought no medical treatment for her back from March 1980 until the July 1982 incident is a strong factor indicating that a new injury took place in July 1982.

A second consideration is the fact that there was a specific identifiable traumatic incident which took place in July 1982, immediately following which claimant sought medical treatment. Although claimant initially experienced pain in her chest and upper back, it became apparent shortly after her upper back pain subsided that her low back was also involved, Industrial Indemnity's arguments to the contrary notwithstanding. The July 1982 incident was clearly of the type which would likely lead to injury. See Valtinson v. SAIF, 56 Or App 184 (1982); Donald M. Drake Company v. Lundmark, 63 Or App 261 (1983).

Lastly, we conclude that the opinions of both Drs. Dinneen and Thompson support our conclusion that claimant sustained a new injury. Dr. Dinneen clearly opined that the July 1982 incident contributed independently to claimant's condition. Although Dr. Thompson felt that claimant's condition did represent an aggravation of the 1979 injury, he nevertheless does appear to indicate that the 1982 incident did contribute in some degree to claimant's current condition. This is sufficient for a finding of new injury.

Although we are not sure it is especially relevant, we reject Dr. Thompson's statement that claimant "attributed the onset of her low back symptoms to getting off an examining table at Kaiser Permanente a week or so after the injury to the thoracic spine on July 20, 1982." It is clear that claimant was only relating to Dr. Thompson that she could barely get off the examining table due to her low back pain.

ORDER

The Referee's order dated August 31, 1983 is reversed. The December 3, 1982 denial issued by United Pacific Insurance Company is reinstated and affirmed. The October 25, 1982 denial issued by Industrial Indemnity is set aside and this claim is remanded to Industrial Indemnity for acceptance and processing. Industrial Indemnity is ordered to reimburse United Pacific for all claim costs, including attorney fees, paid or payable pursuant to the Referee's order.

BETTIE L. ROGERS, Claimant
Roger Wallingford, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-06434
April 19, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of those portions of Referee Gemmell's orders which: (1) Set aside SAIF's July 7, 1981 aggravation claim denial by which SAIF denied the claimant's condition in approximately February 1981 represented an aggravation of her 1978 injury; and (2) which set aside SAIF's March 31, 1982 aggravation claim denial by which SAIF denied that claimant's condition in October 1982 represented an aggravation of her 1978 injury.

Claimant, who was then 55 years of age, was employed as a custodial worker for the University of Oregon Health Sciences

Center on January 3, 1978 when she sustained a compensable back injury. Her claim for that injury was initially denied. However, the denial was set aside in December 1978 by a Referee's order in a prior proceeding. A July 2, 1979 Determination Order awarded claimant 5% unscheduled permanent partial disability for injury to her back.

Claimant was examined by Dr. Colbach, a psychiatrist, on May 31, 1979. Dr. Colbach found claimant to be depressed about the aging process and the resulting loss of her youthful beauty, and the bitter termination of a recent love affair. Dr. Colbach felt that claimant's industrial injury did "precipitate her current nonfunctional condition."

On June 19, 1979 SAIF partially denied the compensability of claimant's psychiatric difficulties. This denial was set aside in April 1980 by a Referee's order in another prior proceeding. The Referee's order was affirmed by the Board. Bettie L. Rogers, 30 Van Natta 35 (1980).

Claimant began treating with Dr. Mighell, a psychiatrist, in May 1980. Dr. Mighell was of the opinion that claimant had a narcissistic and poorly adjusted personality and was having extreme difficulty coping with the aging process. Dr. Mighell diagnosed a moderately severe reactive depression with somatization.

Dr. Mighell's opinion was basically echoed in the May 28, 1980 report of the Psychology Associates. Drs. Colistro and Davis felt that women with claimant's personality defects find that, with increasing age, their fears of failure intensify as their physical beauty and endurance diminish. Drs. Colistro and Davis felt that claimant had been facing this problem for at least the prior 10 years. The industrial injury was believed to have exacerbated claimant's symptoms but was not felt to be the cause of them.

In August 1980 Dr. Mighell reported that he was discouraged with attempts to treat claimant. Dr. Mighell felt that claimant was using her injury to obtain attention and that she was unwilling to give up the attention she received as a result of it. Dr. Mighell felt that claimant insisted on being taken care of one way or another and that disability insurance satisfied this desire. Dr. Mighell also reported that claimant had requested him to qualify her for Social Security disability, but that he refused because he did not feel she was incapable of working.

Claimant, dissatisfied with Dr. Mighell, began treating with Dr. Hughes, also a psychiatrist. Although Dr. Hughes felt that claimant has a long-standing borderline personality disorder, he did not believe that claimant was psychiatrically disabled. Dr. Hughes felt that claimant could return to some type of work activity, but warned that she would attempt to control the type of employment or placement services she would accept. A review of the vocational records contained in the record indicates that Dr. Hughes' prognosis was correct.

On November 26, 1980 claimant was examined by Psychological Consultants. The panel was composed of Dr. Turco, a psychiatrist, and Drs. Rethinger and Yospe, psychologists. After examining

claimant and reviewing her records, the Consultants found that claimant's current depression was due to loss of prestige, loss of her youthful beauty, the aging process and the recent loss of her boyfriend to another woman. The Consultants could find no mental or emotional problems as a direct result of claimant's back injury, and found no indication of any permanent psychological disability due to the 1978 injury. Claimant's current symptoms were found to be attributable to her personality disorder associated with a long-standing depression which was in turn associated with a narcissistic personality and her inability to cope with aging.

A January 14, 1981 Determination Order awarded claimant 10% (32°) unscheduled permanent disability for injury to her low back. Claimant requested a hearing on the Determination Order, which led to yet another prior proceeding. That proceeding convened on January 31, 1981 before Referee Pferdner. Claimant contended at the hearing that she was entitled to an award of permanent disability due to her psychological condition. Referee Pferdner disagreed. Based on the Psychological Consultants' report, he concluded that claimant did not suffer any permanent psychological impairment as a result of her 1978 injury. The Referee did find that claimant suffered a 25% loss of earning capacity due to her back injury. The Referee's order was affirmed by the Board. Bettie L. Rogers, 32 Van Natta 221 (1981).

The hearing before Referee Pferdner constitutes claimant's last award of compensation for purposes of the aggravation claims here in issue. Joseph R. Klinsky, 35 Van Natta 332, aff'd without opinion, 66 Or App 193 (1983).

Following substantial efforts on the part of claimant's vocational counselor, claimant was returned to work at the University of Oregon Health Sciences Center on January 26, 1981 as a PBX operator-trainee. Claimant was to undergo an eight week training period, but she only completed slightly over two weeks (88 hours) of the training program before quitting on approximately February 27, 1981. Claimant felt that the job involved more stress than she was able to cope with.

On April 8, 1981 Dr. Hughes reported that it was somewhat unrealistic to expect claimant to function in a high-pressure job such as PBX operator, but he nevertheless stated that he felt claimant was capable of gainful employment. Dr. Hughes reiterated this position on April 17, 1981. Similarly, in a report dated June 30, 1981, claimant's vocational counselor stated that Dr. Hughes had related to him that claimant was capable of working at a low-pressure job.

On July 7, 1981 SAIF denied that claimant suffered an aggravation of her 1978 injury.

Claimant thereafter obtained employment as a clerk in Swiftmart. Claimant worked there approximately two months. Claimant contends she was forced to quit as a result of her supervisors making sexual advances. Claimant filed a workers' compensation claim against Swiftmart. That claim was resolved by a disputed claim settlement in October 1982.

On March 23, 1982 claimant was examined by Dr. Moss, a

psychiatrist, whose diagnosis was similar to that of previous examiners, namely, a narcissistic personality coupled with inability to deal with the aging process. Dr. Moss was of the opinion that claimant found it convenient to blame all of her difficulties on her 1978 back injury. Dr. Moss stated that claimant did not experience any worsening of her basic condition, but that she was merely exhibiting continuing symptoms. He could not substantiate that claimant's PBX employment was a major factor in relation to her symptomology.

On March 31, 1982 SAIF denied that claimant's psychological condition worsened as a result of her employment as a PBX operator. While the question of what is being claimed and what is being denied gets confusing, we understand this March 1982 denial to be basically redundant of the July 1981 denial.

Claimant was again examined by Dr. Mighell. Dr. Mighell reported on April 12, 1982 that the incident at Swiftmart indicated that claimant was experiencing some psychotic symptoms, but overall he felt that there had been little change since the time of his last examination. Dr. Mighell felt there was no evidence of any disability as a result of claimant's employment at Swiftmart.

On April 13, 1982 SAIF denied that claimant sustained a compensable occupational disease as a result of her employment as a PBX operator.

Claimant was also examined by Dr. Parvaresh, a psychiatrist, who reported that claimant was suffering from a mixed psychoneurotic disorder. He felt that claimant was experiencing an increasing degree of neurotic disorder, but he felt that this was unrelated to her employments and was the result of aging, her personality makeup and her prior life adjustment.

In addition to all of the above evidence, there is a deposition in the record from Dr. Moss, and testimony from Drs. Hughes and Parvaresh.

The Referee concluded that claimant had not estabished a compensable occupational disease claim in relation to her employment as a PBX operator. The Referee also concluded that claimant did experience a worsening of her psychiatric condition after January 30, 1981, and that the worsening was the result of her 1978 industrial injury. The Referee thus set aside SAIF's July 7, 1981 and March 31, 1982 denials and ordered the claim reopened as of February 23, 1981.

We agree with the Referee that claimant failed to establish a compensable occupational disease as a result of her employment as a PBX operator. We disagree with the Referee's conclusion that claimant's current psychiatric difficulties represent a worsening of her 1978 injury.

It seems self evident, at least as self evident as anything is in Oregon's workers' compensation system, that in order to experience a compensable aggravation of a previous industrial injury there must be some condition or residuals from that prior injury in existence before an aggravation can occur. The evidence is convincing in this case that claimant has no such injury-related residuals which could possibly have aggravated.

As recited above, an April 1980 Referee's order concluded, based on Dr. Colbach's report of May 31, 1979, that claimant's 1978 industrial injury, "did precipitate [claimant's] current nonfunctional condition." (Emphasis added.) The claim was ordered accepted and claimant received psychiatric treatment from Drs. Mighell and Hughes. By the time claimant was examined by the Psychology Associates in May 1980, it appeared that claimant's injury related psychological residuals were waning. The Associates concluded that claimant's main problem was her long-standing inability to adapt to ordinary life and the aging process.

By December 19, 1980 Dr. Hughes reported that claimant's psychological condition was not disabling and that she was capable of engaging in work activity. After an examination of claimant and a complete review of her medical records, Psychology Consultants panel concluded that claimant was medically stationary from a psychological standpoint. The panel found no evidence that claimant was suffering any further psychological residuals or disability as a result of her 1978 injury. The Consultants felt that claimant was in need of some continued psychotherapy, but that this was on the basis of her preexisting and underlying condition. The Consultants reported:

> "Most of this patient's symptoms and current difficulties appear to be attributable to a personality disorder associated with a depression of long-standing nature. The antecedents of this problem are well noted in the records, and appear to be related with her difficulties in coping with the aging process, the 'narcissistic' responses that she has to the aging process, and to the failure of her previous methods of adapting to relationships, as well as the loss of an important relationship when she was involved in the love affair with her boyfriend."

The Consultants concluded that claimant did have psychological impairment in the range of 20-40% on the basis of depression and 10-20% on the basis of her hysterical personality disorder. None of this was felt to be related to claimant's industrial injury.

In accordance with the findings of the Psychology Consultants, the January 14, 1981 Determination Order made no award of permanent psychological disability. The question of permanent psychological disability was fully litigated at the January 30, 1981 hearing. Referee Pferdner concluded, based on the findings of the Psychology Consultants, that claimant had no permanent psychological impairment as a result of her compensable injury. In other words, it was determined in prior litigation that claimant's industrial injury resulted in a temporary exacerbation of her underlying psychological condition, and that claimant's psychological condition had returned to its pre-injury status by the time she was declared medically stationary by the Psychology Consultants in November 1980. Those findings are now res judicata.

That being the case, how is it possible for claimant to

establish a compensable aggravation claim based on her psychological condition? Once it is determined that a claimant has sustained only a temporary aggravation of a preexisting condition, that the underlying condition has returned to its pre-injury level, and that there was no resulting permanent impairment, it would seem that there is nothing left to aggravate. Although we do not catagorically state that it is impossible for an aggravation to occur in such circumstances, the chances of convincingly establishing a compensable aggravation in such circumstances are not favorable. In any event, the evidence in this case is convincing that the psychological difficulties claimant experienced subsequent to the January 30, 1981 hearing are not related to her 1978 injury, but rather, are continued manifestations of claimant's preexisting underlying condition.

In reaching her decision, the Referee appears to have relied heavily on the fact that claimant's employment as a PBX operator was inappropriate. However, it is clear that claimant's PBX operator job was not inappropriate due to her 1978 industrial injury, but, rather, due to the fact that claimant's underlying psychological condition prevented her from coping with such a position. The symptoms claimant experienced following termination of her job as a PBX operator and her job with Swiftmart were not symptoms from residuals of claimant's 1978 industrial injury, but were, as noted above, manifestations of claimant's underlying psychological condition surfacing again. This is confirmed by Dr. Moss in his March 24, 1982 report and in his very persuasive deposition. Dr. Moss testified:

> "Q. So, it is your opinion then that the reactive depression or the depression neurosis that she had as a result of her injury, that that totally went away, or was it still there?
>
> "A. I would say that that went away, yes.
>
> * * *
>
> "That particular reaction depression. I didn't say that the depression that was coming on gradually in her life due to her diminution of her capacity generally, I didn't say that went away, because I think that's still there, but that's not job related injury, that['s] just due to life."

The reports of Drs. Mighell and Parvaresh are consistent with the analysis of Dr. Moss. As related by Dr. Parvaresh:

> "In summary, [claimant] in the past few years has suffered increasing degree of her basic neurotic disorder in the form of increased tension, periods of anxiety and depression including overfocusing on somatic problems. In all medical probability these are unrelated to the kinds of employment she has held in recent years and that from the psychiatric standpoint they are due to aging because of the very nature of her make-up and her prior life adjustment."

This appears to be the overwhelming majority opinion of all of the psychiatrists and psychologists who have examined and treated claimant. The only seemingly contrary opinion is from Dr. Hughes.

We do not find Dr. Hughes' opinion persuasive. It is apparent from his reports that Dr. Hughes found that claimant suffered permanent psychological impairment as a result of the 1978 injury. However, as previously noted, it was determined in prior litigation that claimant did not suffer any permanent psychological impairment as a result of that injury and that determination is now res judicata. But even if the question of permanent psychological impairment were properly now before us, we find the opinions of the Psychology Consultants, Dr. Moss, Dr. Mighell and Dr. Parvaresh to establish that there is none due to claimant's 1978 back injury.

For all of the above reasons, we conclude that claimant has not established that she is suffering an aggravation of her 1978 injury. Rather, we conclude that claimant is simply experiencing continued symptoms of her underlying personality disorder. Partridge v. SAIF, 57 Or App 163 (1982). We, therefore, affirm SAIF's denial of July 7, 1981, as well as its denial of March 31, 1981.

With regard to any question concerning the contention that claimant suffered a "new" occupational disease as a result of her employment as a PBX operator, we also affirm SAIF's April 13, 1982 denial. There is no evidence that claimant's employment exposure as a PBX operator was the major cause of her psychological condition or its exacerbation. There is additionally no evidence that this employment caused a worsening of the underlying condition. Weller v. Union Carbide, 288 Or 27 (1979).

ORDER

The Referee's orders dated April 5, 1983 and April 19, 1983 are affirmed in part and reversed in part. Those portions of the Referee's orders which set aside the SAIF Corporation's denials of July 7, 1981 and March 31, 1982 are reversed and the denials are reinstated and affirmed. That portion of the Referee's orders which affirmed SAIF's denial of April 13, 1982 is affirmed.

GERTRUDE E. SPADY, Claimant
Robert E. Nelson, Claimant's Attorney
Bullard, et al., Defense Attorneys

WCB 81-09024
April 19, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of those portions of Referee Leahy's order which awarded compensation for 5% unscheduled psychiatric disability and additional temporary total disability from July 30, 1981 to October 30, 1981. Claimant argues she should receive additional awards of both temporary and permanent disability. Claimant also requests clarification of the Referee's order relating to the employer's duty to pay for medical services. The employer cross-requests review of those portions of the Referee's order which set aside its partial denial of claimant's psychological condition and argues that claimant is not entitled to any award for permanent disability.

We make the following findings.

Before claimant began working for this employer in October 1978, she had a history of: (1) Various respiratory problems, primarily associated with having smoked cigarettes for 30-plus years; and (2) psychological symptoms variously described as post-hysterectomy problems, symptoms associated with menopause, anxiety, nervousness, depression, etc. Before claimant began working for this employer, her respiratory and psychological problems were sufficiently serious that claimant was taking prescription medications for both conditions.

Between October 1978 and June 1981 claimant worked in a grocery store meat department and was exposed to the fumes associated with the meat packaging process. In 1981 claimant was diagnosed as suffering from an additional respiratory disease, meat wrapper's asthma, and filed this claim for that disease.

We have often commented in other cases about ambiguities in what is being claimed and what is being denied. In this case, the employer's claims processing company is to be commended for its efforts to avoid that kind of ambiguity. On August 19, 1981 the processing company issued a document that contained both notice of partial claim acceptance and notice of partial claim denial:

> "[O]ur office has accepted the claim for meat wrappers asthma and will continue to process this claim in accordance with the Oregon Workers Compensation statute.
>
> "[I]t appears that you are treating and have treated in the past for conditions other than meat wrappers asthma.
>
> "Therefore . . . we must respectfully deny all temporary total disability, medical benefits and permanent partial disability for all conditions other than the meat wrappers asthma, inasmuch as these [other] conditions did not arise out of or in the course and scope of your employment . . ."

This document properly included notice of hearing rights in regard to the conditions being partially denied and claimant promptly requested a hearing.

In the meantime, the accepted claim for meat wrappers asthma was processed to Determination Order dated August 28, 1981, which awarded claimant compensation for temporary total disability through July 30, 1981 and no compensation for permanent disability. This case then proceeded to hearing on both the partial denial and the Determination Order.

Claimant did not contend at hearing that her pre-1978 respiratory problems are compensable; so to that extent the partial denial was uncontested. Claimant did contend at hearing that her pre-1978 psychiatric problems were compensable to some extent because her accepted occupational disease produced some exacerbation of those problems. The Referee basically agreed with claimant on this point, although there may be some possible

confusion in the Referee's actual order. The Referee set aside the partial denial in toto, but in context the apparent intent was only to set aside the partial denial insofar as it related to claimant's psychiatric condition. The Referee awarded claimant additional compensation for temporary disability to October 30, 1981, presumably finding that claimant's psychiatric condition rendered her unable to work until that date. The Referee awarded claimant 16° for 5% unscheduled permanent disability, specifically stating that it was for permanent psychiatric disability, not permanent respiratory disability. Yet the Referee implied that the bills for claimant's psychiatric care should only be paid for treatment before October 30, 1981 -- which seems inconsistent with saying that claimant has permanent psychiatric disability which is compensable. While it might primarily be a matter of misunderstanding, we disagree with the Referee on several points.

I

Regarding the compensability of claimant's psychiatric condition, certain matters are relatively clear. First, claimant had fairly long-standing psychiatric/personality problems before she began the employment here in issue. Second, claimant had basically functioned well in a series of jobs despite those preexisting problems. Third, after claimant left her employment in the summer of 1981 because of her meat wrapper's asthma, over the balance of 1981 and into 1982 claimant received more intensive psychiatric treatment than she had ever received previously. The rather hotly disputed problem is to what extent, if any, claimant's occupational disease (meat wrapper's asthma) caused her subsequent psychiatric problems.

The medical opinions are generally conclusory and thus generally unenlightening. Dr. Stolzberg opined that claimant's "current anxiety and depressive reaction are related to her industrial illness" without any explanation of the possible dynamics of that relationship. Dr. Achar also opined that there was a relationship between claimant's meat wrapper's asthma and acute psychiatric disability; but rather than offering no explanation, Dr. Achar has offered several different explanations of the possible dynamics of that relationship. Apparently, it is Dr. Achar's principal thesis that claimant's occupational disease caused shortness of breath which, in turn, caused claimant's acute anxiety.

The employer presents an almost compelling argument to the contrary: (1) Claimant had preexisting breathing problems which were related to tobacco use and are not compensable; (2) all doctors whose reports appear in this record (with the exception of Dr. Achar, who indicated the question was beyond his expertise) agree that any additional respiratory symptoms caused by meat wrapper's asthma would fully resolve within a period of weeks or perhaps a couple of months after claimant was removed from the employment environment containing the offensive fumes; (3) claimant quit working in her job that exposed her to the offensive fumes in June 1981; and (4) therefore, certainly by late 1981 and into 1982 claimant's psychiatric distress due to breathing difficulty had to relate solely to her preexisting, tobacco-related problems and could not possibly be related to her

occupational asthma. We say this analysis is "almost" compelling because there are some flaws in it: (1) Although there is medical consensus that claimant's asthma would be asymptomatic at some point after removal from and avoidance of the offensive environment, there is no clear medical consensus on when that point would be; and (2) the employer's analysis related only to the theory that claimant's psychiatric distress was caused by breathing difficulties -- it does not address the several other possibilities that Dr. Achar mentioned when his deposition was taken.

Resolving considerable doubt in claimant's favor, we conclude that claimant has established that her psychiatric condition is compensable, albeit only in a very limited sense. Claimant's industrial exposure and resulting occupational disease caused an acute symptomatic flare of claimant's preexisting chronic psychiatric condition. That condition has since returned to its premorbid level. Claimant is entitled to medical services and time loss only for the treatment necessary and the time necessary to return her to her premorbid level. In this limited sense, we agree with the Referee that the employer's denial was too broad and has to be set aside in part.

II

The question of claimant's entitlement to additional time loss is really the question of when claimant's psychiatric condition returned to its premorbid status.

The Referee awarded claimant additional compensation for temporary total disability through October 30, 1981 based on Dr. Achar's reports which seem to state that claimant was released for work on that date. However, Dr. Achar testified at deposition that claimant was only released to look for work on that date, primarily so she could qualify for unemployment compensation, but was not actually released to accept employment on that date. The distinction between a medical release to apply for employment and a medical release to accept employment escapes us, at least as explained by Dr. Achar at deposition.

In January 1982 Dr. Stolzberg opined "that short-time supportive [psychiatric] treatment is appropriate in this case and ought to be continued until [claimant] finds herself stabilized once more." This would appear to be an opinion that, as of January 1982, claimant's psychiatric condition had not yet returned to its premorbid level. In context, however, it appears to us that Dr. Stolzberg was unaware of the nature and extent of claimant's pre-1981 psychiatric problems, and thus could not have been addressing the specific question of the duration of an acute flare of a chronic condition.

Dr. Achar testified at his May 1982 deposition that claimant's psychiatric condition had not yet stabilized and he did not expect it to stabilize until about "four to six months . . . after she has secured a job [and] starts feeling comfortable" in that new job. Even claimant does not rely on this opinion and, like much of Dr. Achar's deposition, we find it unpersuasive. Instead, claimant argues that her psychiatric condition stabilized on March 9, 1982, and that the parties so stipulated at hearing. We have searched the record before us and can find no such

stipulation. There is reference to such a stipulation in the written closing arguments claimant filed with the Referee, but we find no actual stipulation.

We conclude that we cannot improve on the Referee's implicit finding that claimant's psychiatric condition stabilized at its premorbid level not later than October 30, 1981. While no medical opinion specifically so states, there is no persuasive medical opinion to the contrary. Moreover, the circumstantial evidence is consistent with this conclusion: (1) Claimant was not exposed to the fumes that make meat wrapper's asthma symptomatic after June 1981; (2) in the absence of such exposure, claimant's asthma would be asymptomatic within a few months at the latest; and, therefore (3) it is certainly reasonable to expect that claimant's psychiatric distress secondary to her asthma would have resolved by the end of October 1981.

III

We turn to the question of the extent of claimant's permanent disability. Based on our conclusions stated above, we disagree with the Referee's award based on permanent psychiatric disability. Claimant's accepted occupational disease claim for meat wrapper's asthma caused only a temporary exacerbation of her preexisting psychiatric condition. Although the date may be debatable, at some point that exacerbation fully resolved in the sense that claimant's psychiatric condition returned to the same status as it had been before any occupational exposure. On these facts there is no basis for a finding of permanent psychiatric disability.

The employer argues that claimant is not entitled to any permanent disability award for her meat wrapper's asthma because that condition is completely asymptomatic in all environments other than those that contain certain fumes associated only with meat packaging. We disagree with the employer's position that this form of sensitization is not a form of cognizable impairment for workers' compensation purposes. See, e.g., Mark O'Hara, 35 Van Natta 587 (1983). While O'Hara involved permanent sensitization in a scheduled area and this case involves permanent sensitization in an unscheduled area, the principal is the same.

The real problem in this type of case is how to assess loss of wage earning capacity "in the broad field of general occupations." ORS 656.214(5). Claimant's meat wrapper's asthma only precludes working in the meat departments of those grocery stores that use certain packaging materials; it has no impact on any other occupation in the "broad field" of occupations. While work in meat wrapping has been claimant's primary career choice for many years, including prior work of this type before going to work for this employer in 1978, the facts remain that claimant has wide experience in a variety of jobs and is now only precluded from one limited area. Considering all relevant factors, we conclude that claimant would be most properly compensated by an award of 32° for 10% unscheduled respiratory disability.

IV

Finally, for sake of clarity, we comment on claimant's entitlement to medical services. The Referee ordered the employer to pay "pertinent medical bills up to October 20, 1981." In

context, we understand this to be a reference to bills for psychiatric treatment, i.e., the Referee found that claimant's psychiatric treatment to October 30, 1981 was compensable, but that claimant's psychiatric treatment beyond that date was not compensable. So understood, we agree with the Referee. As stated above, claimant's psychiatric condition is only compensable to the extent that there was a temporary flare of a preexisting condition, and that temporary flare resolved not later than Ocotber 30, 1981. It follows that psychiatric treatment beyond that date was for a preexisting, noncompensable condition. Claimant remains entitled to future treatment for her respiratory condition which is reasonable and causally related to this claim, and we do not understand the Referee to have said otherwise.

Also for sake of clarity, although it has not been raised as an issue on review, we note that the Referee's order can be read as allowing claimant's attorney 25% of the additional compensation the Referee awarded without limiting the amount that comes from additional compensation for temporary total disability. Under OAR 438-47-030, an attorney's fee allowed out of additional temporary disability awarded at hearing may not exceed $750.

ORDER

The Referee's order dated June 29, 1982 is affirmed in part, modified in part and clarified in part as follows:

That portion of the Referee's order which set aside the employer's partial denial dated August 19, 1981 is affirmed with the qualification and clarification that the partial denial is only set aside insofar as it denied any compensation for psychiatric disability; and the claim for psychiatric disability is only compensable for treatment and time loss through October 30, 1981.

That portion of the Referee's order which awarded claimant 16° for 5% unscheduled psychiatric disability is modified and, in lieu thereof, claimant is awarded 32° for 10% unscheduled respiratory disability.

The remainder of the Referee's order is affirmed.

Claimant's attorney is awarded a reasonable attorney fee of $300 for partially prevailing on the compensability issue on Board review, to be paid by the employer. Claimant's attorney is also allowed a reasonable attorney fee of 25% of the increased compensation granted by this order.

RICHARD O. HAMPTON, Claimant
THOMAS C. RYDER dba R & R Sheetmetal, Employer
Robert Ehmann, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Assistant A.G.

WCB 82-05869 & 82-05870
April 24, 1984
Order on Reconsideration

The Board entered its Order on Review herein on March 8, 1984 affirming the Referee's order which set aside the SAIF Corporation's denial of claimant's claim against The Cinema. We concluded that claimant was deemed to be a subject worker of The Cinema by operation of ORS 656.029(1). 36 Van Natta 230 (1984).

On March 12, 1984 the Board received SAIF's request for reconsideration of that portion of our order which awarded claimant's attorney a $500 fee for services on review. On April 4, 1984 we abated our Order on Review in order to allow sufficient opportunity for consideration of SAIF's request and claimant's response thereto. On April 9, 1984 the Board received a petition for judicial review filed by the Attorney General on behalf of the SAIF Corporation, attached to which is a certificate of service indicating that the petition was mailed on April 5, 1984, i.e., after we had entered our Order of Abatement.

We deny SAIF's request that we modify our prior order by deleting the award of an attorney's fee. Our reasoning for awarding an attorney fee on review was set forth in our prior order, and we decline to be redundant.

In his response to SAIF's request for reconsideration, claimant questions our authority and jurisdiction to reconsider an Order on Review. We find that we have the authority and jurisdiction to do so. See Lewis Twist, 34 Van Natta 290, 293 (1982), aff'd Tektronix Corp. v. Twist, 62 Or App 602 (1983).

ORDER

On reconsideration of the Order on Review dated March 8, 1984, the Board adheres to its prior order, which hereby is readopted and republished.

CHARLES D. CAMPBELL, Claimant
A.J. Morris, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03564
April 25, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Daron's order which upheld the SAIF Corporation's denial of claimant's aggravation claim. Claimant argues that his aggravation claim should be found compensable.

The Board affirms and adopts the order of the Referee with the following additional comment. Claimant relies on Dr. Watts' opinion that claimant's worsened condition was related to claimant's April 1981 industrial injury. The Referee found Dr. Watts' opinion unpersuasive, in part because Dr. Watts did not review x-rays taken during about a year or year and a half following claimant's injury. Claimant states in his reply brief that Dr. Watts "did view the . . . x-rays from August 1982." Claimant does not cite us to any document in the record that supports this contention and we find none. In fact, Dr. Watts specifically testified that he did not review 1982 x-rays, and that the only x-rays he reviewed were the 1979 x-rays and the ones he took in 1983.

ORDER

The Referee's order dated September 14, 1983 is affirmed.

DENNIS D. GRACE, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01053
April 25, 1984
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Mulder's order which directed it to reopen claimant's claim as of February 2, 1983 and to pay for claimant's continued psychiatric treatment. SAIF contends that it is not responsible for claimant's continuing psychiatric difficulties.

Claimant, who was 37 years of age at the time of the hearing, sustained a compensable lumbosacral strain on June 19, 1980 while helping move a ticket booth for Clackamas County School District. Eventually, a bilateral L5-S1 diskectomy was performed on April 22, 1982 by Dr. Rusch.

Claimant was referred to the Callahan Center in August 1982. Dr. Toon reported on August 25, 1982 that claimant had related that he was suffering from depression due to "family problems." Dr. Toon felt claimant capable of returning to minimum duty work. Dr. Norman, a psychologist, reported on August 26, 1982 that claimant had a "history of longstanding psychological complaints," and that claimant had received psychological and psychiatric treatment prior to his 1980 back injury. Psychological testing revealed that claimant had a severe level of emotional disturbance, a moderate to severe level of personality disturbance with severe depression accompanied by schizoidal withdrawal. Claimant presented himself as being "quite phobic" regarding social interaction.

On October 7, 1982 Dr. Rusch reported that claimant was medically stationary and restricted from returning to work requiring repetitive heavy bending and lifting or prolonged sitting. Dr. Rusch also indicated that "a portion" of claimant's depression was a result of his industrial injury.

On November 1 and November 15, 1982 Dr. Colistro performed a comprehensive psychological evaluation of claimant. Dr. Colistro reported that claimant and his wife had separated and that claimant was living alone in a mobile home. Claimant's only social contacts were with his treating physicians and Ms. Green, claimant's vocational consultant. Dr. Colistro also reported that claimant had begun consuming two to four quarts of beer every evening.

Dr. Colistro reported that one of claimant's main problems was his ongoing difficulty with interpersonal relations. Claimant related that "I'm having trouble being with people," and that "I'm afraid of getting into any job where I'll have to." As a result of his fear of interacting with other people, claimant's vocational goals were limited to jobs such as a projectionist in a movie theater, a lighthouse keeper or a shepherd.

Dr. Colistro concluded that claimant was suffering from depression which was partially injury induced and partially the result of claimant's chronic preexisting emotional disturbance. Claimant's alcohol abuse was also considered partially due to his injury and partially due to claimant's underlying condition. Claimant's underlying personality structure was considered to have been temporarily aggravated by his injury. Dr. Colistro felt that

the portions of claimant's psychological conditon which were aggravated by his injury were aggravated only temporarily and that it was highly unlikely claimant would have any permanent psychological residuals as a result of his injury. Dr. Colistro instituted a sixty day therapy program because he felt that the injury related facets of claimant's psychological condition would resolve in that period of time.

Claimant thereafter received psychological treatment from Dr. Colistro and received vocational assistance from a private rehabilitation consultant. Because of claimant's insistence on obtaining only a job where he would have little or no contact with people, claimant's vocational counselor, despite heroic efforts, was unable to place claimant.

On December 30, 1982 Dr. Colistro reported that claimant could be considered psychologically stationary with no significant psychological problems attributable to the industrial injury. Dr. Colistro felt that claimant's failure to return to work was due "primarily to an unwillingness to accept the job opportunities that have been developed for him by his vocational rehabilitation counselor rather than reflecting an inability to do so." A Determination Order issued on January 27, 1983 awarding claimant 15% unscheduled permanent partial disability for injury to the low back, and terminating claimant's temporary disability benefits on December 31, 1982 in accordance with Dr. Colistro's report.

On May 14, 1983 Dr. Johnson, a psychiatrist, reported that he had been seeing claimant since February 2, 1983. Dr. Johnson reported that claimant was 80% disabled due to his psychiatric condition. Dr. Johnson opined that claimant's industrial injury was a material factor in claimant's subsequent psychological difficulties and continued to be such a factor. Dr. Johnson felt that claimant was suffering from a mixed personality disorder with dependent, avoidant and narcissistic features.

Based on Dr. Johnson's report, the Referee concluded that claimant's current psychological and emotional problems were disabling and materially related to his injury. The Referee ordered the claim to be reopened as of February 2, 1983, the date claimant began receiving treatment from Dr. Johnson. We disagree.

Unlike the Referee, we are more persuaded by the opinions of Dr. Colistro than the opinions of Dr. Johnson. Dr. Colistro treated claimant on a weekly basis for a period of 2 1/2 months and worked closely with claimant's vocational counselor. Dr. Colistro related that he initially attempted to control what he originally viewed as claimant's preexisting, but injury exacerbated, alcohol abuse problem. Despite Dr. Colistro's efforts, claimant refused to cooperate. Dr. Colistro testified:

> "Well, initially, it seemed plausible that for somebody who was psychologically unstable -- well, from his adolescence, basically, onward, that any accident that materially affected his life would aggravate his psychological problems, and that's essentially what [claimant] told me. And, as I say, it seemed plausible at the time and I accepted that.

> "As our treatment progressed, really didn't progress, I began to wonder how much of what I was seeing was acute, and how much of it was essentially [claimant] as he's been for a very long time. As that perception solidified I came to question the validity of treating him further . . . ."

Dr. Colistro also testified that during the period of time he was treating claimant, claimant was experiencing family related difficulties which Dr. Colistro felt were, "pretty much dominating his whole life." With regard to the difficulty claimant's vocational counselor encountered, Dr. Colistro related:

> "In keeping in contact with [claimant's] vocational counselor, I developed the opinion that pretty much every idea she came up with was unacceptable to him, and the ideas didn't seem to me, as an outside observer, to be that inappropriate."

It was Dr. Colistro's conclusion that claimant was simply exhibiting personality and character defects that preexisted the injury and were chronic in nature, and that claimant's industrial injury played little, if any, role in claimant's psychological difficulties after about the end of 1982.

Unlike the Referee, we do not find Dr. Johnson's report persuasive. Dr. Johnson made no attempt to delineate the relative amount of contribution claimant's industrial injury made to his psychological condition. It was Dr. Johnson's opinion that claimant had low levels of self-acceptance and self-esteem, and that his low self-esteem was threatened by the disability he suffered as a result of his industrial injury. However, we understand this to be basically the same diagnosis that was initially rendered but later rejected, based on further experience, by Dr. Colistro. Moreover, there is very little evidence in the record indicating that claimant's physical impairment, which has been rated as mild, has been a factor of significant concern to claimant. There is no indication that Dr. Johnson was aware of claimant's alcohol problem. Although Dr. Johnson began treating claimant in February 1983, the only progress he was able to relate by May 1983 was that claimant was now combing his hair and tucking in his shirt whereas he was not doing so before. Claimant testified that he was still drinking five nights per week. It was just such a lack of progress that led Dr. Colistro to the conclusion that he was dealing with claimant's chronic underlying conditions rather than with any injury related residuals.

A factual situation very similar to the current case was presented in Partridge v. SAIF, 57 Or App 163 (1982). The claimant in Partridge suffered an industrial injury which her treating psychiatrist felt exacerbated claimant's underlying psychological condition. It was noted that claimant had family problems all her life, that she never trusted people and that she had ongoing difficulties with her family and children. The claimant in Partridge was diagnosed as suffering from an underlying schizophrenic illness. Despite the fact that claimant received no psychiatric treatment prior to her injury, and the fact that she had been self-sufficient prior to her injury, the court found claimant's psychological condition not compensable. 57 Or App at 167-68.

In this case, claimant has many of the same difficulties that the claimant in Partridge had. Certain facts in the current case are even stronger than those of Partridge. For example, unlike the claimant in Partridge, claimant in the current case did receive considerable psychological and/or psychiatric care prior to his industrial injury, and it would appear that he sought out jobs in the janitorial field as these afforded him a minimum level of contact with other people.

Claimant is currently experiencing an ideal situation for an individual with an underlying personality disorder diagnosed as schizoidal withdrawal. He is living alone in a mobile home in an isolated location. Since he is collecting time loss benefits, there is no need for him to work, and concomitantly, no need for him to have any social contacts. Under these circumstances, it is not particularly surprising that neither Dr. Colistro nor Dr. Johnson nor claimant's vocational counselor were having any success at changing claimant's situation. Considering the record as a whole, we conclude that claimant is no longer suffering any psychological residuals related to his 1980 industrial injury, and that the Referee incorrectly ordered the claim reopened as of February 2, 1983 for the provision of additional psychiatric treatment and time loss benefits.

Since the Referee concluded that claimant was not medically stationary at the time of the hearing, he did not make a determination concerning the extent of claimant's disability, which was an issue at the hearing. See Gary A. Freier, 34 Van Natta 543 (1982). Since we have concluded that claimant was medically stationary as of December 31, 1982, it is appropriate to remand this case to the Referee for a determination of the extent of claimant's disability.

ORDER

The Referee's order dated July 21, 1983 is reversed and this case is remanded to the Referee for further proceedings consistent with this order.

CARLOS IGLESIAS, Claimant
Marvin S. Nepom, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-06774
April 25, 1984
Order on Reconsideration

The Board issued its Order on Review herein on January 13, 1984. We reduced the award of temporary total disability granted by the Referee and increased the award of permanent partial disability granted by the Referee. 36 Van Natta 5 (1984). The insurer requested clarification of our order requesting that we specifically authorize it to offset the overpaid temporary total disability against the increase in permanent disability awarded. We abated our Order on Review in order to give claimant an opportunity to respond to the insurer's motion. Claimant has responded.

On reconsideration, we deny the insurer's request because the award the insurer seeks to recoup via an offset was paid pending review. We have previously interpreted ORS 656.313(2) in an analogous context to mean that amounts paid pending review are not subject to recovery by offset or otherwise. Glenn O. Hall, 35 Van Natta 275 (1983); see also Hutchinson v. Louisiana-Pacific Corp., 67 Or App 577 (1984).

ORDER

On reconsideration of the Order on Review dated January 13, 1984, the Board adheres to its prior order, which hereby is readopted and republished.

TIMOTHY J. NELSON, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04002
April 25, 1984
Order on Reconsideration

The Board entered its Order on Review herein on March 30, 1984. 36 Van Natta 391 (1984). Claimant requests reconsideration of our prior order, correctly noting that that order addressed only claimant's entitlement to claim reopening for a worsened condition pursuant to ORS 656.273, without discussing claimant's entitlement to continuing medical services for conditions related to his original industrial injury, pursuant to ORS 656.245.

The denial at issue before the Referee was a denial of all compensation which formed the basis of this claim, including continuing medical services. The Referee set aside SAIF's denial in its entirety. The SAIF Corporation requested review raising a procedural issue and, in addition, the propriety of that portion of the Referee's order which found that claimant had established a compensable worsening of his injury-related condition since the last award or arrangement of compensation. No issue was presented on review concerning the propriety of that portion of the Referee's order which determined that claimant was entitled to continuing medical care pursuant to ORS 656.245.

In our Order on Review, we reversed the Referee's order and reinstated and affirmed SAIF's denial. In view of the fact that claimant's entitlement to continuing medical services was not an issue before us, we stated our holding too broadly. Accordingly, we modify our Order on Review to reflect that claimant is entitled to continuing medical services and chiropractic care under the provisions of the Referee's order.

ORDER

On reconsideration of the Order on Review dated March 30, 1984, we modify our prior order. The Referee's order dated June 20, 1983 is reversed only insofar as it set aside that portion of the SAIF's Corporation's April 25, 1983 denial which denied that claimant suffered a compensable worsening of his condition pursuant to ORS 656.273. That portion of SAIF's denial is reinstated and affirmed. The remainder of the Referee's order is affirmed. Except as modified herein, we adhere to our prior order which hereby is readopted and republished.

RAMON ROBLEDO, Claimant
MacAfee & Friedman, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01632
April 25, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Daron's order which found claimant entitled to benefits for temporary total disability from February 18, 1983 until closure pursuant to ORS 656.268. SAIF contends that claimant was, and still is, capable of

performing his regular work and, therefore, that he is not entitled to temporary disability benefits for that period of time. Claimant contends that he is entitled to temporary disability benefits from November 23, 1982 rather than from February 18, 1983, and that he is entitled to penalties and attorney fees.

Claimant, who was employed on a seasonal basis as a sorter at a food processing plant, sustained a compensable injury on August 26, 1982 when he fell down some stairs. Dr. Pliska diagnosed a right elbow contusion and a medial collateral ligament strain of the left knee. Claimant returned to his regular work on September 6, 1982.

Dr. Lawton, claimant's treating physician, reported on November 17, 1982 that claimant was experiencing symptoms in his right elbow and left knee, but that he was nevertheless able to continue working. Claimant continued working until November 23, 1982 when the regular season layoff occurred. It was claimant's usual practice to do a variety of short term farm labor and/or tree planting type work during the winter layoff. Claimant continued to be released for his regular cannery work throughout December 1982 and January and early February 1983.

Claimant was examined by Dr. Nickila, a chiropractor, on February 18, 1983. Dr. Nickila diagnosed a variety of conditions including cervical-thoracic sprain and subluxation, vertigo, lumbar and lumbo-sacral subluxation and referred pain to the right elbow and fingers. Dr. Nickila felt that claimant would be unable to perform "typical farm labor" for approximately two months. Dr. Nickila also felt that claimant could not perform cannery work because it involved too much lifting. Dr. Nickila felt that bedrest was appropriate due to claimant's "general malaise." Dr. Nickila was unaware that claimant was receiving prescription medication from Dr. Lawton.

Despite the fact that claimant was receiving chiropractic treatment from Dr. Nickila, claimant continued to consult Dr. Lawton. Until April 15, 1983, Dr. Lawton continued to be of the opinion that claimant could perform cannery work. When Dr. Lawton was deposed on May 10, 1983, he testified that claimant's sorting work at the cannery was light in nature, that claimant continued to be released to perform that type of work and that claimant was physically able to do that work for the entire period in question.

Based on Dr. Nickila's report, the Referee concluded that claimant was entitled to benefits for temporary total disability beginning February 18, 1983. We disagree.

We find that claimant was able to engage in his regular work as of February 18, 1983. Unlike the Referee, we are more persuaded by Dr. Lawton's opinion than by Dr. Nickila's opinion. Dr. Lawton has been claimant's primary treating physician throughout the course of this claim. When Dr. Lawton was deposed in May 1983, he was still treating claimant and he testified that he still considered himself claimant's treating physician. As we noted in Lavona Hatmaker, 34 Van Natta 950 (1982), "A treating physician is in the best position to express an opinion when he or she treats the claimant constantly from injury throughout the recovery period." It is for exactly this reason that we find Dr. Lawton's opinion regarding claimant's continued ability to work more

authoritative and, therefore, more persuasive than the opinion of Dr. Nickila.

In addition, it would appear that Dr. Nickila's opinion is flawed in several respects. For example, it is clear that Dr. Nickila was under the mistaken impression that claimant's regular food-processing work was substantially more strenuous that it was in reality. Dr. Nickila was also unaware that claimant was receiving prescription medication for his symptoms from Dr. Lawton. Moreover, Dr. Nickila's testimony was to the effect that his directions for bedrest for claimant were not based on claimant's injury related elbow and knee conditions, but for a problem described as "general malaise." No claim has ever been made for any such condition.

The fact that claimant may not be able to engage in farm labor or treeplanting work does not entitle him to temporary disability benefits. Claimant was still able to perform regular work as a cannery sorter, the job he was performing at the time he sustained his injury. In Bold v. SAIF, 60 Or App 392, 395-96 (1982), the court held that there is no entitlement to temporary disability benefits where claimant is able to perform work at one job, but is unable to perform work at another job during the off-season. In this case, claimant remained capable of performing the work he was doing when injured during the entire period in question and, under Bold, he is not entitled to temporary disability benefits for the period encompassing his seasonal layoff at the cannery.

The above analysis is equally applicable to claimant's contention that he is entitled to temporary disability benefits beginning November 23, 1982, the day when his seasonal layoff began.

With regard to the issue raised by claimant concerning penalties and attorney fees, we affirm and adopt those portions of the Referee's order relevant to this issue.

ORDER

The Referee's order dated September 20, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which found claimant entitled to temporary total disability benefits from February 18, 1983 until closure and awarding claimant's attorney a $1,000 attorney's fee are reversed. The remainder of the Referee's order is affirmed.

JERRY W. SWEARINGEN, Claimant
SAIF Corp Legal, Defense Attorney

WCB 83-04446
April 25, 1984
Order Denying Request to Dismiss

The Board has received respondent's request to dismiss the claimant's request for Board review on the grounds claimant has not filed an appellant's brief.

There is no requirement in the workers' compensation law or the Board rules which indicates that a brief must be filed by appellant or respondent before the Board will review the case. ORS 656.295(5). While briefs are a significant aid in the review process, the failure to file a brief is not grounds for dismissal of a request for review. The request for dismissal hereby is denied.

IT IS SO ORDERED.

NORMAN R. CHRISTENSEN, Claimant
David C. Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-10390 & 81-10389
April 26, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Baker's order which upheld the SAIF Corporation's denial of claimant's aggravation claim. Claimant argues that his aggravation claim is compensable and that, in any event, he is entitled to interim compensation.

The Board affirms and adopts the order of the Referee with the following additional comment. Claimant states in his brief that his request for claim reopening was accompanied by "Dr. Smith's report indicating the need for medical treatment and that claimant could not return to his previous employment." Claimant does not cite us to any such report, and we find no report from Dr. Smith that indicates claimant could not return to his previous employment or in any other way verifies claimant's inability to work which, of course, is the statutory prerequisite to the duty of an employer/insurer to pay interim compensation on an aggravation claim.

ORDER

The Referee's order dated September 16, 1983 is affirmed.

RONALD C. EARL, Claimant
Charles Hodges, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-11420
April 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Shebley's order which granted him no award for permanent disability. The insurer cross-requests review of those portions of the Referee's order which overturned the insurer's denial of claimant's psychological condition and which held that the claim was prematurely closed and, therefore, awarded claimant temporary disability benefits through April 13, 1983.

The Board affirms and adopts the Referee's order in its entirety, with the exception of those portions which concern the proper date for terminating temporary disability benefits.

We agree with the Referee that claimant was not psychologically stationary on the date of the Determination Order. However, at that time claimant was released to work on the basis of his physical condition, which was then medically stationary. Dr. Colbach, the consulting psychiatrist, opined that claimant was not precluded from working at that time by his psychological condition. In fact, he opined that claimant's return to work would be good for his psychological condition. Dr. Swarner, claimant's treating psychiatrist, also opined in May 1983 that return to work would benefit claimant's psychological condition.

We find that following the medically stationary date of November 9, 1982, assigned by the Determination Order, claimant was no longer precluded by his compensable injury or its sequelae from performing his regular work. Accordingly, we reverse that portion of the Referee's order which ordered the insurer to pay claimant temporary disability benefits after November 9, 1982.

ORDER

The Referee's orders dated July 6, 1983 and July 14, 1983 are affirmed in part and modified in part. That portion of the Referee's order which ordered the insurer to pay temporary disability benefits inclusively from July 26, 1981 through April 13, 1983 is modified to order temporary disability benefits only through November 9, 1982. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

RONALD MEACHAM, Claimant
Doblie & Francesconi, Claimant's Attorneys
Rankin, et al., Defense Attorney

WCB 82-01800
April 26, 1984
Order on Reconsideration

The insurer requests reconsideration of our Order on Review dated March 30, 1984. 36 Van Natta 386 (1984). In the alternative, the insurer moves to remand the case to the Referee to consider "newly discovered evidence." On reconsideration we deny the insurer's motion for remand and adhere to our previous order.

In our Order on Review we granted claimant an award for permanent total disability. The basis for the insurer's motions is that claimant is currently enrolled in a vocational rehabilitation program. This evidence can have no bearing on our decision that claimant was entitled to an award of permanent total disability based on the facts and circumstances existing at the relevant time -- i.e., at the time of hearing. A decision on whether a claimant is entitled to an award for permanent total disability must be based on conditions at the time of decision. Gettman v. SAIF, 289 Or 609 (1980). As the court stated:

> "The legislative provision in ORS 656.206(5) for periodic reexamination of each permanent total disability award further indicates that a permanent total disability award is based upon existing occupational abilities. That award can be adjusted if the claimant is no longer permanently incapacitated from regularly performing work at a gainful and suitable occupation." 289 Or at 614-15.

Accordingly, we decline to modify our prior order.

ORDER

On reconsideration of the Order on Review dated March 30, 1984, we adhere to our prior order which hereby is readopted and republished.

MICHAEL SHABOT, Claimant
Doblie & Francesconi, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 83-02931
April 26, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of that portion of Referee Thye's order which upheld the insurer's partial denial of medical services. Claimant also raises an issue concerning attorney fees. The insurer cross-requests review of that portion of the Referee's

order which directed that it pay for some of the denied medical services pursuant to OAR 436-69-801(4).

With regard to the compensability issue, we affirm and adopt the relevant portions of the Referee's order.

In Kemp v. Workers' Compensation Dept., 65 Or App 659 (1983), as modified, 67 Or App 270 (1984), which was decided subsequent to the hearing in this matter, the court invalidated OAR 436-69-801(4). It follows that those portions of the Referee's order which found the insurer liable pursuant to OAR 436-69-801(4) for medical services rendered by Drs. Van Gordon and Nichols must be reversed. This conclusion makes it unnecessary for us to address the issue raised by claimant regarding attorney fees.

ORDER

The Referee's order dated September 29, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which ordered the insurer to pay for dental services rendered by Drs. Van Gordon and Nichols prior to February 1, 1983, and which awarded claimant's attorney a fee of 25% of the amount of those services are reversed. The remainder of the Referee's order is affirmed.

LEE A. AUSTIN, Claimant
Robert Nelson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-03002
April 27, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Williams' order which, in effect, found that the self-insured employer properly ceased paying claimant temporary disability benefits after: (1) The employer learned that claimant, while his claim was in open and accepted status, was receiving income from self-employment; and (2) claimant refused to supply the employer with information about his income.

Claimant, a truck driver, compensably injured his low back on December 15, 1981 and began receiving compensation for temporary total disability. For several years before his injury, claimant had been augmenting his income from truck driving by operating a home business involving lawn mower repair. Claimant was able to continue working in the mower repair business, and did continue working in that business, after his December 1981 industrial injury. Indeed, claimant apparently expanded the mower repair business in early 1982 when he moved his business to a building about one mile from his home. He reopened the business in March 1982 as "Austin's Small Engine Repair and Saw Sharpening." Surveillance of claimant at his new location revealed that he was able to personally perform the work, which involved bench work and some bending and stooping, at least part of the time. Claimant had a full time employe and was open for business six days a week. As of March 1982, claimant continued to receive compensation for temporary total disability, as he had since the prior December.

The employer sent the following letter to claimant on March 19, 1982:

> "We have determined that you are employed at Austin's Small Engine Repair and Saw Sharpening. . .
>
> "Our information reveals that you are and have been employed for some time. You do not qualify for temporary total disability benefits while employed.
>
> "Will you please provide us with a list of earnings, from any source, for the period of December 15, 1981 through the present. We will be entitled to an offset of all income earned."

Although not stated precisely, it has consistently been the employer's position that it needed information about claimant's income to calculate claimant's possible entitlement to compensation for temporary partial disability. Claimant declined to supply the requested information. The employer then ceased paying claimant compensation for any amount of temporary disability.

The employer's request to claimant for information about his income was consistent with its claims processing duties. OAR 436-54-222(3) states that an employer/insurer shall cease paying temporary total disability and begin paying temporary partial disability to a claimant who earns any wages prior to claim closure. OAR 436-54-222(1) states the formula for calculating temporary partial disability which requires that compensation benefits be reduced by the amount of any wages earned. It is possible for temporary partial disability benefits to be eliminated entirely by operation of OAR 436-54-222(2) which provides: "If the post-injury wage earnings are equal to or greater than the earnings at the time of injury, no temporary disability compensation is due." Obviously, for the employer/insurer in this case to be able to do the calculations to compute the amount of benefits, if any, to which claimant was entitled, it needed information from claimant about his self-employment income.

We have often observed that a claimant has some responsibility to furnish to an insurer or self-insured employer the information needed to process his or her claim. David A. Kimberley, 35 Van Natta 1607, 1609 (1983); Daniel J. Cannon, 35 Van Natta 1181, 1187, 35 Van Natta 1623 (1983); Rick E. O'Dell, 35 Van Natta 1169, 1170 (1983); Douglas Dooley, 35 Van Natta 125, 131 (1983); Kathie L. Cross, 34 Van Natta 1066 (1982); Jeri Putnam, 34 Van Natta 744, 745 (1982); Frank R. Gonzales, 34 Van Natta 551, 554 (1982). That observation is even more applicable to the facts of this case than it was in those prior cases because here claimant's inability or unwillingness to supply essential claims information within his sole control has created a problem that defies simple solution.

On the one hand, claimant seemingly argues that, even though it is not disputed that claimant had some post-injury self-employment income, the self-insured employer had no statutory option except to continue to pay him the full amount of temporary total disability that we know he was not entitled to because he was also earning wages. That position does not produce an entirely satisfactory result for rather obvious reasons. On the other hand,

the employer seemingly argues that, once it was determined that claimant had some income in an unknown amount and once it had taken reasonable steps to attempt to learn the actual amount without success, it was entitled to cease paying claimant any compensation for temporary disability pending receipt of additional information from claimant about the amount of his income. That position might not produce entirely satisfactory results because the case law indicates that the circumstances in which an employer/insurer can unilaterally cease paying compensation on a claim in open, accepted status are very limited.

In our opinion, this dilemma is best resolved in this particular case by viewing the problem not as a unilateral cessation of benefits, but rather as a unilateral calculation of benefits. Oregon's workers' compensation scheme contemplates that employers and insurers will process most claims, making all the day-to-day decisions that claims processing requires, generally without governmental involvement. To this extent at least, the increasingly articulated suggestion that there is something per se wrong with "unilateral" action by an employer or insurer disregards the fact that all claims processing activity involves a series of "unilateral" actions. One of the clearest examples is the calculation of benefits for temporary disability. Even before the decision is made of whether to accept or deny a claim, the employer/insurer must calculate the amount of benefits for temporary disability to pay a claimant and begin making those payments on an interim basis pending acceptance or denial. After a claim is accepted, claims processing duties sometimes involve additional calculations to increase or decrease the amount of benefits being paid for temporary disability. OAR 436-54-222(3) is an example of such a duty. It requires that an employer/insurer cease paying temporary total disability and perform the calculations necessary to begin paying temporary partial disability when a claimant earns wages prior to claim closure.

The initial calculation of amount of benefits and subsequent calculations to increase or decrease benefits are always done "unilaterally" -- at least we are unaware of any prior governmental involvement in this calculation process. Of course, if a claimant believes that the amount of his or her benefits has been computed incorrectly, the claimant has the right to request a hearing. But the question at any such hearing would be what is the proper amount of benefits under the law and facts. It is hard to imagine the issue being whether it was per se wrong for the employer/insurer to make a "unilateral" calculation of the amount of benefits it should be paying.

Once it was known that claimant had some post-injury earnings, and once it became clear that claimant would not advise the employer of the amount of his earnings, how was the employer to calculate the proper amount of benefits it was supposed to be paying claimant? All that was known or knowable for sure at that point is that claimant should probably be paid something less than the full temporary total disability rate, and possibly should not be paid any benefits because, as stated above, OAR 436-54-222(2) recognizes the possibility that the temporary partial disability rate can go down to zero if post-injury earnings are as great as earnings at the time of injury.

Under these circumstances, where a claimant is known to be drawing some income from self-employment, is a sole proprietor and

thus sole custodian of the business records, is requested by the employer/insurer to provide those records, but refuses to do so within a reasonable time, we conclude that the employer/insurer should be permitted to infer that the claimant is earning as much or more as he did at the time of injury unless and until such time as the claimant comes forward with data to the contrary. This is somewhat analogous to Rule 311(1)(c) of the Oregon Evidence Code, which states the presumption: "Evidence willfully suppressed would be adverse to the party suppressing it."

Without allowing an employer/insurer to draw such an inference, it would have no way of calculating the proper rate of temporary partial disability. By allowing such an inference to be drawn, it would follow that the proper rate of temporary partial disability is zero pending receipt of additional information from the claimant. And this approach certainly puts some teeth in our often repeated admonition that claimants have some duty to furnish information necessary to process their claims.

The evidence introduced by claimant at hearing suggests that he earned less at his mower repair, etc., business than he earned as a truck driver. However, the Referee found, partially on credibility grounds, that it was impossible to tell what claimant's self-employment income was. We agree with the Referee on this point. It follows that claimant has not established in this proceeding entitlement to additional compensation for temporary disability, penalties or attorney fees.

Claimant contends in his brief on review that medical benefits were also suspended in March 1982; however, we find no evidence in the record that supports that contention.

ORDER

The Referee's order dated March 11, 1982 is affirmed.

FRANK A. CARSON, Claimant
Gatti & Gatti, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-06760
April 27, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Danner's order which held that claimant's temporary disability compensation should be computed on the basis of a four-day work week pursuant to ORS 656.210 and OAR 436-54-212. SAIF contends that the Referee's order should be reversed because, at the time of claimant's compensable injury, he was not regularly employed on a four-day work week basis; rather, he was employed on an on-call basis and had been employed on that basis since September 1981 -- six months prior to his injury. We agree with SAIF and, therefore, reverse the Referee's order.

Claimant was a full time employe at Cascade Handles, Inc. from 1972 through August 1981. Up until the beginning of August 1981, he worked five days each week as a regular employe. In August 1981 the company cut back to a four-day work week. Subsequently, on August 31, 1981, the company was temporarily closed and all the workers were laid off. Later, in September 1981, all of the

employes were called back except claimant. Claimant has subsequently worked on an irregular basis as a substitute for other employes who become temporarily absent for personal reasons.

Between September 15, 1981 and September 30, 1981, claimant worked 10.5 hours. Between October 1, 1981 and October 15, 1981, claimant worked 72 hours. Between December 1, 1981 and December 15, 1981, claimant worked 31 hours. Between February 15, 1982 and February 28, 1982, claimant worked 10.5 hours. On March 3, 1982 claimant was again called to work for an employe who was taking temporary leave because of a death in his family. It appears from the record that the regular employe planned to take a total of four days off from work and that, therefore, had claimant not been injured the second day he was replacing the regular employe, he would have worked four days in that particular instance. As noted above, the plant was on a regular four-day work week at that time.

Claimant's theory supporting his contention that his benefits should be based on a regular, four-day work week is that, since he was filling in for four days on a temporary basis and since the plant's regular work week was a four-day work week, he was working a regular four-day work week at the time of his injury. We find that, although claimant may have been filling in for four days in this particular instance, that fact alone does not make claimant a regular four-day work week employe. He was still employed on an on-call basis as he had been since September 1981.

Claimant acknowledged at hearing that he was merely filling in for the regular employe. At no time did the employer state that claimant would be permanently substituting for the regular employe or that claimant was rehired on a permanent full time or regular four-day per week basis.

For the above reasons, we find that claimant's temporary disability benefits should be calculated on an on-call basis pursuant to OAR 436-54-212(4)(a).

ORDER

The Referee's order dated October 20, 1983 is reversed.

SALLY K. CUTTS, Claimant
Susan M. Garrett, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10686
April 27, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Johnson's order which: (1) Set aside its denial of claimant's occupational disease claim for vasomotor rhinitis; (2) found that SAIF should have paid interim compensation starting June 1, 1982 and, thus, awarded claimant additional temporary total disability benefits from June 1, 1982 to September 9, 1982; and (3) awarded claimant a 25% penalty and $350 attorney fee because of SAIF's failure to pay the interim compensation that the Referee found should have been paid.

We affirm and adopt that portion of the Referee's order which found the claim compensable and set aside the denial. Because claimant's claim is compensable, she is now entitled to temporary total disability benefits from the date of disability, June 1,

1982. It does not follow, however, that a claimant is entitled to interim compensation from date of disability pending acceptance of a claim, either by action of the employer/insurer or by litigation order. Indeed, the law is to the contrary.

We find the facts relevant to this interim compensation issue to be as follows:

June 1, 1982: Claimant ceased working due to, we now know in retrospect, her vasomotor rhinitis condition. However, that diagnosis had not even been made at that time. Instead, in a "to whom it may concern" letter, Dr. Korn only supplied authorization for claimant to take a medical leave of absence from her work. Dr. Korn said nothing about claimant's medical problem, then identified as "substantial generalized allergy," being causally related to her work.

June 1982: Claimant testified that, about the time she ceased working, she may have mentioned to her employer that there was a possible link between her respiratory problems and chemical fumes to which she was exposed at work. The employer was unable to remember any such conversation. The evidence is too inconclusive to find that there was any effective notice to the employer at this time of a possible workers' compensation claim.

Summer 1982: Various doctors performed various diagnostic tests in an effort to identify claimant's problem. The results were varied.

August 26, 1982: Dr. Korn's report of this date is the first indication that claimant's problem was (or even may have been) caused by her work. There is some evidence that claimant may have immediately delivered a copy of this report to her employer but, again, the evidence is too inconclusive to so find.

September 8, 1982: SAIF received a copy of Dr. Korn's August 26, 1982 report and started paying interim compensation on September 9, 1982.

October 18, 1982: SAIF issued its denial and ceased paying interim compensation, having made timely payments since September 9, 1982.

These findings of fact lead to the conclusion that SAIF properly complied with all of its statutory duties in regard to the payment of interim compensation. Interim compensation is due only from the date of effective notice of a possibly compensable claim to the date of denial. Donald Wischnofske, 34 Van Natta 664 (1982); Stone v. SAIF, 57 Or App 808 (1982). The first notice anybody had in this case of a possible claim for compensation was on September 8 when SAIF received Dr. Korn's August 26 report. SAIF then began paying interim compensation.

The Referee's order suggests and claimant argues that Gilroy v. General Distributors, 35 Or App 361 (1978), stands for the proposition that SAIF's first payment of interim compensation in this case should have been for the entire period of claimant's disability since June 1, 1982. Claimant also argues that Stone v. SAIF, supra, is distinguishable as follows: Stone holds that interim compensation need only be paid from date of notice or knowledge of a claim if the claim is found noncompensable, while Gilroy

requires that interim compensation be paid from date of disability if the claim is found compensable. The fallacy in that position can be easily identified. When, not less than 14 days after notice or knowledge of a claim, it is time for an employer/insurer to issue its first check for interim compensation, it is not then known whether the claim is compensable or noncompensable; but to comply with its statutory duty to pay interim compensation, the employer/insurer needs to know then whether to issue a check in an amount for the period since notice of claim or whether to issue a check in an amount for the period since date of disability; and it is hardly fair or reasonable -- nor could it possibly have been intended by the legislature -- to expect the employer/insurer to issue a larger or smaller check based on a contingency (compensability versus noncompensability) not then known, or to penalize the employer/insurer if it later turns out that it guessed wrong.

To the extent that Gilroy may be inconsistent with Stone, we follow Stone as the more recent precedent. Interim compensation is due only from notice or knowledge of a claim. Only if and when a claim is accepted by an employer/insurer or ordered accepted by litigation order must the employer/insurer then pay compensation for temporary total disability (which is the same in amount, but different in kind from interim compensation) between the date of disability and the date of notice/knowledge of the claim.

The Referee awarded claimant a penalty and associated attorney fee because of SAIF's failure to pay interim compensation from the date of disability. Since the law only required SAIF to pay interim compensation from the date of notice of the claim, and since SAIF did pay interim compensation from the date of notice of the claim, it follows that the Referee erred in assessing a penalty and associated attorney fee.

ORDER

The Referee's order dated March 30, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which awarded claimant a 25% penalty on temporary total disability compensation from June 1, 1982 to September 9, 1982 and which awarded claimant's attorney an associated fee of $350 are reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

THOMAS M. PURCELL, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-04112
April 27, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Quillinan's order which set aside its denial of claimant's myocardial infarction claim. Claimant alleges that the stress of his job caused his myocardial infarction.

Claimant is the president of a steel fabrication company. Beginning in 1980 claimant's business began to decline. In 1981 the decline became severe. Three partners had originally started the company. One partner had been forced out by 1981. The

remaining partner owned a trailer which was parked at the company site. That partner was drinking heavily and was of no assistance to claimant in running the business. Claimant was required to reduce the company's work force and to take on many of the duties of his former employes and partners. Claimant regularly worked twelve to fourteen hours per day as well as weekends. Claimant also cut his own salary during 1981.

In addition to the work stresses which claimant experienced during 1981, he experienced significant off the job stresses. During the summer of 1981 claimant's wife threatened to leave him. In January 1981 claimant was charged with being a habitual traffic offender because of his numerous traffic convictions. Claimant's regular license was suspended, but he was issued an occupational driver's license. In February 1981 claimant was involved in a serious automobile accident in which he hit another vehicle, his vehicle rolled and caught fire. Claimant was charged with hit and run and with driving while suspended. In reaction to the incident claimant quit drinking for several months. Claimant experienced withdrawal symptoms for several days after he stopped drinking. Claimant resumed his drinking sometime during the summer of 1981.

Claimant has smoked cigarettes since his youth. During the summer of 1981 his cigarette consumption increased from about a pack a day to a pack and a half a day.

In October 1981 claimant took his annual hunting trip. During the course of that trip he shot a deer and carried it three to four miles. Following his return from the hunting trip, claimant found company affairs in an even worse condition than before he left. Claimant began working even harder upon his return from the hunting trip.

Early in the morning of October 30, 1981, claimant awakened with chest pains, but returned to sleep. The following night he again awakened with chest pains. He was taken to a hospital emergency room and was diagnosed as having suffered an acute anterior infarction. The treating physician, Dr. Keene, noted that claimant has arteriosclerotic heart disease.

Claimant filed a claim for the heart attack. He stated on his 801 form:

> "The stress from the company losing business and going down hill, also pressure from our creditors was too much stress. I ended up in the hospital with a heart attack."

SAIF denied the claim.

The expert evidence concerning the causal connection between claimant's work and either his arteriosclerosis or his acute myocardial infarction is conflicting. Dr. Keene, the cardiologist who treated claimant at the time of the heart attack, opined:

> "[I]t is my feeling that there is no specific relationship between his work activities and the myocardial infarction sustained on June 17, 1982. By coronary

angiography he has diffuse longstanding coronary artery disease, which I think is related to genetic factors and long-standing tobacco usage. There is nothing to indicate in the medical literature that the stresses documented by Dr. Wilson cause coronary artery disease or result in acute change in the coronary anatomy."

Claimant's family physician, Dr. Joll, opined:

> "I have seen him very regularly since his myocardial infarction and can attest to the emotional problems he has suffered. It is generally accepted in the medical community that unusual amounts of stress are a significant cardiac risk factor for coronary artery disease. [Claimant] did have an excessive amount of stress in the year prior to his myocardial infarction and subsequent coronary artery surgery. I cannot help but believe that consistent with all existing medical knowledge and opinion, that this stress experienced by [claimant] was a very significant contributing factor in the onset of the acute myocardial infarction and subsequent coronary artery bypass surgery he underwent."

We note that Dr. Joll's general reference to "stress" fails to distinguish between claimant's occupational and personal "stress."

Dr. Rogers, a cardiologist, examined claimant and opined:

> "Dr. Keene's 11/24/81 coronary arteriogram showed that the attack was probably generated by a total occlusion of the proximal large anterior descending artery that recanalized to a small degree and there was an additional 50-70% stenosis in the circumflex system, while the right coronary artery was not well visualized. Thus, the medical genesis of this infarction probably involved rupture of a preformed plaque in the proximal anterior descending artery which thrombosed over a 24 hour period, leading to the severe infarction. Neither the development of the coronary atherosclerotic process, the rupture of the plaque, nor the occcurrence of thrombosis is recognized cardiologically as being materially related chronically to emotional stress."

Dr. Wilson, a psychiatrist who treated claimant, opined:

> "I do believe that psychosocial factors, including work stresses, do play a role in the precipitation of heart attacks. I also believe that this has been a matter of

> general medical knowledge for many years.... The entire matter is extremely complex and the current state of knowledge, in my opinion, does not allow one to be exacting and specific in most instances. I believe that for me to state that [claimant's] heart attack was caused by his work stresses, is primarily speculative; there is simply insufficient data to be specific."

Dr. Griswold, a cardiologist, examined claimant and opined:

> "There is little question that [claimant] suffered a myocardial infarction. There is also little question that he was under enormous stress in the preceding months prior to his myocardial infarction. It would be my medical opinion based upon reasonable medical probability that this is a situation in which unusual stress not of a person's choosing of a severe and chronic nature could and probably did accelerate atherosclerosis and result in his acute myocardial infarction."

Dr. Kloster, also a cardiologist, reviewed claimant's records and opined:

> "It is my opinion that [claimant] developed atherosclerosis which led to his myocardial infarction and need for coronary bypass surgery primarily because of the risk factors of cigarette smoking and Type A behavior pattern and that work-related stress while it may have influenced his coronary disease to some extent, was not a major contributing factor.
>
> "The other possible causitive[sic] relationship of stress to coronary disease might be in the precipitation of an acute event such as myocardial infarction....Since the onset of these symptoms clearly occurred while he was away from work and at least a number of hours from his most recent work activity, it is my opinion that his work activity was not a material contributing or aggravating cause. Although the possibility of chronic stress provoking an acute myocardial infarction was alluded to in some of the records, it is not my personal opinion that an accumulation of chronic stress is likely to provoke an infarction at some remote unpredictable time and this opinion is supported by the American Heart Association Task Force Report...."

We are unsure exactly what claimant's theory of compensability is. The 801 form seems to indicate an occupational disease theory. However, claimant's brief seems to focus more on an injury theory. We believe that the claim fails under either theory.

The occupational disease theory is best expressed in Dr. Griswold's report. In essence, that theory is that chronic job stress was the major cause of a worsening of claimant's atherosclerosis which culminated in claimant's heart attack. We find that the evidence preponderates against that theory. The evidence is equivocal whether any stress contributed to a worsening of claimant's preexisting atherosclerosis. Dr. Griswold and Dr. Joll believe it did; Dr. Kloster believes it could have been something less than the major cause of the worsening; Dr. Keene and Dr. Rogers believe it did not; and Dr. Wilson is unable to tell. Even if we accept it as proven that some form of stress was the major cause of the worsening of claimant's atherosclerosis, which we do not, claimant has failed to prove that work stress was more significant than nonwork stress. While it is true that claimant's job was very stressful during the year prior to his heart attack, the record indicates that several off the job factors also provided significant stress during that same period. Claimant had marital problems and legal problems; he was involved in a serious accident; he quit and later resumed drinking; he increased his cigarette smoking. We find that claimant has failed to prove by a preponderance of the evidence that his job stress was the major contributing cause of a worsening of his preexisting atherosclerosis.

The injury theory is necessarily weak when a worker has a heart attack at home many hours removed in time from any work activity and with no record of symptoms at the time of any work activity. On the injury theory, aside from this adverse circumstantial evidence, we find the opinions of Drs. Rogers, Kloster and Keene as persuasive or more persuasive than those of Drs. Joll and Griswold. Accordingly, we find that claimant has failed to sustain his burden of proving medical causation.

ORDER

The Referee's order dated June 20, 1983 is reversed. The SAIF Corporation's denial dated May 10, 1982 is reinstated and affirmed.

ROBERT L. SNOOK, JR., Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-11090
April 27, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Peterson's order which granted claimant an award of 15° for 10% scheduled disability to the right leg in addition to the 22.5° for 15% scheduled disability previously awarded by Determination Order and which assessed a penalty and attorney's fee against SAIF for unreasonable delay in payment of compensation. Extent of disability and the penalty and attorney's fee are the issues on review.

The Board affirms and adopts that portion of the Referee's order concerning the penalty and attorney's fee.

On the issue of extent of disability, we reverse. The medical evidence indicates that claimant's impairment is in the mild range. Dr. Singer opined on July 1, 1982:

"I do not think that he has significant

intra-articular pathology. When he left the office he walked down the hall quite briskly with a very minimal limp, so while he may have discomfort, I don't think it is a major functional problem for him. I don't think there would be really very much advantage to his having further surgery. He has very minimal quadriceps atrophy, and therefore, he is using his knee a fair amount in his normal daily activities."

Dr. Degge opined that 15% awarded by Determination Orders accurately reflected claimant's impairment. Claimant himself testified that he continues to be able to bowl, to hunt, to jog and to rototill his garden, albeit not as well or as strenuously as before his injury.

Considering the guidelines contained in OAR 436-65-550 and comparing this case with other similar cases, we conclude that claimant is appropriately compensated by the 22.5° for 15% scheduled disability previously awarded by Determination Orders.

ORDER

The Referee's order dated September 13, 1983 is affirmed in part and reversed in part. That portion of the order granting claimant an additional award of 15° for 10% scheduled disability is reversed. Claimant's total scheduled award to date, therefore, is 22.5° for 15% loss of the right leg (knee). The balance of the Referee's order is affirmed. Claimant's attorney is awarded $300 for services on Board review, to be paid by the SAIF Corporation.

ROY C. SULLIVAN, Claimant
Roberts, et al., Defense Attorneys

WCB 81-09296
April 27, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Knapp's order which: (1) Awarded him a total of 35% (112°) unscheduled permanent partial disability for his low back condition, which was an increase of 10% (32°) from the July 15, 1981 Determination Order which had awarded him 25% (80°); and (2) found claimant's weekly temporary total disability rate was $89.59. Claimant apparently contends that: (1) He is permanently and totally disabled or that his permanent disability award should be increased; and (2) his weekly temporary total disability rate should be increased. The insurer cross-requests review of the Referee's order, contending the permanent disability award should be reduced, and that claimant is not entitled to temporary total disability or the weekly rate should be reduced.

Claimant has enclosed two additional medical reports with his request for review. We regard this submission as a motion to remand for the taking of further evidence. We deny the motion for remand. Our review of the record reveals that this case has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

We agree with the insurer's contention that claimant's permanent disability award is excessive. We think the

Determination Order's award of 25% is more than sufficient. Therefore, we reverse the Referee's additional award of 10%.

Claimant's condition has been diagnosed as lumbar strain. He suffers from underlying osteoarthritis of the lumbar spine and preexisting compression fractures of the upper lumbar and lower dorsal spine. Claimant also has trochanteric bursitis of the left hip. The medical evidence preponderates in favor of a finding that claimant's underlying and preexisting conditions were not permanently affected to any degree by his industrial injury. Further, we are persuaded that claimant's hip symptoms were not work-related.

Orthopaedic Consultants opined that the total loss of function of claimant's lumbosacral spine was mild but attributed only a minimal loss to his compensable injury. They believed claimant would be unable to return to his usual occupation as a carpenter. However, they felt claimant could perform light duty work which did not require climbing ladders or heavy lifting of more than 35 pounds.

Dr. Blaylock, a former treating physician, substantially agreed with Orthopaedic Consultants' report. In his final report, Dr. Blaylock indicated claimant's injury-related symptoms had "pretty much resolved." Dr. Eilers, an examining orthopedist, and Dr. Platt, an examining neurologist, concurred with Orthopaedic Consultants' evaluation.

Claimant was 67 at the time of hearing. Carpentery has been his profession for 35 years. He has an eighth grade education. Claimant retired in 1978 but continued to work for his former employer on a part-time basis as a means to supplement his social security income. He was working on this basis when he suffered his compensable injury. Most, if not all, of claimant's physical impairment is attributable to his underlying osteoarthritic condition and preexisting compression fractures, not his compensable injury.

Pursuant to OAR 436-65-600, et seq., we consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings and physical impairment due to his compensable injury, including residual pain, in rating the extent of claimant's disability. Considering the above guidelines and comparing this case to similar cases, we conclude that the Determination Order's award of 25% sufficiently compensated claimant.

The Board affirms the Referee's order on the issues concerning claimant's entitlement to temporary disability and the weekly rate thereof.

ORDER

The Referee's order dated July 28, 1983, as republished September 13, 1983, is reversed in part and affirmed in part. That portion which increased claimant's award for unscheduled disability by 10% (32°) is reversed. The July 15, 1981 Determination Order which awarded claimant 25% (80°) unscheduled disability is affirmed. The remainder of the Referee's order is affirmed. Claimant's attorney's fee shall be adjusted accordingly.

FRANK L. TAYLOR, Claimant
Myrick, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-06077
April 27, 1984
Order on Review

Reviewed by the Board en banc.

The insurer requests review of Referee Brown's order which granted claimant an award for permanent total disability. Claimant had previously received a total of 64° for 20% unscheduled disability. Extent of disability is the only issue on review.

Claimant compensably injured his back on May 16, 1978 while attempting to lift a case of frozen foods which was stuck in the ice of a freezer. Claimant at that time was working as a restaurant manager/chef. Prior to this injury, claimant had undergone three low back surgeries including a laminectomy and two fusions. However, according to claimant, his back did not limit his ability to work at the time of the 1978 injury.

Dr. Saez, a neurologist, diagnosed severe nerve root compression secondary to a lumbar disc herniation. A myelogram revealed a large posterolateral defect at L3 on the right and ventral bulging of the L3 disc causing encroachment of the neural elements at L3-4. Dr. Saez performed a laminectomy, foraminotomy and discectomy of the L3 disc July 26, 1978. The post-operative diagnosis was severe stenosis of the lumbar canal at L3-4 with a protruded L3 disc on the right.

In September 1978 Dr. Saez noted that claimant had residual lumbosacral pain which at times became severe. In December 1978 Dr. Saez stated:

> "His problem is pain. His condition is chronic but not medically stationary. He is well motivated to work and has high goals for himself. He cannot return to his previous managerial occupation because, locally, it requires his performance of kitchen work which is medically inadvisable. . ."

In March 1979 Dr. Saez noted that claimant was also experiencing leg cramps. In February 1979 Dr. Saez prescribed a TNS unit in an effort to reduce claimant's pain. At that time he noted:

> "Physical examination reveals there is tenderness at lumbosacral region on the right with trigger point. The back motions are 50% reduced. The motor testing is normal. The straight leg raising testing is 80 degrees on the left. The deep tendon reflexes; the knee jerks are normal bilaterally, the ankle jerks are absent on the right and normal on the left."

In June 1979 Dr. Saez found claimant medically stationary. He opined: "There is moderately severe subjective and objective partial permanent disability involving the lumbar spine." Later that month Dr. Saez stated: "The above patient is totally disabled for usual and customary occupations."

A Determination Order issued on August 24, 1978 which granted claimant an award for 10% unscheduled disability.

In November 1979 claimant attempted to return to work. Dr. Saez reported:

> "Relapsing symptoms probably represent relapse of inflammation and irritation of nerve roots by arachnoidal adhesions or epidural scar. . . His physical capabilities may be further curtailed by his lumbar spine problem and appropriate job change may need to be considered. Avoidance of reinjury is crucial to his condition."

In February 1980 the insurer referred claimant to Dr. Franklin, a neurologist, who reported:

> "In summary then, this man both by history and examination has clear-cut evidence of ongoing paraspinous lumbar spasm which is rather severe, causing scoliosis in the lumbar area and ongoing S1 radicular symptoms and signs including an absent right Achilles reflex, sensory loss in the medial calf region, decreased muscle mass in the right gastrocnemius muscle and chronic EMG changes....The amount of pain that he is having, however, and limitations of his activities is much greater than the objective findings and would not bode well for his returning to any sort of work that is anything more than sedentary."

A myelogram was performed in May 1980 which revealed epidural scarring. Dr. Stainsby, who saw claimant in consultation, recommended against any further back surgery. Dr. Franklin stated:

> "Because of the scarring found on myelography this patient's prognosis for good recovery is not very positive and he may well have pain for some years to come. He definitely will be limited in what he will be able to do in terms of his work, and should avoid any heavy lifting and bending."

In May 1980 Dr. Saez stated that he considered claimant permanently disabled for his previous occupations. He urged a vocational rehabilitation program to retrain claimant for "gainful employment compatible with his severe back limitations which preclude any lifting, bending, twisting or persistent back posture."

In late 1981 claimant experienced increased pain. Dr. Smith reported:

> "Approximately two to three months ago, he experienced an exacerbation of his pain for uncertain reasons. There was no antecedant

injury. He began to experience increasingly severe pain in the left buttock, hip, posterolateral thigh, upper calf and anterior thigh, just proximal to the knee. This pain became quite severe and disabling....He cannot walk more than a block without experiencing severe discomfort.

Despite the doubts that had previously been expressed about further surgery, Drs. Smith and Wilson then recommended repeat laminectomy and removal of the disc at L3-4 on the left. The laminectomy was performed on December 10, 1981.

Claimant was considered medically stationary on February 17, 1982. On April 22, 1982 an Orthopaedic Consultants panel evaluated claimant. They noted that claimant reported feeling 80% better following his latest surgery. They noted that claimant had been trained in computer programming and was then looking for work in that field. They opined:

> "We feel that his new occupation as a computer programmer is well chosen. At this time no additional treatment is necessary but might conceivably be necessary in the future.
>
> "The total loss of function as it exists today in the back is felt to be moderately severe and the loss of function due to this injury (5-16-78) is considered moderate."

The panel found no interference due to functional disturbance.

A Determination Order issued on July 2, 1982 which granted claimant an additional 10% award for a total unscheduled permanent disability award of 20%.

On July 12, 1982 Dr. Wilson reported:

> "The patient has had about 20 physical therapy treatments over the past month which he states help for a couple of hours, but gives no long term relief. He states that he spends about 80% of his time lying down, 15% sitting and about 5% walking. Most of his pain is below his last surgery site, with pain into the left leg that is both back of the leg and inside the leg....
>
> "At this time, I feel the patient is really, for all intents and purposes, totally disabled and unable to return to gainful employment. He has already had five back surgeries and it is unlikely that any additional surgery would be of benefit to him."

In October 1982 claimant prepared a written statement in which he detailed the limitations which he felt his pain imposed on him. Dr. Saez examined claimant and then commented on claimant's written assessment.

> "The physical examination demonstrated that he had severe loss of the lumbar range of motion with tenderness of the paraspinal musculature and considerable pain in attempting to move his trunk at waist level in any direction. He also demonstrated positive straight leg raising of only 30° on both sides, indicating the presence of significant sciatic root entrapment in the lumbar spine bilaterally. . .
>
> "The medical history and the physical examination do appear generally consistent with the patient's description of his physical limitations which I highlight as follows: (1) maximum lifting of up to 20 lbs. Lifting from the ground up to waist level is inadvisable. (2) Carrying up to 15 lbs. for only a distance of a few paces. (3) No bending or back twisting. (4) The sitting position for up to four or five hours per day, medically advisable for him to relieve the sitting position at least hourly. (5) Driving for up to twenty or thirty minutes. The patient would be advised to stop driving for relief of body position, and for a period of rest as needed every twenty to thirty minutes of driving time. (6) Standing up for up to fifteen minutes. Walking or pacing as tolerated intermixed with other body positions such as reclining or sitting."

Claimant was again evaluated by another Orthopaedic Consultants panel on November 8, 1982. This panel described claimant as walking with an unusual gait which they described as "camptocormic." They said:

> "This is a giat[sic] with the knees flexed, and the lumbar spine hyperextended, and the hips flexed. It is not described as being caused by pain, and in itself is an uncomfortable posture."

The panel felt that there was severe functional interference with the examination which was manifested by inconsistencies and refusals. They felt that from a physical standpoint claimant "should be able to function as a computer programmer, which he is trained to do."

At hearing a vocational expert testified that in his opinion he did not believe claimant was capable of performing any regular work. He testified that he based that opinion on claimant's own assessment of his physical limitations.

The Referee stated that the "primary question is one of credibility":

> "And I have reason to question [claimant's] credibility. His work history was reviewed in detail on direct examination. Claimant

> significantly did not mention the fact that he had worked as a vocational counselor for the Department of Vocational Rehabilitation prior to starting work as a restaurant manager. The November 1982 [Orthopaedic Consultants] examination, manifest with inconsistencies and apparently bizarre behavior, when read in comparison with the April [Orthopaedic Consultants] examination, bothers me, particularly when viewed in the chronological context: the April exam was predetermination order; the November exam was in the throes of litigation."

Despite stating that credibility is the primary issue, the Referee did not make a specific credibility finding. Rather, he noted that Dr. Stolzberg, a psychiatrist who examined claimant, did not specifically state that claimant was exaggerating for secondary gain. He then found that claimant is permanently and totally disabled.

The Court of Appeals has recently discussed credibility findings by Referees:

> "Although we defer to the referee with respect to findings of credibility, where, as here, that finding or conclusion is based on an objective evaluation of the substance of a witness' testimony, the referee has no greater advantage in making the assessment than do we on de novo review." Davies v. Hanel Lbr Co., 67 Or App 35 (February 22, 1984).

Similarly, where the Referee's credibility finding, whether express or implied, is based on the record as a whole without reference to demeanor, the Refere has no greater advantage than do we on de novo review. Primarily because of the inconsistencies in claimant's testimony and in the second Orthopaedic Consultants' examination, we are unable to conclude that claimant's testimony is completely credible.

We thus discount the opinions of Dr. Saez and Dr. Wilson that claimant is totally disabled because those opinions are based in part on the doctors' acceptance of claimant's pain complaints. We also discount the opinion of the vocational expert because his opinion is based on claimant's own statement of his physical limitations.

Having discounted these opinions, we think the primary question becomes: Has claimant proven that he is unable to work in the area of computer programming, in which he has been retrained? Even accepting for sake of discussion all of the physical restrictions suggested most recently by Dr. Saez, we are unable to conclude that these restrictions would preclude claimant from work as a computer programmer. It follows that claimant has not sustained the burden of proving that he is totally disabled.

There is objective evidence that claimant is significantly

disabled. After considering the guidelines contained in OAR 436-65-600 et seq., we find that claimant is entitled to a total award of 224° for 70% unscheduled disability which is an increase of 160° for 50% unscheduled disability over that previously awarded by Determination Orders.

ORDER

The Referee's order dated June 10, 1983 awarding permanent total disability is reversed. Claimant is awarded a total of 224° for 70% unscheduled disability which is an increase of 160° for 50% unscheduled disability over that previously awarded by Determination Orders and is in lieu of all prior awards. In lieu of the attorney's fee allowed by the Referee's order, claimant's attorney is allowed 25% of the additional compensation awarded herein (160°), not to exceed $2,000, payable out of claimant's compensation and not in addition thereto.

BOARD MEMBER LEWIS DISSENTING:

I would affirm the order of the Referee awarding claimant permanent total disability.

The majority concludes claimant is less than credible on the basis of an inconsistency in his testimony and a report of the Orthopaedic Consultants. Finding claimant's credibility questionable, the majority discounts the opinions of Drs. Saez and Wilson. I do not find the facts relied upon by the majority in reaching their credibility finding to be significant enough to outweigh the balance of the record.

I find that the record as a whole portrays claimant as a severely disabled person who is in a great amount of pain and who is unable to perform gainful activity. Dr. Saez describes claimant as a well-motivated and intelligent individual who strives to retain his personal independence. I am particularly persuaded by the medical evidence which shows that claimant has had five low back surgeries, including a laminectomy and two fusions prior to the 1978 industrial injury at issue here. After his 1978 injury claimant had a fourth surgery involving a laminectomy, foraminotomy and discectomy. Later, claimant had a fifth surgery involving a laminectomy. Myelogram studies show significant epidural scarring which causes pain and will continue to cause pain.

Dr. Wilson opined that claimant is totally disabled and unable to return to gainful employment. Dr. Saez's exam shows severe limitations in claimant's ability to lift, bend, twist, stand, sit and walk, which were factors considered by the vocational expert in concluding claimant could not perform any gainful activity. On the record as a whole, I find that claimant has proven that he cannot perform work in the area of computer programming, or any other gainful activity. I also find that claimant has met the seek work requirement of ORS 656.206(3).

I would affirm the Referee's award of permanent total disability, and therefore, I respectfully dissent.

MARIAN E. TENNENT, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-10141
April 27, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Quillinan's order which found that claimant's claim was prematurely closed by a November 1981 Determination Order, and which assessed a penalty and associated attorney fee.

Claimant has two conditions related to her compensable injury, a physical problem and a psychological problem. The Referee apparently concluded that neither condition was stationary on the date of claim closure. We disagree in part. The overwhelming weight of the evidence is that claimant's physical condition was medically stationary at the time of the Determination Order. Only Dr. Rasmussen believed that claimant's physical condition was not then stationary. We do not find Dr. Rasmussen's opinion, as explained in his deposition, to be at all persuasive.

We find, however, that claimant's psychological condition was not stationary at the time of the Determination Order. Claimant's treating psychiatrist, Dr. Radmore, opined in July 1982 that claimant was not medically stationary at the time of the November 1981 Determination Order. She based her opinion on the fact that she had been treating claimant for some time and, even in July 1982, continued to observe improvement. The evidence to the contrary is contained in a report from Psychological Consultants dated November 2, 1981. It states that claimant is stationary, that claimant has no permanent impairment and claimant's claim should be closed. However, the same report states that psychophysiological factors constitute 5% of claimant's disability; and urges that claimant continue treating with Dr. Radmore to attain the "goals established and to allow the client to proceed therapeutically and adaptively...." We find this report confused and contradictory and hence give it little weight. On this record, we conclude that Dr. Radmore's position is the more persuasive and thus find that claimant has established that she was not psychiatrically stationary at the time of claim closure.

We affirm and adopt that portion of the Referee's order relating to the issue of a penalty and attorney fee.

No attorney fee on Board review will be awarded as no brief was filed.

ORDER

The Referee's order dated February 22, 1983 is affirmed.

KENNETH K. BEHNKE, Claimant
Evohl Malagon, Claimant's Attorney
Spears, et al., Defense Attorneys

WCB 83-02000
April 30, 1984
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Seifert's order and Order on Reconsideration which affirmed the February 1, 1983 Determination Order which awarded claimant benefits for temporary total disability from April 29, 1981 through September 27, 1981, temporary partial disability from September 28, 1981 through January 5, 1983 and no benefits for permanent disability. Claimant contends that the Determination Order prematurely closed his claim, or in the alternative, that he is entitled to an award of 50% permanent partial disability.

The Board affirms and adopts the well-reasoned order of the Referee.

ORDER

The Referee's orders dated October 4, 1983 and October 24, 1983 are affirmed.

BOARD MEMBER BARNES CONCURRING:

In Darlene J. Emerson, 36 Van Natta 141 (1984), a majority of this Board found that a claim was prematurely closed because the claimant's treating psychiatrist opined that the claimant was not then medically stationary. As I noted in my dissent in Emerson, the only apparent basis for the doctor's opinion was that he was not going to regard the claimant to be stationary until she was, in the doctor's words, "productively, gainfully employed," and being "treated like you would treat any human being," and not being "afraid that she's going to be fired" and not being "discriminated against and harrassed." 36 Van Natta at 142.

This is a very similar case, but fortunately the Board does not make the same mistake again.

Here claimant has received considerable psychiatric treatment from Dr. Radmore over about a two year period. Dr. Radmore's most recent report opines that claimant is not medically stationary, and that the doctor does not expect claimant will be stationary until he is, "working in a situation which is satisfying to him, financially rewarding, and associated with some degree of assurance that he will not be subjected to personal recriminations and harrassment or that he will be transferred once again as soon as he has made the necessary arrangements to relocate. . ." As I said in my dissent in Emerson, there is no provision of the workers compensation law that requires that claimant be paid time loss indefinitely until he obtains sufficiently "satisfying" employment.

CARL R. BINGAMAN, Claimant
Noreen Saltveit, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 82-05592 & 82-11335
April 30, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Aetna Casualty Company requests review of Referee Galton's order which set aside its denial of claimant's aggravation claim and which upheld the SAIF Corporation's denial of claimant's alternative new injury claim. Aetna contends that claimant suffered a new injury while in the employ of SAIF's insured, and that SAIF, therefore, is responsible for claimant's present disability. Aetna also contends that the $2,500 fee the Referee awarded to claimant's attorney is excessive.

In October 1981 claimant suffered a compensable injury to his low back while employed by Amerco, which was insured by Aetna. In January 1982 Dr. Donkle noted slightly positive straight leg raising and spasm in his examination of claimant's low back. Dr. Gambee found no objective evidence to support claimant's subjective complaints. In May 1982 Dr. Waldram examined claimant for complaints of pain in his low back and left leg but reported no objective findings. Claimant was released to return to work without limitations.

Claimant began working for All Time Fence Co., insured by SAIF, in June 1982. On June 7, 1982 some fencing fell on claimant, causing his knees to buckle as he put up his hands to protect himself. Claimant had increased pain in his low back, hip and leg when he went home that evening. Claimant continued working at All Time Fence until July 1982, when he was laid off because he could not perform the work due to his back and leg pain. On August 4, 1982 claimant saw Dr. Thompson, who reported objective findings which indicated a preliminary diagnosis of a herniated disc with nerve root compression at L4-5 on the left. Dr. Thompson referred claimant to Dr. Ziven, who basically concurred with Dr. Thompson's opinion. A myelogram showed a probable laterally herniated fragment at L4-5.

Initially, Dr. Thompson attributed claimant's condition to his previous injury while working at Amerco, and not to any specific injury at All Time Fence. At his deposition, however, Dr. Thompson testified that claimant did not tell him about the June 7 incident at All Time Fence. After being given the facts of the June 7 incident, Dr. Thompson opined that it caused a worsening of claimant's condition and not just an increase of symptoms.

We find Dr. Thompson's opinion and reasoning to be very persuasive and to be consistent with claimant's testimony that he had increased pain and numbness after the June 7 incident. Therefore, we find that claimant suffered a new injury while employed by All Time Fence which independently contributed to claimant's disability. Accordingly, we find that claimant's disability is the responsibility of SAIF as the insurer of All Time Fence.

ORDER

The Referee's order dated March 22, 1983 is affirmed in part and reversed in part. That portion of the Referee's order that set

aside Aetna's denial dated December 15, 1982 is reversed, and that denial of claimant's aggravation claim is reinstated and affirmed. That portion of the Referee's order that upheld the SAIF Corporation's denial dated December 21, 1982 is reversed, that denial is set aside and claimant's new injury claim is remanded to SAIF for acceptance and processing. SAIF shall reimburse Aetna for all claim costs paid or payable pursuant to the Referee's order. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $300 for services on Board review, to be paid by the SAIF Corporation.

BILLY W. CAMERON, Claimant
David Force, Claimant's Attorney
George W. McLean, Jr., Defense Attorney

WCB 83-00368
April 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Neal's order which found claimant's claim was not prematurely closed and which declined to grant him an award for permanent scheduled disability to his left arm. Claimant moved to remand and then amended that motion to move to vacate the Referee's order.

The Board affirms and adopts the Referee's order and denies claimant's motion with the following comments.

Claimant sustained a compensable laceration to his left forearm. A Determination Order issued January 5, 1983 which granted no award for permanent disability and found claimant medically stationary on November 1, 1982. Claimant requested a hearing. Prior to the hearing the only medical evidence on the issue of whether claimant's condition was stationary indicated that it was. Shortly before the hearing claimant obtained a report from Dr. Jewett which supports the position that claimant's condition was not stationary. In essence, Dr. Jewett opined that claimant had partially severed the median nerve as a result of his compensable injury. He also mentioned the possibility of future treatment. At hearing the insurer objected to admission of the report based on the 10-day rule. A compromise was reached whereby the report was admitted but the insurer was allowed to obtain and submit its own report. At hearing the Referee described the issues as extent of disability, premature closure and penalties and attorney fees for late payment of benefits and for the insurer's allegedly cancelling a doctor's appointment set up by claimant. Claimant's then attorney agreed that those were the issues.

Following the hearing, claimant's attorney obtained an additional report from Dr. Jewett in which he set forth his reasons for believing claimant had partially severed the nerve. He also stated: "The patient should undergo exploration of the median nerve at the site of injury . . ."

The insurer countered with a report from Dr. Nathan which explained why he found fault with Dr. Jewett's conclusions. The Referee held in her order that, "[C]laimant has not sustained his burden of proving that his claim was prematurely closed because of misdiagnosis." In reaching that conclusion she accorded greater weight to the opinions of Dr. Nathan and Dr. Klubert, the treating physician, than she did to the opinion of Dr. Jewett. On de novo review we agree with the Referee.

Claimant argues that the Referee decided an issue which was not before her. He contends that her order somehow upholds a de facto denial of the surgery mentioned by Dr. Jewett. We do not so understand her order. The issue before the Referee was premature closure, and she decided that issue based on the expert medical evidence before her. The fact that she did not find Dr. Jewett's report suggesting surgery persuasive does not mean that she is upholding a denial of that surgery. The evidence does not show a request for authorization for surgery; it merely shows a recommendation of surgery in a report prepared for litigation purposes. Without a request for authorization for surgery there can be no denial of the surgery.

Claimant's motion to vacate the Referee's order is denied.

ORDER

The Referee's order dated August 24, 1983 is affirmed.

DARLENE L. CAMP, Claimant
Robert L. Burns, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-10590
April 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Gemmell's order which: 1) Found the claim was not prematurely closed by a Determination Order dated November 3, 1981; 2) found the claim was not prematurely closed by a Determination Order dated November 3, 1982; 3) declined to grant claimant an award for permanent disability; and 4) upheld the SAIF Corporation's denial of claimant's psychological condition and her alleged ulnar neuropathy. SAIF cross-requests review of that portion of the Referee's order which set aside its February 11, 1983 denial of aggravation for claimant's right shoulder condition.

The Board affirms and adopts the order of the Referee on all issues except the compensability of the aggravation claim.

The facts material to the aggravation claim are that on October 5, 1982 Orthopaedic Consultants reported that claimant's compensable shoulder condition was stationary and that she had no impairment due to her on-the-job injury. On October 18, 1982 her then-treating physician, Dr. Borman, stated that he generally concurred with Orthopaedic Consultants' report. The claim was closed by a Determination Order issued November 3, 1982. We have affirmed that Determination Order and found that claimant has no permanent impairment due to her compensable injury. We base that finding on the reports of Orthopaedic Consultants and Dr. Borman.

Following claim closure claimant began seeing a chiropractor, Dr. Cannard. On December 29, 1982 Dr. Cannard reported that claimant reported to him with upper back and right scapular pain. This is precisely the complaint claimant reported to Orthopaedic Consultants in October 1982 when they found her stationary. Dr. Cannard reported his objective findings on January 12, 1983. He did not state that claimant's condition had worsened but merely

felt that she could return to work in three to four weeks without permanent residuals. We are unconvinced based on Dr. Cannard's reports that claimant's condition which is caused by her compensable injury has materially worsened. Accordingly, we reverse the Referee on the issue of whether she has proven by a preponderance of the evidence that her condition has worsened since the last Determination Order.

ORDER

The Referee's order dated September 16, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the SAIF Corporation's denial of February 11, 1983 is reversed. The remainder of the Referee's order is affirmed.

SHIRLEY J. CHASE, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10712
April 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Seymour's order which set aside its denial of claimant's aggravation claim. The issue is whether claimant's current low back symptoms are compensably related to her 1980 industrial injury.

In May 1980 claimant fell about three to five feet into a pit while working. Claimant struck her shins on some steam pipes in the pit and landed with her weight on her left hand. Claimant was initially diagnosed as suffering from abrasions and bruises on her right leg, left shoulder and left hip. Claimant had previously undergone a cervical laminectomy for a nonindustrial condition in 1975, and a lumbar laminectomy for a nonindustrial condition in 1977.

Claimant completed an 801 form on May 22, 1980. There is no indication on the claim form that claimant injured her back in her fall. Similarly, there is no mention in the emergency room report of May 22, 1980 of any back difficulties; and there is no mention in the chart notes of Dr. Freeman, who treated claimant after her fall at work, of any low back complaints. In a comprehensive report dated August 19, 1980 Dr. Freeman reported that, following her injury in May 1980, claimant continued working until July 30, 1980 when her shoulder pain was again aggravated. Dr. Freeman diagnosed claimant as suffering from an acromioclavicular joint strain. There is no indication whatsoever that claimant injured her back in the May 1980 fall, or that she was suffering from any low back symptoms. Similarly, there is no mention of any low back symptoms in any of Dr. Freeman's subsequent chart notes.

Claimant was examined by Dr. Lechnyr, a psychiatric social worker, on October 24, 1980 in regard to a pain therapy program. Dr. Lechnyr noted that claimant was suffering from cervical pain, left arm pain and, mentioned for the first time, low back pain. Claimant informed Dr. Lechnyr that she had undergone a lumbar laminectomy several years ago and, "She is wondering if she needs to be re-evaluated by Doctor Golden since she felt that was helpful in the past."

Claimant was examined by Dr. Golden on November 17, 1980.

The majority of Dr. Golden's examination was restricted to claimant's shoulder difficulties. Dr. Golden noted that he performed a lumbar laminectomy on claimant in 1977 and stated that, "Patient continues to have some low back pain."

Claimant underwent further diagnostic testing in relation to her shoulder condition, and surgery was performed on her left shoulder on December 30, 1980. There is no mention in any of the related medical reports of any low back difficulties.

Claimant was referred to Orthopaedic Consultants in May 1981 for a closing examination. The Consultants reported on June 1, 1981 that, following her lumbar laminectomy in 1977, claimant continued to experience intermittent back pain, but that it had not been incapacitating. The Consultants also reported that claimant felt that her low back symptoms were somewhat worse following her May 1980 fall than they were before. The Consultants found claimant to be medically stationary. The final diagnosis was:

> "1. Status post cervical laminectomy for disc excision 1975 with residuals.
>
> "2. Status post lumbar laminectomy 1977 with residuals.
>
> "3. Status post-operative left acromioplasty 1980 with residuals.
>
> "4. Chronic low back strain."

The Consultants apparently were of the opinion that claimant did experience some increased back symptoms following her May 1980 fall, as they stated:

> "As far as the low back is concerned, the total loss of function as exists today is considered to be in the mild range with the loss of function due to this injury to be in the minimal range."

A Determination Order dated August 7, 1981 awarded claimant 25% unscheduled permanent partial disability for injury to her left shoulder and 5% scheduled disability for loss of her left arm. Claimant received no award for her low back and did not appeal the Determination Order.

Claimant thereafter moved to Reno, Nevada and began working as a desk clerk and night auditor with a hotel in November 1981. Claimant continued working in the hotel until she quit in August 1982 when her husband accepted employment in Oregon.

On April 18, 1982 claimant was examined by Dr. Rosenauher, a neurosurgeon in Reno. Dr. Rosenauher reported that claimant was complaining of recurrent low back pain. Dr. Rosenauher noted that claimant had a history of prior low back surgery. Dr. Rosenauher diagnosed, "residual from previous lower lumbar disc disease." A myelogram performed on May 4, 1982 was interpreted as normal with regard to the lumbar area of claimant's back.

SAIF requested Dr. Brooke to examine claimant's medical file

in order to determine whether claimant's 1982 low back symptoms were related to the 1980 injury. Dr. Brooke answered that question in the negative, apparently on the basis that there was no mention of any back difficulties in any of the medical reports generated subsequent to claimant's 1980 injury. On November 2, 1982 SAIF denied any relationship between the 1980 injury and claimant's current low back symptoms.

On January 31, 1983 claimant was examined by Dr. Degge, who was on the Orthopaedic Consultants panel which examined claimant in May 1981. Dr. Degge found claimant to be suffering from some residuals of her prior lumbar laminectomy. He felt claimant sustained no residuals to her low back as a result of the May 1980 injury and that claimant's current complaints were relatable to the prior laminectomy.

The Referee stated: "It appears to me that the report of Orthopaedic Consultants amply demonstrates a low back residual which could very easily result in future problems to the low back." On that basis, the Referee set aside SAIF's denial. We disagree.

It appears that SAIF, claimant and possibly the Referee focused on the question of whether claimant's low back was involved in her May 1980 injury. However, even if claimant's low back was involved in that injury, there is still the question of whether claimant's current back symptoms are related to that injury, or instead to her previous and unrelated lumbar laminectomy.

There is a substantial question of whether claimant's low back was involved in the 1980 industrial injury. Claimant made no mention of back involvement on the 801 form which she completed and signed, and there is no mention of any back complaints in any of the initial medical reports. Dr. Freeman, who treated claimant extensively after her injury, makes no mention of any back difficulties in his comprehensive report of August 19, 1980, or in any of his chart notes. The first reference to back pain is contained in Dr. Lechnyr's report of October 24, 1980. However, it appears from the remainder of that report that claimant was relating her back pain to her previous lumbar laminectomy rather than her May 1980 injury. The same is even more obviously true of Dr. Golden's report of November 17, 1980. This would be consistent with the statements in other medical reports that claimant experienced intermittent low back pain ever since the 1977 laminectomy. Viewed against the background of our analysis of the rest of the record, the one anomaly is Orthopaedic Consultants' report of June 1, 1981, which does seem to suggest some low back involvement in the May 1980 injury.

Claimant argues that the lack of notation of low back symptoms in most medical reports written after her 1980 injury is due to the fact that she was taking pain medication for her more serious shoulder injury. Although that is a possibility, it would be speculation to so conclude. Moreover, if claimant's back was injured in 1980, it would be surprising that she would not have mentioned any back pain when <u>first</u> seeking medical attention <u>before</u> any medication was prescribed.

We conclude that it is not necessary to decide whether claimant's low back was involved in the May 1980 incident. Even assuming that it was, despite serious doubts, the question still

remains of the relationship between that prior injury and claimant's current symptoms. In Oakley v. SAIF, 63 Or App 433 (1983), the court stated that aggravation of a chronic lumbosacral strain presents a complicated question requiring expert medical evidence. We find such evidence to be lacking in this case.

Dr. Rosenauher expresses no opinion about the causation of claimant's 1982 back symptoms, except that his diagnosis of residuals from previous lumbar disc disease implies that he relates claimant's 1982 symptoms to her 1977 laminectomy. Although somewhat vague, Dr. Degge's report also appears to relate claimant's recent back problems to her prior surgery. Dr. Brooke's analysis to the effect that there is absolutely no mention of back pain in the medical records following the 1980 compensable injury, is incorrect; but even discounting Dr. Brooke's opinion, which is adverse to claimant, there is nevertheless a dearth of supportive medical evidence.

In view of the distinct possibility, if not probability, that claimant's 1982 back symptoms are related to her nonindustrial 1977 back surgery, on this record we cannot say that we are persuaded that claimant has established that those same back symptoms are residuals from her compensable 1980 shoulder/hip surgery.

ORDER

The Referee's order dated June 10, 1983 is reversed. The SAIF Corporation's denial dated November 2, 1982 is reinstated and affirmed.

LEWIS E. EASLEY, Claimant
Michael Dye, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 83-00910
April 30, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The insurer requests review of Referee Brown's order which set aside a November 26, 1982 Determination Order as a premature reclosure of claimant's back injury claim.

Claimant sustained a compensable back strain in October 1980 and initially obtained chiropractic treatment from Dr. Wolansky. In February 1981 Dr. Smith performed a neurological evaluation. Dr. Smith opined that claimant might have a protruded lumbar disc. A myelogram revealed a slight shortening on the left side of the L5-S1 interspace. However, as Dr. Smith noted, claimant was complaining of right leg pain. In May 1981 Dr. Smith reported:

> "He has been at bedrest for almost three weeks at home with no help. He is unable to work. I do not believe there is any nerve root pressure. I have discussed this with the patient. I think probably his best option is to return to the chiropractor, Dr. Wolanski for further management."

On August 4, 1981 Dr. Wolanski wrote the insurer:

> "Corrective low back exercises were begun along with maintenance treatment on 5/4/81 and have continued for a 3 month period.

> To date, no noticeable improvement has been observed. The patient's condition is essentially medically stable, with findings the same as reported on 2/18/81. We see no improvement in further treatment, although they seem to stabilize the condition."

Claimant's claim was first closed by a Determination Order dated September 30, 1981 which granted claimant an award of 15% unscheduled disability. Claimant's award was later increased to 20% by stipulation.

Claimant began treating with another chiropractor, Dr. Webb, in February 1982. The following month Dr. Webb requested claim reopening because there had been "a flare up and worsening of" claimant's back pain. The insurer ultimately reopened the claim.

In May 1982 Dr. Anderson, an orthopedist, evaluated claimant and reported:

> "The patient has had adequate diagnostic and therapeutic measures. His condition is stationary. He has reached maximum improvement and his claim should be closed. He could carry on an occupation which does not require the heaviest type of bending, stooping and lifting. Vocational assistance would be of some help, if he chose to seek . . . work.
>
> "Total loss of function of his back as it exists today is minimal.
>
> "Total loss of function due to this injury is 0."

Apparently seeing the situation quite differently, in June 1982 Dr. Webb reported that claimant's condition was not stationary. That same month Dr. Webb referred claimant to another chiropractor, Dr. Robinson, who also opined that claimant was not stationary.

On July 28, 1982 Dr. Bolin, also a chiropractor, evaluated claimant at the insurer's request. He noted that claimant's chronic back problem "is complicated by a pre-existing osteoarthritis condition," but opined that claimant was medically stationary, i.e., "maximum benefit has been obtained by [claimant's] present care since he does not continue to improve."

In August 1982 claimant accepted a position managing a motel. In September 1982 Dr. Webb stated that claimant's back condition apparently deteriorated because of his work at the motel:

> "[Claimant's] condition had definitely regressed since his last treatment and there was moderate to marked increase in his symptomatologies which I attributed to the long periods of time which he is required to stand on his feet . . ."

On October 29, 1982 Dr. Webb reported that claimant was

medically stationary. About the same time, Dr. Smith, who had first treated claimant shortly after his 1980 injury, examined claimant again and reported: "It is my opinion that [claimant] is medically stationary and I think that his condition is about the same as when I last saw him." It was on the basis of these reports that the claim was reclosed by the November 26, 1982 Determination Order.

Dr. Webb continued to submit reports about the cycles of claimant's back condition. In November 1982 Dr. Webb reported that claimant's back condition was then worse than it had been in September 1982. Dr. Webb did not explain why he found claimant medically stationary in October 1982. We think the best explanation for this "on-again, off-again" worsening is provided by Dr. Smith's December 13, 1982 and January 17, 1983 reports. The former states that it is impossible to evaluate claimant's back pain because it is solely subjective. The latter amplifies:

> "[A]fter reviewing the situation regarding his back pain, I would agree there is no physical documentary evidence that his condition has worsened, only his complaint of pain, as in my letter to you of December 13, pain is subjective and it is very difficult to evaluate."

The Referee gave greater weight to Dr. Webb's opinions than to Dr. Smith's and consequently found that claimant was not medically stationary on November 3, 1982. The Referee recited numerous inconsistencies in claimant's testimony. However, he concluded that claimant's credibility or lack thereof did not affect Dr. Webb's findings and analysis. We disagree. Dr. Webb does recite some objective findings in an early report and again in his November 15, 1982 report. However, it is clear to us that most of Dr. Webb's findings, analysis and opinions are predicated primarily or solely on the subjective symptoms which claimant related.

Based on the inconsistencies in claimant's testimony which the Referee recited, we have serious doubts about the credibility of that testimony. Therefore, we accord less weight to Dr. Webb's opinions, which we understand to be based in whole or in large part on claimant's subjective complaints. Dr. Smith opines that there is no objective basis for concluding that claimant's condition was other than medically stationary in November 1982. Considering the whole record, we find Dr. Smith's opinion persuasive. We are reinforced in this position by the fact that the opinions of Drs. Anderson and Bolin, although rendered some months before the time of claim closure, are quite consistent with Dr. Smith's opinion at the time of claim closure. It follows that the November 26, 1982 Determination Order has not been proven to have been issued prematurely.

Claimant apparently alternatively contended at hearing that, assuming the November 1982 Determination Order was not premature, he was entitled to have his claim later reopened because his condition worsened. What we have already said about the premature closure issue also disposes of this issue: There being no objective medical evidence of any worsening, the issue necessarily depends on claimant's credibility, about which we have already expressed our opinion.

The final issue raised at hearing, also raised in the alternative, is the extent of claimant's disability. The November 26, 1982 Determination Order awarded no compensation for permanent disability in addition to the 20% unscheduled award claimant had previously received. We conclude that claimant has not proven by a preponderance of the evidence that his permanent disability is in excess of the 20% unscheduled disability previously awarded. Accordingly, we find that claimant is entitled to no additional award for permanent disability.

ORDER

The Referee's orders dated June 10, 1983 and July 20, 1983 are reversed. The Determination Order dated November 26, 1982 is reinstated and affirmed, both as a timely claim closure and as the proper award for unscheduled permanent partial disability. The insurer's denial of reopening dated December 27, 1982 is affirmed.

ANGELA FLEMING, Claimant
Robert L. Chapman, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03115
April 30, 1984
Order on Review (Remanding)

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Brown's order which set aside its partial denial of claimant's trochanteric bursitis, and which thus found that claimant's claim was prematurely closed. The partial denial and premature closure issues are not really separate issues; if claimant's bursitis is compensable, claim closure was premature; if it is not compensable, claim closure was not premature.

Claimant compensably injured her low back on April 8, 1982 while working as a cook for a nursing home. A herniated disc was discovered. Dr. Potter performed a laminectomy on July 28, 1982. Claimant became unhappy with the care she received at the hospital and requested that she be transferred to another hospital. When claimant was discharged from the second hospital, the diagnosis was: "1) Hysterical personality disorder. 2) Post operative panic reaction with hysterical conversion symptoms."

On August 31, 1982 claimant returned to Dr. Potter who opined that she was recovering satisfactorily from her laminectomy. However, later that very same day claimant reported to a hospital emergency room with muscle spasms in her back and legs. She was admitted to the hospital on September 6, 1982. A myelogram was essentially normal. Claimant was treated conservatively and discharged on September 13, 1982. Shortly thereafter, claimant began treating with Dr. Kho, a neurologist.

On October 12, 1982 Dr. Kho reported that claimant had developed subtrochanteric bursitis. On November 16, 1982 Dr. Kho reported that claimant's subtrochanteric bursitis was resolved. On January 3, 1983 Orthopaedic Consultants evaluated claimant and noted that claimant was complaining of pain in both trochanteric areas. The panel opined that claimant was then medically

stationary. On January 6, 1983 Dr. Kho reported that claimant was complaining of pains in both subtrochanteric regions. On January 27, 1983 Dr. Kho concurred with the Orthopaedic Consultants' report, including specifically the finding that claimant was medically stationary.

Claimant reported to Dr. Kho on February 8, 1983 with "significant discomfort in the right hip." On February 10, 1982 Dr. Kho recommended reopening the claim for treatment of the bursitis which he said was "indirectly related to her industrial injury." On February 22, 1983 Dr. Potter saw claimant at Dr. Kho's request. Dr. Potter diagnosed "probable trochanteric tendinitis."

A Determination Order issued on February 25, 1983, granting claimant an award of 15% unscheduled disability and finding claimant medically stationary on January 27, 1983. On March 7, 1983 Dr. Kho wrote SAIF that, due to claimant's bilateral trochanteric bursitis, she was not medically stationary.

On March 17, 1983 Dr. Embick reviewed claimant's medical file and opined:

> "The patient's trochanteric pain began two to three months postop and probably cannot be related to bed rest on a firm bed. Therefore, I do not believe such a bursitis can be related to the patient's injury or the treatment of the same. Frequently, trochanteric bursitis occurs with long periods of bed rest necessitated by a back problem. This generally subsides with medical treatment and injection. I do not recall seeing a patient with this problem who required crutches. In fact, most of the pain occurs at bed rest or on sitting. The degree of pain usually is not severe and does not require medication such as demoral."

On March 23, 1983 SAIF partially denied the compensability of the trochanteric bursitis and further treatment for that condition. On April 18, 1983 Dr. Kho wrote SAIF. He recited the chronological history of claimant's bursitis. He then opined that the bursitis was caused by "the prolonged bedrest."

On June 22, 1983 Dr. Dunn examined claimant. He opined that claimant's trochanteric bursitis was indeed caused by prolonged bedrest due to her compensable injury. His opinion is suspect, however, because he reported that claimant began complaining of her bursitis within one week of her back surgery. In fact, this record reveals no such complaints until over two months later. In May 1983 Dr. Tennyson evaluated claimant's file for SAIF and opined that her trochanteric bursitis was caused by prolonged bedrest following her July surgery.

The Referee set aside SAIF's denial of claimant's bursitis and, therefore, found premature closure. We disagree. The weight of the medical evidence is that, when claimant developed trochanteric bursitis during the fall of 1982, it was caused by

bedrest following surgery for her compensable low back condition. However, claimant's treating physician opined on November 16, 1982 that the bursitis had resolved. We do not understand SAIF's partial denial to be denying the compensability of the bursitis prior to the time Dr. Kho said it had resolved.

Following Dr. Kho's statement that claimant was medically stationary she again developed symptoms of bursitis months later. No physician explains to us how a condition which, according to undisputed evidence, is not characterized by exacerbations and remissions and usually resolves within one month, suddenly flared up two months after it had resolved. Accordingly, we conclude that claimant has failed to prove by a preponderance of the evidence that her bursitis condition as it existed after Dr. Kho found that it had resolved was caused by her compensable injury. We, therefore, reinstate SAIF's partial denial. Because we find that claimant's alleged bursitis as it existed in January 1983 is not compensable, it follows that the claim was not prematurely closed because the experts agree that at that time all other conditions were medically stationary.

Our conclusions on the partial denial/premature closure issues render moot an issue raised concerning attorney fees. Our conclusion on these issues makes it necessary to remand this case to the Referee to reach the issue of permanent disability.

ORDER

The Referee's order dated September 21, 1983 is reversed. The SAIF Corporation's partial denial dated March 23, 1983 is reinstated and affirmed. The Determination Order dated February 25, 1983 is reinstated and affirmed as a timely closure of claimant's claim. This case is remanded to the Referee for further proceedings consistent with this order.

JERRY H. FOSS, Claimant
Roll, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 82-11140
April 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Gemmell's order which awarded claimant a total of 50% (160°) unscheduled permanent partial disability for his left shoulder and low back injury. Claimant had been awarded 15% (48°) by a December 3, 1982 Determination Order. The employer has filed a request for remand, asking that claimant's permanent disability award be reassessed in light of claimant's subsequent employment.

We deny the request for remand. Our review of the record reveals that this case has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

As to the issue of the extent of claimant's disability, we find that claimant's award should be decreased. Therefore, we modify the Referee's order.

Claimant was 36 years old at the time of hearing. At the time of his injury, he was employed as an edgerman for a wood products company. Most of his treatment has been conservative. However,

claimant did undergo an acromioplasty to his left shoulder, following which Dr. Hunt, claimant's treating orthopedic surgeon, diagnosed his condition as left shoulder impingement and low back strain. Claimant has been restricted to no lifting over 10 pounds with his left hand and to no work above shoulder level with his left arm. Based on the employer's job description, Dr. Hunt felt claimant could return to his job as an edgerman. Dr. Hunt rated claimant's permanent impairment as mildly moderate for his left shoulder and minimal for his low back.

Claimant also has been examined by two other orthopedists. Dr. Cherry opined that claimant had permanent impairment of the left shoulder and left upper extremity in the range of moderate and permanent impairment of the low back and left lower extremity in the range of mild. Dr. Cherry reported claimant had no sensation to a pinwheel on the left side of his neck, over his left shoulder in the upper and lateral area. Dr. Gripekoven opined that claimant had mild residual impairment of his shoulder and a minimal residual impairment of his lumbar spine. Dr. Gripekoven reported significant exaggerated pain behavior. This suggested to Dr. Gripekoven a functional component to claimant's ongoing problem.

On August 26, 1983 a Determination Order issued awarding claimant 15% permanent disability for his left shoulder and low back injury. Claimant requested Board review.

At hearing, claimant testified that he experiences pain in his left shoulder and low back. He also experiences a popping in the shoulder. Claimant believes he has lost strength and endurance in his left arm. The low back pain prevents claimant from comfortably bending at the waist or from lifting from floor level. Repetitive pushing and pulling is difficult, as is prolonged sitting. These problems prevent claimant, in his opinion, from returning to his edgerman job on a full-time basis. He also feels that these limitations prevent him from returning to his past work experiences. These experiences all included work in the wood products industry such as a choker setter, log bucker, green chain laborer, barker operator, forklift driver, gobbler driver, trim saw operator and grader.

Claimant has a tenth grade education. He has obtained his GED certificate. He does not read well. Claimant's vocational counselor felt that it would be difficult for claimant to obtain work other than in the wood products industry because claimant did not possess job search skills or interview capabilities.

We think the Determination Order's award of 15% is inadequate. However, we find the Referee's total award of 50% to be excessive.

Pursuant to OAR 436-65-600, et seq., we consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings and physical impairment, including residual pain, in rating the extent of claimant's disability. Considering the above guidelines and comparing this case to similar cases, we conclude that an award of 35% would more appropriately compensate claimant.

ORDER

The Referee's order dated August 26, 1983 is modified. In

lieu of the Referee's award, and in addition to the 15% (48°) unscheduled disability awarded by the December 3, 1982 Determination Order, claimant is awarded 20% (64°) unscheduled disability for a total award to date of 35% (112°) unscheduled disability for his left shoulder and low back injury. Claimant's attorney's fee shall be adjusted accordingly.

MARJORIE K. GINTHER, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01300
April 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Howell's order which upheld the SAIF Corporation's denial of claimant's claim for a fingernail condition.

Claimant, who was 32 years of age at the time of the hearing, had been employed by a food processing company as a sanitation worker for 14 years. On October 9, 1982 claimant was cleaning some machinery with a foam cleaning mixture and a liquid taken from a barrel which she understood to contain acid. Although claimant was wearing protective clothing, some of the cleaning agents she was using got inside her gloves, pooling at her fingertips. A small amount also splashed on claimant's face. Claimant began to notice a burning sensation after a short time and she rinsed her hands and face with cold water.

The next day, October 10, 1982, claimant showed her hands to her crew leader. Claimant and her crew leader testified that claimant's fingernails were raised from the nail bed and light blue in color. Claimant reported the incident to the company nurse. The nurse found no signs of chemical burns on claimant's skin and noted that claimant's right thumbnail had abnormal ridging on it. Claimant saw the nurse again on October 11, 13 and 14, 1982. There are no further notations of fingernail problems in the nurse's record. The nurse was apparently concerned with some unrelated abrasions on claimant's hands for which she had previously treated claimant.

Claimant thereafter began developing ridges and concavities on several fingernails on both hands, as well as softening and lifting of the fingernails from their beds. Claimant saw Dr. Peterson on December 2, 1982. Dr. Peterson diagnosed "damaged nails -- cause unknown -- probably secondary to detergent exposure." Dr. Peterson referred claimant to Dr. Wright, a dermatologist. Dr. Wright, in a report dated December 9, 1982, diagnosed a chronic fingernail deformity probably due to acid damage to the nail beds. Dr. Wright referred claimant to Dr. Nisbet, a plastic and reconstructive surgeon.

Dr. Nisbet found deformities on the fingernails, nail beds and fingers of both of claimant's hands. He noted that there were horizontal ridges and extreme deformities. Dr. Nisbet felt that claimant's nails would grow out normally after a few months.

Apparently at the request of SAIF, claimant was examined by Dr. Hanifin, a dermatologist at the Oregon Health Sciences University. Dr. Hanifin reported that claimant had a similar

experience with her fingernails in 1976 or 1977 after being exposed to a cleaning solution called "Allbright." Claimant related that the 1976-77 episode had resulted in no permanent damage to her fingernails. Dr. Hanifin found transverse ridging on claimant's fingernails and noted that claimant had throbbing pain with sensitivity to cold and heat exposure of the fingers which she developed only since October 1982. Dr. Hanifin reported that he found it difficult to believe claimant's nail deformities were caused by exposure to toxic or irritating chemicals because claimant had no similar damage to the surrounding skin. Dr. Hanifin believed claimant was suffering from an unrelated vascular condition. He stated that he could not rule out the possibility of the condition being the result of chemical exposure, but felt that on a scale of probabilities, chemical exposure would score 4 out of a possible 10, and a vascular problem would score 7 out of 10. Dr. Hanifin felt that, if claimant's condition was actually caused by chemical exposure, the deformities would disappear as claimant's fingernails grew.

On June 6, 1983 Dr. Nisbet reported that:

> "[Claimant] was last evaluated by myself on 2-28-83 at which point it was obvious that the deformity of the nails had progressed distally with approximation of normal growth of the nail proximally. This left dramatic improvement in the cosmetic appearance of the nails since her previous visit."

Dr. Nisbet stated that the improvement in claimant's fingernails over a four-month period of time coincided with the normal period of time allowed for growth of an adult's nails. He felt that this development lent support to the proposition that claimant's condition was the result of chemical exposure at work.

We note that this is a claim based on industrial injury rather than occupational disease. Claimant thus need only establish that chemical exposure at work was a material contributing cause of her fingernail condition.

A factor much in claimant's favor in this case is the very strong temporal relationship between claimant's exposure at work and the almost immediate appearance of her symptoms. The appearance of symptoms was verified by claimant's crew leader and at least initially by the company nurse. Although the Referee correctly noted that there is some discrepancy concerning exactly when claimant's fingernails actually began lifting out of the nail bed, we find this discrepancy to be so minimal as to be of no particular significance. Additionally, although the company nurse's records contain only a single reference to ridges on claimant's right thumbnail on October 10, 1982, the nurse testified that she was not sure that claimant's other fingernails were not affected also. There is no question that claimant had no such difficulties with her fingernails prior to her exposure.

However, temporal relationships alone are generally insufficient to sustain a claimant's burden of proof. Edwards v. SAIF, 30 Or App 21, 24 (1977). Claimant here has more. Dr. Hanifin stated that if claimant's condition was actually the result of chemical exposure, he would expect the deformities in claimant's

fingernails to disappear in time with normal nail growth. In fact, when claimant returned to Dr. Nisbet on February 28, 1983, her nails were nearly completely normal. By the time of the hearing, the deformities had apparently totally vanished. Dr. Nisbet felt that this was consistent with a history of chemical exposure, and even Dr. Hanifin's report could be interpreted to support compensability under these circumstances. We consider the fact that transverse ridges were found by Dr. Hanifin in January 1983 rather than longitudinal ridges as noted by the company nurse in October 1982 to be insignificant in view of the fact that all of the physicians involved in this case reported that claimant's fingernails exhibited multiple and severe deformities.

Although we agree with the Referee that there is no conclusive evidence as to the precise nature of the chemical or chemicals claimant was exposed to at work on October 9, 1982, we find that a preponderance of the evidence supports the conclusion that claimant was exposed to some form of acidic or otherwise caustic chemical. Claimant is generally familiar with the substances she uses in her work on the sanitation crew, and she testified that the substance was in a barrel and labeled "acid." She also stated that the substance had the strong and bitter smell of acid. Additionally, it is not necessary that we know the precise nature of the chemical claimant was exposed to, so long as we find the evidence convincing that claimant was exposed to a chemical which had the effect claimed. See Widman v. PECO Manufacturing Company, 66 Or App 472 (1984). We so find.

The testimony of the plant manager to the effect that there had been no acids used in the plant for some time sheds little light in view of additional testimony that he had nothing to do with the handling of chemicals in the plant, and that the ordering was done by several different individuals at various times.

Although the Referee's concern with the fact that the skin surrounding claimant's fingernails surprisingly suffered no damage is well-taken, we do not find that this defeats the claim. Claimant had a similar experience in 1976 or 1977 when exposed to another chemical at work. There is no indication in the record that there was any skin damage associated with that exposure, even though it had a very similar effect on her fingernails. Although Dr. Hanifin was puzzled by the lack of skin damage following the October 1982 exposure, Dr. Nisbet expressed no such concerns. Additionally, claimant did testify that she ran cold water over her skin shortly after she began to notice a burning sensation.

Considering the record as a whole, we find that the claimant has established the compensability of her claim by a preponderance of the evidence. This conclusion makes it unnecessary for us to address several other issues claimant has raised on review.

ORDER

The Referee's order dated September 27, 1983 is reversed. The SAIF Corporation's denial, dated January 31, 1983, is set aside, and this claim is remanded to SAIF for acceptance and processing. Claimant's attorney is awarded $800 for services before the Referee and $400 for services before the Board, to be paid by the SAIF Corporation.

STEPHANIE A. GRIMSLEY-BRUNI, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03880
April 30, 1984
Order of Dismissal

The Referee entered his order herein on December 8, 1983, ordering that the SAIF Corporation provide claimant with disputed medical services and reopen her claim for payment of temporary disability benefits from a date certain until closure pursuant to ORS 656.268. The Referee awarded claimant's attorney $900 for prevailing on a denied claim. Claimant thereafter requested reconsideration of that portion of the Referee's order awarding attorney fees, in response to which SAIF requested an opportunity to respond in the event that the Referee was inclined to reconsider.

On December 16, 1983, the Referee entered an order entitled Order Abating Award of Attorney Fees Pending Reconsideration. Claimant thereafter submitted materials in support of her request for an additional insurer-paid attorney's fee. The SAIF Corporation requested that the Referee place his December 8, 1983 order in abeyance in its entirety, as opposed to abating only that portion of the order awarding attorney fees, as the Referee's December 16, 1983 order purported to do. No further order was entered by the Referee, and SAIF requested Board review, designating the Referee's orders of December 8 and December 16, 1983, as the orders for review.

Claimant filed a "Cross Request for Review and Partial Motion to Dismiss," requesting review of that portion of the Referee's original order awarding a $900 attorney's fee, and, alternatively, moving to dismiss that portion of SAIF's request for review purporting to appeal the Referee's December 16, 1983 order, which claimant contended was an interim order and, therefore, not appealable. See generally Harris E. Jackson, 35 Van Natta 1674 (1983).

We find and conclude that this Board lacks jurisdiction to entertain SAIF's request and claimant's cross-request for review. Although the Referee purported to abate only a portion of his original order, by his order of December 16, 1983, the Referee effectively placed his entire order of December 8, 1983 in abeyance. To conclude otherwise could create significant administrative problems for the parties and this agency, such as the difficulties inherent in attempting to process a request for review of only a portion of the Referee's order, while the Referee retains jurisdiction of the unabated portions.

For the foregoing reasons, SAIF's request and claimant's cross-request are premature, and this Board presently lacks jurisdiction over this proceeding.

ORDER

The SAIF Corporation's request for review and claimant's cross-request for review are dismissed as premature.

MICHAEL R. HARMAN, Claimant WCB 82-02979 & 82-03232
Hayner, et al., Claimant's Attorneys April 30, 1984
Foss, Whitty & Roess, Defense Attorneys Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of those portions of Referee Seymour's order which: (1) Awarded claimant 40.5° for 30% scheduled permanent left foot (ankle) disability, an increase of 20.25° and 15% from the Determination Order of August 12, 1981; (2) found that claimant was not entitled to penalties for an allegedly unreasonable refusal to pay medical bills; and (3) found that claimant was not entitled to penalties for an alleged failure to provide medical reports in a timely fashion. Claimant contends that he is totally disabled and renews his arguments concerning penalties.

In July 1979 claimant, a diesel mechanic, sustained a compensable injury to his left ankle. Claimant suffered an undisplaced fracture of the distal fibula. The fracture eventually healed in an excellent position and alignment. However, in September 1980 an arthrotomy was performed to remove cartilage from his left talotibial joint.

Dr. Freudenberg stated that claimant's "range of motion in the left ankle goes from 5° of dorsiflexion to 50° of plantar flexion." The doctor also noted that claimant experienced pain with dorsiflexion. Claimant was fitted with a brace, which extends from his knee to his foot, and with a special boot. Orthopaedic Consultants reported that claimant's range of motion tests went from 5° of dorsiflexion to 30° of plantar flexion. They also found inversion of 5° and eversion of 10°. They reported that they believed claimant's stated symptoms to be in excess of objective findings.

Claimant testified that he cannot walk without the brace. He suffers from constant pain which limits his use of his ankle. Specifically, he can walk no more than 200 feet before he must sit down. He cannot run or jump. His ankle swells after standing 10 to 20 minutes. He cannot squat or stand on his left leg alone, nor scale ladders, and he must walk up stairs sideways. He can only drive cars with automatic transmissions.

Despite claimant's description of his limitations, in January 1981 a special job was created for claimant. The job was arranged between claimant's vocational rehabilitation counselor and claimant's former employer. In this job, claimant repaired and rebuilt engine components while seated at a work bench in a specially designed chair. The chair allowed claimant to stand whenever he needed to. Claimant was able to and did perform this modified job satisfactorily for about a year until his employment was terminated for reasons not relevant to this proceeding.

Despite working for approximately one year with his physical limitations, claimant contends that he is permanently and totally disabled. We agree with the Referee that the record does not support claimant's contention. The record is devoid of any medical opinion suggesting that claimant is permanently and totally disabled. Dr. Freudenberg's notes and reports arguably come the nearest to such an assessment. However, we think it is

clear that he was primarily concerned with the parameters of claimant's modified job, not claimant's ultimate physical impairment. We do not find the vocational rehabilitation counselor's conclusory opinion, even in conjunction with Dr. Freudenberg's specific light-duty restrictions, sufficiently persuasive to conclude that claimant is totally incapacitated. Therefore, we affirm that portion of the Referee's order which found that claimant was not entitled to compensation for permanent and total disability.

The interrelated issues of payment for medical services and associated penalties and attorney fees are a bit obscure on this record. After his industrial injury, claimant developed an ulcer. Bills for treatment of the ulcer condition were submitted to SAIF by Drs. Potter and McCowan. SAIF denied payment for this treatment (although not by a denial that sufficiently complies with our subsequent decision in Billy J. Eubanks, 35 Van Natta 131 (1983)), stating that the billings appeared unrelated to claimant's industrial ankle injury. Dr. Potter then submitted a report to claimant's attorney explaining that the ulcer condition was caused by the medication prescribed by claimant's orthopedist in connection with the treatment of claimant's injured ankle.

At one point at the beginning of the hearing, SAIF's counsel apparently conceded that the ulcer treatment was compensable; but that concession, if indeed one were ever intended, was promptly withdrawn -- suggesting that an issue of compensability remained. The Referee stated that, within a reasonable time after receiving a copy of Dr. Potter's letter of clarification, SAIF paid the medical bills for claimant's ulcer treatment -- suggesting that no issue of compensability remained. This confusion from the hearing record is compounded on review because claimant argues only about penalties, not compensability, and SAIF does not respond at all.

Assuming it is an issue before us, we find that claimant's ulcer treatment is compensable and, assuming anybody regards it as still outstanding, SAIF's partial denial should be set aside.

We also conclude that SAIF's partial denial was sufficiently unreasonable to warrant a modest penalty. The Referee stated that SAIF paid the bills for claimant's ulcer treatment within a reasonable time after receipt of Dr. Potter's letter of clarification. The Referee indicated that claimant had so testified. The Referee was mistaken. Claimant testified that the bills had not been paid. Furthermore, copies of the doctors' bills in the record indicate that the balances were unpaid.

Sorting through all this confusion, we conclude that a penalty of 10% of the bills of Drs. Potter and McCowan for ulcer treatment is appropriate.

There is also some confusion in regard to SAIF's alleged failure to comply with its discovery obligations. In a letter dated March 24, 1982, claimant's attorney requested that SAIF furnish him with all medical reports. On April 9, 1982 claimant was examined by Dr. Smith at SAIF's request. On April 21, 1982 SAIF received Dr. Smith's April 13 report. By letter dated May 13, 1982, claimant's attorney acknowledged receipt of some medical reports submitted to him by SAIF, but specifically asked where the report from Dr. Smith was. It is unclear when, if ever, SAIF

forwarded a copy of Dr. Smith's report to claimant's attorney, but it is reasonably clear that claimant's attorney had received a copy of that report from some source at some point before the hearing.

The Referee acknowledged that SAIF may have violated OAR 436-83-460 by not providing a copy of Dr. Smith's report within 15 days of SAIF's receipt of it. However, he failed to assess a penalty against SAIF because the discovery delay did not actually result in any delay of compensation due claimant.

We are not sure we agree completely with the Referee's reasoning. See Stella Phillips, 35 Van Natta 1276 (1983); Kathryn P. English, 34 Van Natta 1469 (1982). However, considering the entire record before us, and especially the notable lack of detail in it about SAIF's alleged noncompliance with its discovery obligations, we agree with the Referee's conclusion on this point.

ORDER

The Referee's order dated December 30, 1982 is affirmed in part, supplemented in part and reversed in part.

Primarily for sake of clarity and completeness, SAIF's partial denial of treatment of claimant's ulcer condition is set aside and that claim is remanded to SAIF for acceptance, processing and payment of all benefits provided by law, including payment of the outstanding bills for such treatment provided by Drs. Potter and McCowan. Claimant's attorney is awarded a reasonable attorney fee of $300 for prevailing on this partial denial.

Those portions of the Referee's order which did not assess a penalty against SAIF for its unreasonable refusal to pay medical bills are reversed. SAIF is ordered to pay claimant a penalty of 10% of the bills from Drs. Potter and McCowan for ulcer treatment, as those bills appear in the record herein, and is ordered to pay claimant's attorney a fee of $100 for unreasonable denial of medical services.

All attorney fees awarded by this order are payable in addition to and not in lieu of the attorney fees awarded by the Referee's order.

The remainder of the Referee's order is affirmed.

DEBORAH L. JONES, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorneys

WCB 81-10155
April 30, 1984
Order on Reconsideration

On March 30, 1984 the Board issued its Order on Review herein, reversing the Referee's order which found that claimant's 1977 injury claim was prematurely closed in 1982 and which set aside the SAIF Corporation's partial denial of claimant's psychiatric treatment. We reinstated and affirmed the Determination Orders entered in April and June of 1982 and reinstated and affirmed SAIF's partial denial. We remanded to the Referee for further proceedings on the issue of the extent of claimant's permanent disability. 36 Van Natta 377 (1984).

The SAIF Corporation has requested that the Board authorize

its recovery of temporary total disability compensation paid pursuant to the terms of the Referee's order and pending Board review, by entering an order allowing SAIF to offset this compensation against existing permanent partial disability awarded by the aforementioned Determination Orders and future permanent partial disability that the Referee may award on remand. See generally Forney v. Western States Plywood, 66 Or App 155 (1983). We regard this request as one for reconsideration of our Order on Review.

Compensation paid pending Board review, which is ultimately determined to have been erroneously ordered, is not subject to recovery by offset or otherwise. ORS 656.313(2); Glenn O. Hall, 35 Van Natta 275 (1983); see also Hutchinson v. Louisiana-Pacific Corp., 67 Or App 577 (1984). Accordingly, SAIF's request is denied.

ORDER

On reconsideration of the Order on Review dated March 30, 1984, the Board supplements its prior order by denying the SAIF Corporation's request for an offset of temporary total disability compensation paid pending Board review. Except as supplemented, the Board adheres to its prior order, which hereby is readopted and republished.

JOHN E. RUSSELL, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-01841
April 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Shebley's order which upheld the insurer's partial denials on the grounds that claimant failed to request a hearing within 60 days and failed to establish good cause for requesting a hearing beyond 60 days. ORS 656.319(1).

At hearing two partial denials were in contention: One dated October 4, 1982 by which the insurer denied the compensability of claimant's dental problem; and one dated December 22, 1982 by which the insurer denied the compensability of claimant's neck, back and hip conditions. On review claimant has abandoned any challenge to the denial of compensability of his dental problems; and claimant does not argue that the Referee's good cause finding is in error. Claimant contends only that the insurer's December 22, 1982 denial is a backup denial, is thus prohibited by the Supreme Court's subsequent decision in Bauman v. SAIF, 295 Or 788 (1983), and that, therefore, the denial should be set aside despite claimant's failure to request a hearing in a timely manner.

We have serious doubts that the Bauman doctrine can or should be applied to partial denials. However, assuming arguendo that a partial denial can ever be invalid because of Bauman, and that the partial denial here in issue is therefore invalid if we were to reach the merits, we nevertheless conclude that claimant's failure to request a hearing in a timely manner makes it impossible to reach the merits. 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."

See also ORS 656.262(8) ("The worker may request a hearing on the denial at any time within 60 days after the mailing of the notice of denial."); Norton v. Compensation Department, 252 Or 75 (1968); Madwell v. Salvation Army, 49 Or App 713, 715 (1980).

In order to vest this agency with jurisdiction to decide the propriety of an employer/insurer's denial, it is incumbent upon an aggrieved claimant to request a hearing within the 60 day period. There is a good cause exception, ORS 656.319(1)(b), but good cause is not now in issue in this case. In order to find in claimant's favor, therefore, we would have to be persuaded that the Bauman court intended to create another exception to the statutory and jurisdictional requirement that a hearing be requested within 60 days, assuming the authority of the court to do so.

While this case involves a hearing requested just a couple of days after expiration of the statutory period, under claimant's reading of Bauman a hearing could be requested on a backup denial without any time limit and thus possibly many years after the denial was issued. We are not persuaded that the Supreme Court intended such a result in Bauman.

Accordingly, we agree with the Referee's conclusion that the insurer's partial denial necessarily remains in effect. We note, however, that the proper disposition of claimant's hearing request would be dismissal for lack of jurisdiction, and we modify the Referee's order to so provide.

ORDER

The Referee's order dated August 8, 1983 is modified to provide that claimant's request for hearing is dismissed for lack of jurisdiction. The Referee's order is affirmed as modified.

DEBORAH A. WELCH, Claimant
Evohl Malagon, Claimant's Attorney
Gates, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 83-03524
April 30, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Quillinan's order which granted claimant an award of 7.5° for 5% scheduled disability for each hand. Extent of disability is the only issue on review.

The Board affirms the order of the Referee. In view of the medical evidence which indicates little or no physical impairment

following claimant's surgery for bilateral carpal tunnel syndrome, we think the contrary lay testimony is insufficient to support any award greater than that granted by the Referee. See Hilaria O. Silva, 35 Van Natta 1223 (1983); James G. Thomas, 35 Van Natta 714 (1983).

ORDER

The Referee's order dated October 19, 1983 is affirmed.

VERNON K. BARKER, Claimant
SAIF Corp Legal, Defense Attorney

WCB 82-11715
May 3, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Knapp's order which upheld the SAIF Corporation's denial of claimant's claim for neck pain, headaches and dizzy spells. The primary issue on review is compensability.

Claimant's request for Board review refers to "new medical evidence not available at the time of hearing" in connection with a myelogram and orthopedic examination in August of 1983. With the assistance of the SAIF Corporation, we have obtained copies of an August 5, 1983 report from claimant's physician and an August 3, 1983 myelogram report. In addition, SAIF has provided reports relative to claimant's March 1983 hospitalization in Tuality Community Hospital. The discharge summary written in connection with this hospitalization is part of the record developed before the Referee, although the additional hospital records are not part of the record. We have considered this additional material solely for the purpose of determining whether to remand this case to the Referee for further evidence taking pursuant to ORS 656.295(5).

The Referee concluded that claimant had failed to establish legal and medical causation. He found claimant's allegation that he sustained an accidental injury to be "strongly suspect." He further concluded that claimant failed to establish the requisite causal connection between his work activity and his present symptomatology. None of the additional evidentiary material, particularly the August 1983 myelogram report and related physician's report, suggests the conclusion that the record of this case has been incompletely developed on the legal and medical causation issues. We conclude that a remand for further evidence taking is not warranted.

On the merits of the compensability of this claim, we affirm the Referee's order.

ORDER

The Referee's order dated July 11, 1983 is affirmed.

RALPH J. BENCOACH, Claimant
Flaxel, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 81-11360
May 3, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Baker's order which awarded claimant 256° for 80% unscheduled permanent disability for injury to claimant's low back on review of a Determination Order which awarded no compensation for permanent disability. The Referee also modified the Determination Order by establishing claimant's five-year aggravation period as commencing December 10, 1981. There are primarily two issues on review: (1) Whether this Determination Order properly was issued pursuant to ORS 656.268, or whether this claim closure should have been effected by the Board pursuant to ORS 656.278; and (2) the extent of claimant's permanent disability, including permanent total disability.

The pertinent facts were succinctly stated by the Referee and are as follows. Claimant sustained a compensable injury to his back on December 4, 1973, when, while using a picaroon to unplug a hammer hog, he slipped and fell backward, wrenching his back. On December 7, 1973, claimant completed and signed a workers' compensation claim form. He was examined by Dr. French on December 7, 1973. The diagnosis was low back strain. Heat, analgesics, muscle relaxants and a lumbosacral belt were the prescribed treatment. Dr. French noted that claimant had experienced pain occasionally in the same area of his back without injury. The physician's report form completed by Dr. French indicated that claimant's condition was not medically stationary, that further treatment would be required, that claimant's injury did not prevent his return to regular employment, and that it was undetermined whether the injury would result in permanent impairment. The claim was accepted by the employer, apparently as a disabling injury, as evidenced by a handwritten entry on the injury claim form.

Claimant continued to work following his injury without losing time from work. His job duties were not very demanding, and he wore the prescribed corset. His back pain persisted, but, except for some limitations in stooping and bending, did not interfere with his work. Claimant found that he had to sleep on his side because of his back pain, and he suffered some lack of sleep. He did not return to Dr. French after December 8, 1973.

The employer sent a letter to claimant, dated April 12, 1974, advising claimant that if he was continuing to experience difficulty with his industrial injury, he should so advise the employer and contact his physician for an appointment. The employer advised that, in the absence of some word from claimant or his doctor within two weeks, it would be assumed that claimant was well, and the employer would submit the claim for closure. Claimant testified that, after receiving the letter, he spoke with an employer representative and informed the representative that his back was continuing to bother him, that Dr. French had not helped, and that he would like to consult a specialist. Claimant testified: "That is the last I heard from them." The Referee found claimant's testimony credible, and we have no reason to question this finding, although it is conceivable that, considering the passage of time, claimant's memory concerning the exact series of events might be slightly blurred.

On June 25, 1974, the employer submitted a final report form requesting claim closure, indicating that claimant had lost no time from work, that his medical treatment had been completed, and that his condition was medically stationary. A physician's supplemental report form completed by Dr. French on March 15, 1974, had indicated that it was unknown whether or when claimant's condition had become medically stationary. The employer's final report form noted that no reply to the April 12, 1974 inquiry had been received.

There is nothing in the record to indicate that any further action was taken, either on the part of the employer or the Workers' Compensation Board, to effectuate closure of the claim.

The record contains a handwritten letter from claimant to the employer, dated January 20, 1977, which documents a telephone conversation between claimant and one of the employer's representatives. Claimant advised that his back was no better, that he was required to wear his corset during the day and night, and that he wanted to have his claim "reopened." Claimant also advised that he would try to see a doctor "as soon as possible."

Claimant began treatment with Dr. Bert, an orthopedic surgeon, who first examined claimant on February 24, 1977. Claimant gave the history of intermittent pain since the 1973 injury, which had increased during the preceding ten weeks. Dr. Bert stated that, according to claimant's history, his current problems were related to his 1973 injury. On May 9, 1977, the employer advised claimant that his claim had been "reopened for medical benefits only at this time." Claimant was continuing to work, and the employer requested that it be advised immediately in the event that claimant began losing time from work.

There is no further documentary evidence until October 5, 1979, at which time claimant consulted Dr. Bert with complaints of back pain, "which has been progressive since I last saw him in 1977." Dr. Bert prescribed an analgesic, and claimant continued working.

On July 1, 1980, claimant's attorney requested information from the employer with respect to claimant's back claim, as well as a 1978 claim for injury to the left hand or thumb. A subsequent letter from counsel to the employer, dated September 2, 1980, confirms a telephone conversation and states, in part:

> "I understand that you now believe the back claim should be handled as a disabling injury and will so notify the Workers' Compensation Department, and that when appropriate, the claim will be submitted for determination.
>
> * * *
>
> "Please provide me a with a copy of your notice to the Workers' Compensation Department advising them the back condition is being treated as disabling, and also of your notice to the claimant advising him of his appointment with Dr. Bert."

The employer scheduled an appointment for claimant with Dr. Bert, for the purpose of evaluating the extent of claimant's permanent disability resulting from his back and left hand/thumb injuries. Claimant was advised of this appointment by the employer's letter dated September 8, 1980. On September 17, 1980, the employer submitted a Form 1502 to the Compliance Division of the Workers' Compensation Department, advising that claimant's 1973 injury had been accepted as disabling. This Form 1502 is designated as the insurer's first report and notes: "No compensation paid -- possibility that this claim may be disabling."

Dr. Bert examined claimant on October 22, 1980. In connection with claimant's back condition, Dr. Bert diagnosed progressive degenerative arthritis of the lumbar spine. Dr. Bert authorized time loss, stating: "Will keep him off work for two weeks and recheck at that point in time. I believe we are approaching a time when this gentleman should no longer do his work because of increasing discomfort in his back." Dr. Bert found claimant's thumb condition medically stationary.

In a report dated March 6, 1981, Dr. Bert stated that claimant's pain, at the present time, was stationary:

> "* * * [T]hat is, it has not changed in the past several months. It is considerable when he attempts to stand quickly, when he sits too long or when he walks any great distance. There is no gross neurologic deficit in his lower extremities but he is restricted in motion in all planes, perhaps 50% of normal. He is taking continuously Naproxen and Tranxene for discomfort relief [sic]. His old job is that of a clarifier operator which he states now has additional duties including cleaning up and some climbing and loading waste lumber.
>
> * * *
>
> "I feel he will not return to his old job and is fit only for the lightest of duty, where he would not have to sit or stand for any length of time and could frequently change positions and certainly no lifting or climbing. I feel he could be released for this very light duty at the present time. I feel his impairment is permanent and that there will be some slow deterioration with time."

On March 23, 1981, the employer submitted a Form 1503 requesting a Determination Order closing claimant's 1973 injury claim.

There is no indication in the record developed before the Referee as to how the request for closure made its way from the Evaluation Division of the Workers' Compensation Department to the Workers' Compensation Board; however, it is apparent that the Evaluation Division referred the claim to the Board for closure

pursuant to the provisions of ORS 656.278, on the basis of a perception that the proper procedural avenue by which to effect claim closure was through the Board's exercise of its own motion authority. By an Own Motion Determination Order dated May 6, 1981, the Board awarded claimant compensation for temporary total disability from October 22, 1980 through March 6, 1981, and no compensation for permanent disability. On November 20, 1981, pursuant to a request from claimant's attorney, the Board reconsidered its own motion determination and vacated that order, stating agreement with claimant's contention that the claim should have been closed pursuant to ORS 656.268. The matter was referred to the Evaluation Division for closure.

The Determination Order which gave rise to the present proceeding was entered December 10, 1981, which awarded the same benefits awarded by the Board's previous Own Motion Determination Order. This Determination Order, entered pursuant to ORS 656.268, established the aggravation period as commencing May 6, 1981.

Correspondence subsequently was exchanged by and between counsel for the claimant, counsel for the employer and the Workers' Compensation Board, by and through the chairman. Counsel for the employer advised the Board that a copy of the Board's November 20, 1981 Order on Reconsideration had not been forwarded to his office, in spite of the fact that the Board had been notified of his representation. Counsel for the employer requested that the Order on Reconsideration itself be reconsidered, set aside or held in abeyance, "pending full and fair opportunity to have the issues involved litigated."

The parties took the deposition of Dr. Bert in order to obtain his explanation of the relationship between claimant's 1973 injury and the present diagnosis of degenerative arthritis.

Claimant requested a hearing contesting the Determination Order dated December 10, 1981 and also requested penalties and attorney fees. The employer responded that claimant admittedly sustained the nondisabling compensable injury on December, 1973; that no determination was made with regard to the claim; that the nondisabling injury did not become disabling on or before December 4, 1978; that, therefore, claimant's aggravation rights expired on December 4, 1978; that the Determination Order of December 10, 1981 was entered in error for lack of jurisdiction; and that the Hearings Division, additionally, lacked jurisdiction with regard to the nondisabling injury of December 4, 1973. The employer also contended that the conditions for which Dr. Bert was treating claimant were not compensable. Claimant filed a reply, stating that claimant's aggravation rights never began to run; that the employer's request that the Board reconsider or vacate its November 20, 1981 Order on Reconsideration had become final and, therefore, the employer could not object to entry of the December 10, 1981 Determination Order pursuant to ORS 656.268; alternatively, that the employer voluntarily reopened the claim, provided benefits and requested a Determination Order pursuant to ORS 656.278(4) (which, according to claimant's contentions, somehow leads to the conclusion that the employer is prevented from objecting to the jurisdiction of the Workers' Compensation Department to enter its Determination Order); and that the employer should be ordered to pay claimant's attorney a reasonable fee pursuant to ORS 656.382(2), as well as ORS 656.382(3), for initiating a request for hearing without reasonable grounds.

I

As is apparent from the introductory portion of this order, the Referee concluded that claimant's aggravation rights had not expired and that claimant, therefore, was entitled to a Determination Order as a matter of right pursuant to ORS 656.268, which includes the right to request a hearing pursuant to ORS 656.283. It is implicit in the Referee's reasoning that he determined the claim was originally one for a disabling injury, rather than a non-disabling injury. For the following reasons, we agree with the Referee's determination concerning the procedural/jurisdictional issue presented in this case, and we affirm that portion of his order.

We note that the effect of the Board's November 20, 1981 Order on Reconsideration vacating the prior Own Motion Determination was an issue which permeated the proceeding before the Referee, who concluded that:

> "* * * [T]he Board Order of November 20, 1981 remains in effect and is binding on the referee. I conclude that the Determination Order of December 10, 1981 was procedurally proper pursuant to the Board referral, and also pursuant to the employer's request for a determination of March 23, 1981."

The Board's order had no "binding effect" on either the parties or the Referee. The only effect of this order was to rescind the May 6, 1981 Own Motion Determination Order and thereby wipe the slate clean, allowing the parties to litigate the jurisdictional issue concerning the proper procedure for claim closure. The Board's act, pursuant to ORS 656.278, of withdrawing its prior order and referring the matter to the Evaluation Division had no effect other than to allow the parties a full and fair opportunity to present evidence and argument on the jurisdictional issue, and to allow the Referee to make his determination on a complete record, to the fullest extent possible. Nor did the employer's failure to appeal the Board's order have any procedural or substantive effect. Indeed, it is very questionable whether the employer had any right to appeal this order. ORS 656.278(3).

We believe that the jurisdictional question is determined by answering the threshold question of whether claimant's injury claim, from its inception, was one for a nondisabling injury, or a disabling injury. An examination of the statutes in effect at the time of claimant's December 1973 injury, ORS 656.202(2), as well as some of our own decisions, leads us to conclude that if claimant's original claim was one for a nondisabling injury, claim closure properly should have been effected pursuant to ORS 656.278; but that if the claim originally was one for a disabling injury, closure by the Evaluation Division pursuant to ORS 656.268 was proper.

Claimant's injury occurred on December 4, 1973. Amendments to former ORS 656.002, 656.262, 656.268, as well as the repeal of former ORS 656.271 and the enactment of ORS 656.273, recently had

become effective on October 5, 1973, by virtue of Oregon Laws 1973, chapter 620. On the date of claimant's injury two months later, these statutes provide as follows.

ORS 656.002(7):

> "(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.
>
> "(b) 'disabling compensable injury' is an injury which entitles the workman to compensation for disability or death.
>
> "(c) 'nondisabling compensable injury' is any injury which requires medical services only."

ORS 656.262(5):

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the fund or direct responsibility employer within 60 days after the employer has notice or knowledge of the claim. The fund shall also furnish the contributing employer a copy of the notice of acceptance. The notice of acceptance shall:
>
> "(a) Advise the claimant whether the claim is considered disabling or nondisabling.
>
> "(b) Inform the claimant of hearing and aggravation rights concerning nondisabling injuries including the right to a decision that his injury is nondisabling by requesting a determination thereon pursuant to ORS 656.268."

ORS 656.262(10):

> "The fund and all direct responsibility employers shall report every claim for disabling injury to the board within 21 days after the date the employer has notice or knowledge of such injury. If within one year after the injury, a workman claims a nondisabling injury has become disabling, the fund or direct responsibility employer shall report the claim to the board immediately after receiving notice or knowledge of such claim. A claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as for a claim for aggravation."

ORS 656.268:

"(2) When the injured workman's condition resulting from a disabling injury has become medically stationary . . . the State Accident Insurance Fund or direct responsibility employer shall so notify the Board, the workman, and contributing employer, if any, and request the claim be examined and further compensation, if any, be determined. * * * *

"(3) Within 30 days after the Board receives the medical reports relating to a disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the Board's supervision. * * * *

"(4) The Board shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination made under subsection (3) of this section within one year after copies of the determination are mailed.

* * *

"(6) Upon receipt of a request made pursuant to subsection (6) of ORS 656.262, the board shall determine whether the claim is disabling or nondisabling. A copy of such determination shall be mailed to all interested parties in accordance with subsection (4) of this section."

ORS 656.273:

"(1) After the last award or arrangement of compensation, an injured workman is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury.

* * *

"(3)(a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the first determination made under subsection (3) of ORS 656.268.

"(b) If no determination was made, the claim for aggravation must be filed within five years after the date of injury.

"(c) If a nondisabling injury did not become disabling within at least one year from the termination of medical services, the claim for aggravation must be filed

within five years from the date of injury rather than the date of any detrmination issued in the claim."

Prior to the 1973 amendment, ORS 676.268, governing the procedure for claim closure, contained no specific reference to closure of a claim "resulting from a disabling injury" or "relating to a disabling injury." In addition, the 1973 Act imposed upon the employer or insurer the obligation to notify the claimant as to whether the claim had been accepted as one for a disabling injury or a nondisabling injury, and provided the procedure for the claimant to contest the nondisabling classification, as well as the substantive right to do so.

By virtue of the 1973 amendments to ORS 656.268, employers and insurers were no longer obligated to submit a claim to the Board for closure where the claim was one for "medicals only," i.e. a nondisabling injury claim. This apparently represented a codification of an administrative procedure that had been implemented by the Board shortly after its creation in 1965. This procedure of administratively closing a "medical only" claim was discussed in Elizabeth Simmons, 11 Van Natta 282, 286 (1974):

> "The Workmen's Compensation Board was created by the 1965 Oregon Legislature. Among other duties it was assigned the task of evaluating claims and determining compensation.
>
> "On May 4, 1966, the Board issued its first rules of practice and procedure. Those rules, WCB 5-1966, provided --
>
> > '4.01 The law requires the Board to make a determination of compensation due on every compensable injury.
> >
> > * * *
> >
> > '4.05 The Board will refer all such requests for determination to the Closing and Evaluation Division. This division will, in addition to necessary administrative personnel, be assigned a full-time physician and assistant attorney general for the purpose of resolving medical and legal issues.
> >
> > '* * *
> >
> > '4.07 The determinations of the Closing and Evaluation Division shall be deemed determinations of the Board. The determinations shall be deemed made the date the determination is mailed to the parties.'
>
> "The agency soon learned that the great majority of the approximately 100,000

> injury claims each year involved only nominal medical care. Realizing that formally closing these claims would result in enormous administrative costs, and because the statute permits the employer to specifically request a determination in any case, the Board concluded an informal 'administrative' closure could sufficiently fulfill and carry out the legislative intent while saving the unnecessary costs. The administrative practice of making 'medical only' closures was therefore developed. In the process an estimated one million dollars of unproductive administrative expense, a cost ultimately borne by employers, was saved. It was the Board's position, however, that since no formal written Determination Order was issued or mailed, the medical only closure did not, under ORS 656.268(4), start the running of the aggravation."

Although it is not necessarily relevant to the issue before us, it is interesting to note, for the historical perspective it lends, that by Oregon Laws 1979, chapter 839, the legislature created the "carrier closure" provisions presently codified as ORS 656.268(3), for nondisabling injury claims or disabling injury claims where there is no permanent disability. This 1979 Act made appropriate amendments to the aggravation statute, ORS 656.273. (We note in passing that this 1979 Act created or perpetrated an ambiguity concerning the "obligation" of the employer or insurer to "close" a "medicals only" claim.)

Under the newly effective law at the time of claimant's injury in December of 1973, and the employer's acceptance during that same month, the employer was obligated to inform claimant as to whether his claim was accepted as one for a disabling or nondisabling injury. Claimant had a panoply of rights in this regard, including the right to contest the nondisabling classification in the event that he believed he sustained a disabling injury. There is no evidence that the employer notified claimant that his injury had been accepted as nondisabling. In fact, the only evidence, the reliability or value of which the employer attempts to minimize, is the handwritten entry of "disabling" in that portion of the injury report form provided for the employer's acceptance or denial of the claim. It is also interesting, although possibly not terribly informative, that, although there is a space provided for the employer to designate whether the "workman's condition is medically stationary," this box does not appear to have been checked off. We appear to be confronted with a situation in which the employer, at the inception of the claim and during the processing of what might otherwise be considered an aggravation claim (reference is made to the employer's request for closure submitted to the Evaluation Division in 1981), the employer well may have believed that the claim was, or should have been processed as, one for a disabling injury; but the employer now contends that the injury, from its inception, was nondisabling and only recently, i.e. during October of 1980, <u>became</u> disabling. The difference is crucial with respect to claimant's continuing rights under the Workers' Compensation Act.

Assuming, for the sake of analysis, that claimant's original injury actually was nondisabling, it is tempting to say that, in view of the employer's failure to properly notify claimant that his claim was being classified as nondisabling, his aggravation rights never expired. Indeed, the evidence indicates that claimant's condition did worsen during 1977 and again in 1979, which ultimately led to claimant's being taken off work by Dr. Bert in October of 1980. This "claim reopening" in 1980, which resulted in the employer's request for claim closure in March of 1981, could only be considered an "aggravation reopening" pursuant to ORS 656.273 if the aggravation period somehow was tolled by the insurer's failure to notify the claimant, at the inception of the claim, of the fact that his claim was accepted as one for a nondisabling injury. We so held in Virgil Young, 28 Van Natta 658 (1980).

> "There is no evidence in this case that the employer advised claimant in writing that his claim was accepted, that his claim was considered nondisabling or informed claimant of his hearing and aggravation rights concerning a nondisabling injury including his right to object to the decision that his injury was nondisabling by requesting a determination of it. As a result of the employer's failure to so notify claimant, his claim is still open. The employer has the duty to process the claim. In this case the employer has failed to do so. Since there has never been a closure of claimant's claim, the Board finds it is not possible to rule on an aggravation of the original injury. Therefore, the Board . . . remand[s] the claim to the employer for processing of the claim and payment of benefits due under Oregon Workers' Compensation Law." 28 Van Natta at 660.

We distinguished the holding in Young by our subsequent decision in Darreld W. Rayl, 34 Van Natta 1204 (1982), by holding that because claimant's "aggravation claim" in that case was filed beyond the five year limitation period for nondisabling injuries under the law in effect at the time of claimant's 1975 injury (ORS 656.273(4), the same provision in effect on the date of claimant's 1973 injury in this case, then Subsection (3), claimant's aggravation rights had expired.

> "Had the aggravation claim in this case been filed within five years of the date of claimant's injury, we would agree that the claim would have remained in an open status based on Virgil Young. However, despite the fact that a claimant may not have received notification under ORS 656.262(5), the statute in effect at the time of the claimant's injury established an absolute aggravation period of five years from the

> date of injury for nondisabling injuries which were not submitted for determination pursuant to ORS 656.268." 34 Van Natta at 1205-06.

See also Ronald Queen, 34 Van Natta 116 (1982) (under the law in effect before the 1973 Act amending ORS 656.268 and creating ORS 656.273, which provided for commencement of the aggravation as of the date of injury, administrative "medical only" closures would not start the running of the aggravation); Elizabeth Simmons, supra.

This case is arguably different from the above-cited cases in which the employer or insurer failed to properly process the claim under the applicable provisions of law. At the time the claim arose and claimant's injury was accepted, as previously noted, the new law requiring notice of the claimant's rights vis-a-vis the disabling-nondisabling classification had been in effect for approximately two months. In addition, and perhaps most significantly, it is all too apparent that any inference that arises, concerning nonfeasance or misfeasance in the processing of this claim, points not to wrongdoing, if any, on the part of the employer; rather it appears that the employer submitted the claim for closure pursuant to the provisions of ORS 656.268, but the Board took no action to close the claim. Perhaps no action was taken in view of the fact that when the claim was submitted for closure in June of 1974, the existing statute provided for closure of "disabling injuries," and the final report form completed by the employer indicated that claimant had returned to work the day after his injury and no temporary disability had been incurred. See ORS 656.210(3) (subsection (4) in 1973). Perhaps the responsibility was shared, possibly due in part to the employer's failure to obtain a definitive closing examination and statement of a medically stationary date. ORS 656.268(2). In any event, the facts that the employer submitted the claim for closure and that the Board did not close the claim are only some evidence in support of the inferences that the employer believed the claim was disabling and the Board believed it was not. These facts are not, however, determinative in light of the statutes and cases discussed above. What is crucial is whether, in fact, claimant's original injury was disabling.

We find and hold that claimant's injury, from its inception, was disabling. We reject the employer's present arguments to the contrary. The employer's nondisabling theory is based upon the premise that claimant did not incur any compensable temporary disability until October 1980, almost seven years after his industrial injury. This is a fact; but a fact which does not, in and of itself, resolve the controversy.

The 1973 Act stated the definition of a "disabling compensable injury" as one which entitles the worker to "compensation for disability or death." The definition has remained the same. See present ORS 656.005(8)(b). The statute does not define a disabling injury as one which results in temporary disability, and the entire statutory scheme, as it existed in 1973 and had since developed, indicates the clear legislative intent that, in determining whether to process a claim as one for a disabling or nondisabling injury, the employer or its insurer shall consider not only the presence or absence of compensable temporary disability, but also the likelihood that the injury will result in

permanent disability. The most graphic example that comes to mind is the situation of a worker who sustains a traumatic amputation of a portion of a finger on a Friday, leaves work to seek medical attention and returns to work the following Monday. Under such circumstances it is clear that the worker will sustain permanent disability in spite of his or her ability to continue working.

A bulletin published by the Workmen's Compensation Board subsequent to enactment of the 1973 amendments discussed above, established a procedure for determination of the disabling or nondisabling status of an injury when requested by a worker as provided by ORS 656.262. Workmen's Compensation Board Bulletin No. 99 (November 2, 1973). The bulletin provided in part:

> "A claim shall be considered disabling for the purpose of this Bulletin if:
>
> "(1) The worker has lost time from work beyond the three-day waiting period.
>
> "(2) The worker was returned to modified work by his doctor and the modification to his work resulted in a reduction in pay.
>
> "(3) If permanent impairment as a result of this injury is obvious or highly probable."

In view of the current provisions for closure by the insurer or self-insured employer, it would presently appear as though, as a general rule, doubt should be resolved in favor of classifying a claim as one for a disabling injury.

The following facts support our conclusion that this claim, from its inception, was one for a disabling injury. The injury resulted in a low back strain. The history was one of prior occasional pain in the same area without injury. X-rays taken three months before disclosed that the L5 vertebra was sacralized, and some arthritic changes were present. Dr. French's March 15, 1974 supplemental report form indicated that claimant's back continued to be symptomatic "off and on," although claimant usually stayed on the job. Claimant's testimony, as well as the history related to Dr. Bert in February of 1977, establish that claimant experienced pain on a continuing basis; that he continued to wear the corset prescribed by Dr. French; and that he experienced difficulty sleeping due to pain and discomfort. Claimant was capable of continuing his employment because he had "an easy job," and "[t]here wasn't much to it."

It is certain that the condition of claimant's low back worsened subsequent to his original injury; however, for the reasons stated, we are satisfied that the record establishes the original injury as a disabling injury because it resulted in permanently disabling consequences.

Nothing in this order should be construed as circumventing the reclassification procedures provided by ORS 656.262 and 656.268. The notice contemplated by the statute is a prerequisite to the exercise of these rights and procedures by an injured worker. See generally Anthony A. Bono, 35 Van Natta 1 (1983),

rev'd on other grounds, 66 Or App 138 (1983). In order for us to determine the proper procedure for effecting closure of this claim in 1981, it has been necessary for us to determine whether the claim, from its inception, was one for a disabling injury, or a nondisabling injury.

Having determined that the claim was originally disabling, it follows that the aggravation period in connection with the claim never began to run because: (1) The provisions of ORS 656.268 in effect at the time of claimant's injury required closure by Determination Order in disabling injury claims; and (2) the five year aggravation period commenced as of the date of the first claim closure, ORS 656.273(3)(a). Although ORS 656.273(3)(b) provided that if no determination was made, an aggravation claim must be filed within five years after the date of injury, this provision applied only to nondisabling injury claims.

Accordingly, it was appropriate for the employer to submit the claim to the Evaluation Division for closure by Determination Order pursuant to ORS 656.268. The Determination Order which finally issued on December 10, 1981 marked the beginning of claimant's five year aggravation period. The Evaluation Division apparently considered the Board's original Own Motion Determination as the "first determination" in the claim, as evidenced by the use of the date of the Own Motion Order, May 6, 1981, for commencement of the aggravation period. Aside from the fact that the Board's subsequent Order on Reconsideration vacated the May 6, 1981 Own Motion Determination, the first proper claim closure was by the Determination Order issued pursuant to ORS 656.268. Therefore, it was proper for the Referee to modify the Determination Order to provide that claimant's aggravation rights extend until five years from December 10, 1981.

II

Although it may be implicit in what we have stated with regard to our conclusion that claimant's injury, from its inception, was a disabling injury, we explicitly find and hold that the employer's contention that it is not responsible for the progressive degenerative deterioration of claimant's lumbar spine is not supported by the evidence. In fact Dr. Bert's reports and deposition constitute the only medical opinion discussing the interrelationship of claimant's original industrial injury and the progressive degenerative changes of claimant's lumbar spine. This opinion, quite clearly, establishes that claimant's 1973 injury is a material contributing cause to the present condition of claimant's low back, diagnosed as progressive degenerative arthritis (lumbar spondylosis).

This compensability-type issue is part and parcel of the question concerning the extent of claimant's permanent disability. See Frank Mason, 34 Van Natta 568, aff'd. without opinion, 60 Or App 786 (1982); Emmons v. SAIF, 34 Or App 603 (1978). In his respondent's brief on review, claimant contends that the Referee erred by failing to award compensation for permanent total disability. The employer argues that not only is claimant not permanently and totally disabled as a result of his 1973 industrial injury, claimant has failed to establish that his present disabling low back condition results from the compensable injury.

We agree with the Referee's conclusion that claimant is not permanently and totally disabled. We have already stated our conclusion that claimant's present low back condition, as established by a preponderance of the persuasive evidence, is causally related to his original industrial injury. We find, however, that the Referee's award of 256° for 80% unscheduled disability is excessive. According to our evaluation of the evidence, claimant's physical impairment is in the range of 50%. Considering this factor together with relevant social/vocational factors, which include the claimant's age of 59, his tenth grade education and two years of undergraduate study at the University of Washington, his work experience as a clerk, cashier, grocery manager, retirement fund claims examiner and sawmill worker, as well as claimant's residual capacity to perform only light work, we find that claimant is adequately compensated by an award of 192° for 60% of the maximum allowable for unscheduled disability. We modify the Referee's order accordingly.

III

Claimant raises an issue concerning his attorney's entitlement to an insurer-paid fee. The Referee declined to award a fee in addition to claimant's compensation because "these proceedings were initiated by the claimant." Although claimant contended at hearing that he was entitled to a penalty and associated attorney's fee, see generally ORS 656.262(10), 656.382(1), (3) any such contention appears to have been abandoned on review. Claimant's single argument in support of his entitlement to an insurer-paid fee is premised upon ORS 656.382(2), which presently provides in pertinent part:

> "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's fee . . . . "

This provision has been substantially the same at all times material herein.

Subsequent to issuance of the Referee's order, the Supreme Court interpreted this statutory provision in the context of entitlement to an insurer-paid fee before the Court of Appeals, where the claimant had initiated judicial review raising an issue concerning attorney fees, the employer cross-appealed raising a compensability issue, the claimant prevailed on the compensability issue, and the Court of Appeals denied claimant's petition for a reasonable attorney's fee. Teel v. Weyerhaeuser Co., 294 Or 588 (1983). The Supreme Court reversed and remanded to the Court of Appeals for an award of fees holding: "[T]he word 'initiated' encompasses raising issues that would otherwise not be dealt with by the reviewing body, and thus an initiation may take the form of a cross-appeal." 294 Or at 590.

Claimant contends that, although he initiated the hearings procedure by requesting a hearing contesting the Determination Order and seeking additional compensation, the employer, in essence, cross-requested a hearing raising the additional issue of claimant's entitlement to claim closure pursuant to the provisions of ORS 656.268. We find, as a matter of fact, that significant effort was expended by claimant's attorney in order to establish that the claim closure by the Evaluation Division was proper, and that the employer raised an issue which otherwise would not have been dealt with by the Referee. It is true that claimant's original hearing request designated as an issue the proper date to commence the aggravation period (i.e. May 6, 1981, or December 10, 1981); however, in the absence of the employer's response, which, for all intent and purposes served as a cross-request for hearing, the question concerning the jurisdictional foundation for the Determination Order would not have been an issue. Accordingly, we find that claimant's attorney was entitled to an insurer-paid fee, in addition to the fee payable out of claimant's additional compensation, for services at hearing.

ORDER

The Referee's order dated October 26, 1982 is modified in part. In lieu of the Referee's award of 256° for 80% unscheduled disability, claimant is awarded 192° for 60% unscheduled permanent partial disability for injury to his low back. The maximum attorney's fee payable out of claimant's compensation under the terms of the Referee's order and this order is $2,000. Claimant's attorney is awarded an additional fee of $800 for prevailing on the jurisdictional issue raised by the employer at hearing, to be paid by the employer in addition to and not out of claimant's compensation. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $600 for services on Board review in connection with the procedural/jurisdictional issue, to be paid by the employer.

For purposes of clarity, we reiterate that the five year aggravation period runs from December 10, 1981.

KATHERINE E. CASTEEL, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-03575 & 82-03576
May 3, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Daron's order which found that the SAIF Corporation was entitled to credit total disability benefits paid pending review of a Referee's order in a prior proceeding, against the Court of Appeals' final determination of partial disability in that prior case. Claimant contends the Board should follow the holding of Glenn O. Hall, 35 Van Natta 275 (1983), and reverse the Referee's order.

We find the present case analogous to Hall and reverse the Referee's order. In Hall we held, pursuant to ORS 656.313(2), that amounts paid pending review are not subject to recovery by offset or other means. In accordance with Hall, we hold that SAIF is not entitled to a credit.

ORDER

The Referee's order dated September 23, 1983 is reversed. The SAIF Corporation is not entitled to credit total disability benefits paid pending review of a Referee's order against the Court of Appeals' final determination of partial disability. Claimant shall be paid and receive $3,362.44, the amount withheld from his permanent partial disability award. Claimant's attorney is allowed a reasonable attorney's fee equal to 25% of the increased compensation granted by this order, payable out of claimant's compensation and not in addition thereto.

GOLDIE M. DALLMAN, Claimant
Leeroy Ehlers, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-01057
May 3, 1984
Order on Review

The Board previously entered its Order on Review herein. 34 Van Natta 1223 (1982). We reversed that portion of the Referee's order which set aside the SAIF Corporation's denial of claimant's mental condition and associated hospitalization in January 1981, and we affirmed that portion of the Referee's order which upheld SAIF's denial of claimant's back aggravation claim. The Court of Appeals affirmed and remanded for a determination of the extent of claimant's unscheduled disability in connection with her accepted low back condition. 63 Or App 380 (1983).

Considering the circumstances of this case, including the fact that claimant presented substantial evidence on the issue of the extent of her unscheduled disability at the time of the hearing before Referee Johnson, we have determined that it is more appropriate to evaluate claimant's permanent disability (which we inadvertently failed to do when this case was before us on review) rather than remand to the Referee for further proceedings on this issue.

The relevant facts are that claimant sustained an injury to her low back on December 14, 1978 while working as a jointer for the employer which is engaged in the business of manufacturing furniture. Claimant experienced right sacroiliac discomfort, and, her attending physician, Dr. Weeks, prescribed a lumbosacral corset. Claimant continued to experience low back symptoms, and Dr. Weeks administered an injection for relief of pain. Dr. Weeks had claimant examined by Dr. Smith, another orthopedic physician in the same clinic, who prescribed an anti-inflammatory medication.

Claimant was examined by Dr. Pasquesi in August of 1979. Dr. Pasquesi diagnosed chronic lumbar instability with sciatic radiation of pain. He recommended claim closure and stated that claimant had chronic moderate pain equivalent to 10% impairment of the whole person. Dr. Weeks subsequently stated that he did not concur with Dr. Pasquesi's findings, apparently referring to Dr. Pasquesi's recommendation concerning claim closure.

Claimant was examined by Dr. Dumke in September of 1979. He diagnosed low back strain and possible nerve root compression phenomenon, and he found it appropriate to make a thorough evaluation and rule out all possibilities of nerve root disease. Accordingly, claimant submitted to a myelogram which was negative.

Dr. Dumke concluded that the nature of claimant's low back condition was a lumbosacral strain.

On December 10, 1979 Dr. Weeks reported that claimant's low back continued to cause her discomfort and that this condition would be likely to interfere with her employment.

By January of 1980 claimant was not taking any medication, and her treatment consisted primarily of physical therapy. On January 16, 1980, Dr. Weeks reported that claimant's work limitations would consist of no bending or stooping, no lifting in excess of 15 pounds and no prolonged sitting.

Claimant was examined by Orthopaedic Consultants on February 27, 1980. Their diagnosis was strain of the lumbosacral spine without evidence of radicular pain. They concluded that claimant was capable of returning to her previous occupation, although with limitations. Her work limitations, according to the Consultants, placed claimant in the light work category, with limited bending and alternating standing and sitting during the day. Lifting was to be limited to 15 pounds and carrying to 25 pounds. The Consultants found the total loss of function of claimant's back to be in the mild category, and the total loss of function due to claimant's industrial injury to be the same.

A Determination Order was issued on April 11, 1980, awarding claimant compensation for temporary total disability through February 27, 1980, and 80° for 25% unscheduled disability for injury to the low back.

Claimant apparently was unable to return to work with this employer because there were no limited work positions available. With vocational assistance, claimant was able to obtain a part-time job working in a plant and flower shop, where she began to work in May of 1980. She eventually was required to terminate this employment, primarily due to the effect of her job activities upon her low back condition.

Dr. Weeks reported on May 9, 1980 that claimant was experiencing increasing back discomfort. He believed this to be a continuation of her industrial condition, and he gave claimant a prescription to obtain a transcutaneous nerve stimulator. On October 3, 1980, Dr. Weeks reported mild to moderate improvement in claimant's condition, apparently as a result of the TNS unit. Claimant indicated her desire to see a chiropractor, and Dr. Weeks recommended that claimant be permitted to do so.

On November 14, 1980, Dr. Weeks stated that claimant's condition had not improved with physical therapy. His examination demonstrated mild limitation of motion in the lumbosacral area and increased discomfort to palpation associated with paravertebral muscle spasm. He stated that claimant had stopped working as of approximately October 13, and he recommended that she continue to remain off work until further evaluation. He prescribed medication, physical therapy two to three times a week, use of the lumbosacral corset and TNS unit and other conservative measures.

Claimant was examined by Dr. Puziss on December 2, 1980. He diagnosed a chronic mild low back strain by history. He found that claimant's condition was stationary and not objectively worse than her condition at the time of the Orthopaedic Consultants'

examination. Dr. Puziss reported claimant's limitations as no lifting over 15 pounds, no carrying over 20 to 25 pounds, no repeated stooping and that claimant should occasionally be allowed to stand and walk around a room to change positions. He also stated: "It appears that the patient's symptoms are somewhat exaggerated, but there is no functional interference in this examination."

On March 25, 1981, Dr. Weeks stated his "complete agreement" with Dr. Puziss' report.

Claimant's testimony indicates that she continues to experience the residuals of her chronic low back strain. The owner of the plant and flower shop at which claimant worked on a part-time basis corroborated claimant's testimony that she was unable to continue this employment due to the condition of her low back.

Claimant was 44 years old at the time of hearing. Claimant has an eighth grade education. Her job as a jointer at the time of her injury is considered to require exertion in the medium strength category. Her prior work experience includes employment as a nurse's aide in a psychiatric hospital, as well as a food service worker in such an institution, cannery work working on belts, mill work and working as a maid in hotels. All these jobs involve strength demands in the medium category, as well as other physical demands which claimant is either incapable of performing or capable of performing only on a limited basis.

Based upon the reports of the various examining physicians, as well as claimant's testimony, we find that her physical impairment is in the mild category, and that it is appropriate to assign a positive value in the range of 15 to 20. Utilizing the administrative guidelines for evaluating unscheduled disability, OAR 436-65-600, et seq., and comparing this case to other cases involving similarly situated injured workers, we find that claimant is entitled to an award for 112° or 35% unscheduled disability for injury to her low back, and we modify the Determination Order accordingly.

ORDER

The Determination Order dated April 11, 1980, which awarded claimant 80° for 25% unscheduled disability, is modified. Claimant is awarded an additional 32° or 10% unscheduled disability for a total unscheduled award to date of 112° or 35% of the maximum allowable for injury to the low back. Claimant's attorney is allowed 25% of the additional compensation (32°) awarded herein as a reasonable attorney's fee, payable out of claimant's compensation and not in addition thereto.

MICHAEL S. McCOLLAM, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-11448
May 3, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Mongrain's order which modified the October 28, 1982 Determination Order by increasing claimant's scheduled permanent disability award for his right arm from 50% for 96° to 60% for 115.2°. The Referee also affirmed the Determination Order's award of 15% for 48° for unscheduled permanent disability of claimant's right shoulder, neck and upper back.

We affirm and adopt the Referee's order.

Claimant additionally requests that we approve an attorney fee of $375 to be paid out of claimant's current temporary disability pursuant to OAR 438-47-015. The fee is for claimant's attorney's successful efforts in obtaining the Director's approval for a vocational rehabilitation program for claimant. Although this issue was initially raised at hearing, it was not litigated at that time because the Director's final decision had not yet been rendered. The final decision was obtained after the hearing and before the time of review. We approve this request for attorney fees.

ORDER

The Referee's order dated October 31, 1983 is affirmed. Claimant's attorney is allowed 25% of the compensation for temporary total disability currently being paid to claimant, not to exceed $375.

FLOYD E. ROGERS, Claimant
Leichner, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-07063
May 4, 1984
Order Denying Request to Dismiss

The Board has received respondent's request to dismiss the claimant's request for Board review on the grounds claimant has not filed an appellant's brief.

There is no requirement in the workers' compensation law or the Board rules which indicates that a brief must be filed by appellant or respondent before the Board will review the case. ORS 656.295(5). While briefs are a significant aid in the review process, the failure to file a brief is not grounds for dismissal of a request for review. The request for dismissal hereby is denied.

IT IS SO ORDERED.

GENE TAYLOR, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 82-0129M
May 4, 1984
Own Motion Order

By Own Motion Order dated February 8, 1983 the Board reopened claimant's 1972 shoulder injury claim for payment of temporary total disability commencing November 21, 1982. On or about that date claimant submitted to surgery for revision of his left total shoulder replacement. The most recent information from claimant's physician which has been made available to the Board is a physician's supplemental report form dated November 3, 1983, in which it is indicated that claimant's condition is not medically stationary and that the estimated period for further treatment and temporary disability was three to six months. Claimant's physician also indicated that permanent impairment would result from this injury in the form of limited shoulder function. We note that claimant has received permanent disability awards totaling 310.5° of unscheduled permanent partial disability for injury to his left shoulder.

The SAIF Corporation referred claimant to the Callahan Center for enrollment in the Assessment and Treatment Program in early December of 1983. On January 4, 1984 the Administrator of the Callahan Center consented to the suspension of claimant's compensation benefits pursuant to OAR 436-67-138, until such time as claimant resumed participation in the Center's program. The Administrator's letter advised claimant of his hearing rights pursuant to ORS 656.325 and 656.283. See also OAR 436-54-284; ORS 656.726(4).

On or about February 1, 1984 claimant requested a hearing contesting the suspension of his compensation. That hearing request has been assigned WCB Case No. 84-01144 and is presently pending in the Hearings Division.

SAIF has submitted this own motion claim for closure pursuant to ORS 656.278, noting that claimant has been administratively discharged from the Callahan Center and, as a consequence, has had his compensation suspended pursuant to ORS 656.325 and applicable administrative rules.

There may be a jurisdictional issue concerning the proper forum for determining the propriety of the suspension of claimant's compensation; however, we believe that, for purposes of this own motion order, any present doubt should be resolved in favor of allowing the litigation to proceed in the Hearings Division. See ORS 656.726, 656.325(2) and (6); but see ORS 656.273(4), 656.278. Compare ORS 656.245(1) (the duty to provide medical services continues for the life of the worker). Any potential jurisdictional issue can, and we think should, be addressed in the first instance by a Referee's order pursuant to ORS 656.289.

For the following reasons, we deem it appropriate to provisionally close the own motion aspects of this matter at this time. First, as of this date, the claim has been in open status for about a year and a half as a result of the November 1982 surgery, and the most recent forecast from claimant's doctor -- his November 1983 statement that claimant will likely be

stationary in about three to six months -- suggests that claimant is likely stationary at this time.

Secondly, and more importantly, it now appears that claimant may be entitled to receive compensation for temporary total disability for reasons other than own motion reopening of his claim, and leaving this own motion matter in open status could thus create the possibility of claimant's receipt of double benefits -- a situation certainly not to be encouraged. Upon enrollment in the Callahan Center Assessment and Treatment Program, it presently appears that claimant became entitled to receive temporary total disability benefits under the provisions of ORS 656.726(4). See also OAR 436-67-005(21). To the extent that claimant has a substantive right to receive temporary disability benefits under ORS 656.726 -- a right that claimant is currently asserting in WCB Case No. 84-01144 -- there is no reason, or certainly significantly less reason, for the Board to leave in effect its discretionary February 8, 1983 Own Motion Order, which obligates SAIF to pay claimant temporary total disability compensation "until closure under ORS 656.278." Under these circumstances, we deem it appropriate to terminate SAIF's obligation to process the claim further under our February 1983 Own Motion Order pending resolution of the question of claimant's substantive right to receive compensation in connection with his referral to the Callahan Center.

This is a provisional closure only. We will again entertain a request for additional benefits under our own motion jurisdiction upon resolution of the litigation which is the subject of claimant's hearing request in WCB Case No. 84-01144.

IT IS SO ORDERED.

JOHN C. HALE, Claimant
David Jensen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB TP-83005
May 8, 1984
Order on Reconsideration

Claimant has requested reconsideration of our Third Party Distribution Order entered herein on April 10, 1984, wherein we held that claimant's attorney was not entitled to a fee in excess of 33-1/3% of the proceeds of claimant's third party recovery, as provided by OAR 438-47-095. 36 Van Natta 585 (1984). Claimant's attorney's petition for reconsideration states that the SAIF Corporation, the paying agency, has agreed that 40% of claimant's third party recovery is a reasonable fee in this case.

Counsel apparently is referring to the SAIF Corporation's original submission to the Board, in which counsel for SAIF stated:

> "SAIF is not claiming that an attorney fee of 40 percent is unreasonable under the facts of this case. It simply is stating, however, that it has no authority to allow a fee greater than 33-1/3 percent as provided by OAR 438-47-095."

As the Board's order in this case indicates, it is within the sole province of the Board to authorize payment of an attorney's fee in excess of the maximum amount provided by the

above-referenced administrative rule. Although the paying agency's possible objection to allowance of an enhanced fee is a factor to be considered, its presence or absence is not dispositive. The Board considered all pertinent factors, including the statement of SAIF's counsel, in arriving at its determination that an enhanced fee is not appropriate under the facts and circumstances of this case. No new information has been presented in support of claimant's request; therefore, we adhere to our original determination.

ORDER

On reconsideration of the Third Party Distribution Order dated April 10, 1984, the Board adheres to its prior order, which hereby is readopted and republished.

GARY W. CLARK, Claimant
Olson Law Firm, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 78-06542
May 9, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The insurer requests review of Referee Goss's order which set aside its partial denial of claimant's psychological condition. The insurer also requests that the Board remand the claim to the Referee to consider a medical report which the Referee declined to admit.

We consider the evidentiary issue first. Claimant testified that prior to his industrial injury he had never had psychological problems. The insurer then offered a report of claimant's preemployment medical examination which indicated that claimant previously had psychological problems. Claimant objected to consideration of the report on the basis of the ten day rule, OAR 436-83-400(3). The Referee declined to admit the report. We disagree with the Referee in part. OAR 436-83-400(3) does not require prehearing submission of documentary evidence offered for impeachment. We understand the report of claimant's preemployment physical to be offered to impeach claimant's testimony about lack of prior psychological problems. The report was admissible for this purpose and we have thus considered it on review for this purpose.

On the merits, we reverse. Claimant compensably injured his back in November 1977. Contemporaneous medical reports indicate that claimant suffered a mild strain while lifting. X-rays were unremarkable. In June 1978 claimant attended the Callahan Center. He was thought to have a chronic thoracic strain with anxiety neurosis. In September 1978 Dr. Quan, a psychiatrist, evaluated claimant. He opined that claimant had a preexisting personality disorder. He noted that based on claimant's history, the compensable injury had heightened claimant's anxiety. He opined that claimant's psychological condition had, by that time, returned to its preinjury state.

On November 3, 1978 a Determination Order granted claimant an award for 10% unscheduled disability. In January 1979 claimant's treating physician terminated physical therapy because he felt it would no longer benefit claimant.

Claimant continued to seek medical treatment. A myelogram performed in March 1979 revealed no pathology. Orthopaedic Consultants evaluated claimant in June 1980 and opined that claimant had a lumbosacral strain, resolved and severe psychopathology which was unrelated to the compensable injury. Claimant's then treating physician concurred. On August 8, 1980 the insurer issued a partial denial of claimant's psychiatric condition. On August 14, 1980 Dr. Roberts, claimant's psychiatrist, stated:

> "Initially he was referred to me by Dr. Homer Winslow, M.D., and I have seen him on a weekly basis since 5-22-80. At that time the patient was quite depressed....
>
> "It should be noted that he has been seen by one psychiatrist, Dr. Quan, who felt he had a personality disorder. This examiner is in strong disagreement with Dr. Quan's diagnosis, and I in no way see this individual as a personality disorder....
>
> "It is my belief that the patient extended himself extremely when working at Publishers, and set himself up with an anxiety state that has gradually progressed to the point now that he is unable to cope with even minor phases of his life. It should be noted that prior to his accident he was working approximately six days per week, frequently spending twelve hours per day, and had no significant prior history of emotional difficulties."

Dr. Parvaresh, a psychiatrist, subsequently evaluated claimant for the insurer and opined:

> "I share the clinical impression of the previous examiners, that undoubtedly within reasonable medical probability, anxiety neurosis has been in existence for many years, that in light of an emotionally nontraumatic accident, the accidental injury has had nothing to do with the psychiatric disorder and that the underlying psychological problems have tended to impede his recovery from an otherwise benign injury....Finally in response to the etiology of his psychiatric disorder, one would have to look at his background history. This gentleman grew up in a family in which there were many stresses....His marriage apparently was not by choice....That marriage ended in divorce....These are psychologically important contributing factors compared to a rather benign accidental injury and therefore [it] would be reasonable to assume those have been greater contributing

> factors than an injury which was not by description emotionally traumatic."

Dr. Winslow, claimant's treating physician, concurred. Dr. Roberts, agreed with Dr. Parvaresh's findings, but disagreed with him on the cause of claimant's problems. He stated that:

> "[Claimant] was working successfully in a full time capacity prior to his accident, and a psycho-physiological response was triggered from the accident along with an underlying latent neurosis or tendency. The patient's history of anxiety and depression were not present until after the accident which made him feel dependent and helpless...."

Dr. Parvaresh testified at hearing and reiterated his opinion that the compensable injury "did not cause the problem and it was my opinion that it could not have aggravated it."

The Referee apparently found Dr. Roberts' opinion more persuasive than Dr. Parvaresh's and consequently found claimant's psychological condition compensable. We disagree. Dr. Roberts' opinion is predicated on his belief that claimant did not have preexisting personality defects prior to the compensable injury and had a stable work history prior to the injury. Both Dr. Parvaresh and Dr. Quan found preexisting personality defects. Dr. Parvaresh explained that he based his conclusion concerning the preexisting personality defects on the history which claimant related to him including claimant's family and school history. Dr. Parvaresh also noted that claimant did not have a stable work history with the employer. Dr. Parvaresh was aware that claimant had been suspended for slashing lumber and that the employer had considered claimant to be a problem employe. Dr. Roberts apparently was unaware of these facts. Consequently, we find Dr. Parvaresh's opinion more persuasive and reverse the Referee.

ORDER

The Referee's order dated April 18, 1983 is reversed. The insurer's partial denial dated August 8, 1980 is reinstated and affirmed.

STEVEN EDWARDS, Claimant
Doblie & Francesconi, Claimant's Attorneys
Scott Terrell, Defense Attorney

WCB 84-00538
May 9, 1984
Order on Remand

A hearing was convened March 2, 1984, an Opinion and Order was published March 16, 1984, and claimant's request for Board review was mailed April 5, 1984.

Counsel for both parties join in requesting a remand to the Hearings Division for completion of the record. It appears claimant had not testified or rested his case and defendant had not cross-examined any of claimant's witnesses or had the opportunity to call any witnesses of its own when the hearing session was adjourned at noon March 2, 1984. It was the understanding of the parties that the hearing would be

continued for the receipt of a deposition-transcript and would reconvene on another day for the completion of testimony and the presentation of closing arguments.

Claimant separately requests that this matter be assigned to a different referee for re-hearing. Defendant opposes that request.

The Board finds the record in this case is incomplete and the March 16, 1984, Opinion and Order premature.

The Board finds the most expeditious method of reaching a final, reviewable decision in this case would be after remand to the Hearings Division for completion of the record and issuance of another Opinion and Order.

The Board finds that claimant's request for a change of referee should be referred to the Presiding Referee for handling in accordance with established practice and procedure.

THEREFORE, the Request for Board review is dismissed, and

FURTHER, this matter is remanded to the Hearings Division for:

(1) Decision by the Presiding Referee on claimant's request for change of referee, and

(2) Assignment of the case to a referee for:

(a) Completion of the hearing, and

(b) Issuance of an Opinion and Order in place of the hereby vacated March 16, 1984, Opinion and Order.

LAWRENCE A. GILLPATRICK, Claimant
Green & Griswold, Claimant's Attorneys
Miller, et al., Defense Attorneys

WCB 82-00010
May 9, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The insurer requests review of Referee St. Martin's order which set aside its partial denial of claimant's psychological condition.

Claimant is a 45 year old former heavy equipment mechanic. In March 1979 claimant fell from a lower step of a ladder at work and injured his back. Dr. Duff initially diagnosed a lumbar disc injury with left sciatica and ultimately performed a lumbar laminectomy and discectomy at L4. In July 1979 Dr. Duff reported definite improvement in claimant's back and leg symptoms. On July 28, 1979 Orthopaedic Consultants evaluated claimant. The panel diagnosed degenerative disc disease, a herniated disc at L4-5 on the left and L-5 radiculopathy on the left. They noted no interference from functional disturbance. They opined that claimant was not then medically stationary.

In September 1979 Dr. Duff reported that claimant continued to improve and was eager to return to at least part-time work. In October 1979 Dr. Duff approved a light duty job for claimant. That same month claimant was seen at the Callahan Center. The orthopedic examination done at the Callahan Center revealed status post laminectomy superimposed on early degenerative disc disease. There was no objective evidence of nerve root compression or irritation and no functional disturbance was noted. A psychological evaluation revealed moderate to moderately severe psychoneurotic involvement associated with the probability of underlying anxiety or depression. The center's closing report indicates that claimant did not complete a full program and that he worsened slightly while at the center.

In November 1979, following claimant's stay at the Callahan Center, Dr. Duff reported that claimant had increased pain and some radiating pain on the right for the first time. In January 1980 a second myelogram was performed, which revealed only a slight defect at L4.

Orthopaedic Consultants again evaluated claimant in February 1980. They opined that claimant's stated symptoms exceeded objective findings, and suggested marked functional overlay. Dr. Duff essentially agreed with this report. He opined that psychotherapy would not particularly benefit claimant because he felt claimant would resist that approach.

During the spring of 1980 claimant was seen by Dr. Ho for acupuncture treatments and injections in trigger points in his back. In April 1980 Dr. Ho recommended a pain clinic approach because claimant had developed a dependency on analgesics.

Claimant entered the Northwest Pain Clinic in May 1980. Dr. Painter performed a psychological evaluation. He noted that claimant's wife of 24 years was working full time and that claimant felt guilty about this. Claimant reported increasing irritability and reduction in sexual interest. Dr. Yospe, of the Pain Clinic, performed a neuropsychological examination. He reported:

> "His MMPI results reveal a depressed and somatically focused and ruminative individual who has many of the features associated with psychophysiological musculoskeletal disorder. Indications are that the patient has a very strong tendency to somatize stress and tension and presently feels somewhat overwhelmed by his situation. Although he is quite anxious and depressed, there is no evidence for an underlying thought disorder or any other psychotic manifestations."

The summary of the pain center's findings notes that claimant was considered a mild to moderate suicide risk.

On August 7, 1980 Dr. Duff opined that claimant was then medically stationary, and opined that claimant's impairment was in the moderate range. On September 15, 1980 a Determination Order issued awarding claimant 15% unscheduled disability.

On October 25, 1980 claimant blew the large toe off his right foot with a shotgun. The emergency room report states: "appears to be depressed over unemployment." Claimant was then referred to Dr. Jolly of the Kaiser Mental Health Clinic. She reported in the notes of her initial consultation:

> "States he wanted to amputate foot because of chronic pain. Had back surgery 1 1/2 years ago, has had pain and has not worked since. States he was 'taking pain pills and drinking' at the time. Is worried about finances and health of wife. Feels he will 'do something else' if pain continues. Brother admitted to Dammasch Hosp 1 wk ago, has been upset about this....No gross thought disorder, but excessive rumination re poverty, pain. Suicidal impulses over past several weeks, 'waiting to see' effects of gunshot. Judgment & insight poor. Impression: Reactive depression."

In July 1981, Dr. Levine, a clinical psychologist at Kaiser evaluated claimant and reported:

> "[Claimant] is handicapped in his ability to adapt to his physical limitations by a number of factors; dyslexia; conservative rather rigid patterns of coping thus far; lack of education; inability to communicate verbally regarding needs and feelings impaired ability to process abstract information; depression and tension. Since his accident and subsequent surgery, he has been unable to perform vocationally or sexually. He has attempted to cope with this in a psychological sense, with a somatic defense. Stress has probably heightened perception of his pain, and possibly increased sensitivity to pain in other parts of his body."

On September 15, 1981 Dr. Fleming, a clinical psychologist, evaluated claimant and opined:

> "[Claimant] suffered an industrial injury about 3 and 1/2 years ago. He attempted to return to work after that, but was unable to do so. He has been a steady and stable employee and a good family man. He is now having a difficult time dealing with his constant pain and his limitations, and is currently receiving psychological assistance."

On October 9, 1981 Dr. Jolly reported:

> "[Claimant's] psychological status remains grave. He is extremely depressed and has

> recently amputated a second toe from his right foot. He refuses voluntary hospitalization, and we are presently exploring commitment proceedings, but this may be difficult as he denies suicidal intent. * * * In my opinion, he is currently 100% disabled on a psychiatric basis."

On November 6, 1981 Dr. Stolzberg, a psychiatrist, evaluated claimant for the insurer. She opined:

> "The appearance of mutilating behaviors in this gentleman is quite bizarre and also quite ominous. This appears to be related to the compensation issues and attempts to return him to work. It also appears to be related to his neurotic preoccupation with his childhood experience with a disabled father and brother....
>
> "In answer to your letter, I would say that there is here a complex interaction between this man's industrial accident and his pre-existing personality and neurotic orientations. I do not believe that the industrial accident has any relationship to his pre-existing passive-aggressive personality, chronic tension and anxiety, and a neurotic preoccupation with childhood experiences. In my opinion, all of these conditions have caused this patient, in the setting of an industrial injury to become entrenched in a highly disabled state with pain symptoms out of proportion to the actual findings, drug and alcohol abuse, blocking behaviors to rehabilitation efforts and growing embroidering complaints of depression, anxiety, tension and irritability and difficulty concentrating. In my opinion, an industrial accident may provide the opportunity for this type of reaction but is not in and of itself the cause of this type of reaction."

On December 10, 1981 the insurer issued a partial denial of claimant's psychological condition.

On March 17, 1982 Dr. Jolly wrote that in her opinion claimant's psychiatric difficulties were caused by his industrial injury.

Four mental health professionals testified at the hearing. Dr. Levine, the clinical psychologist who treated claimant along with Dr. Jolly at Kaiser, opined that claimant's psychiatric difficulties were caused by the industrial injury. He explained:

> "They [personality factors] pre-existed, at the same time they contributed to the

person he was that made him successful rather than unsuccessful. In other words, that is the thing, these things functioning for him, and the result of the pain, the accident, no longer function, in fact, they worked against him, and this is what we know, that the morbid personality, instead of helping him, resulted, literally had a very--were no longer serviceable to him."

Dr. Smith, a psychiatrist, evaluated claimant and testified in claimant's behalf at hearing. He testified that claimant had essentially no psychological difficulties prior to his industrial injury. He opined that claimant developed a depressive disorder as a result of the industrial injury. He testified:

"I think it's important to differentiate between the symptom, depression, and the mental disorder, depressive disorder. Each and every person in this room has had the symptom of depression at one time or another and yet need not be faced with the diagnosis of depressive disorder. In this case I think there were times he must have been depressed with--had to leave school and--but worked his way out of these things, and this disability is of such a major catastrophic degree that he was unable to work his way out by logical means and chose some illogical means to deal with the situation, such as shooting or cutting off toes."

Dr. Yospe, one of the psychologists at the Northwest Pain Clinic, testified as a witness for the insurer. He testified:

"Let me try to put this into more concrete terms. It is my feeling on the basis of the findings, that this was a man who was defending against his dependency needs and had found a way of expressing his psychological problems by, for example, overcompensating and, with a rigid kind of work pattern, and this was a way he defended against his underlying psychological difficulties, and when the injury came along, this, in some ways, provided a ready way for him to express these underlying problems much more directly, so that while they looked different, they really came from the same source. In some ways the injury was a solution rather than a problem because he could now legitimately express his passive tendency and there was a system out there which continued to reinforce this."

Dr. Yospe also testified:

"Well, again, perhaps I could make it clearer than when I talked about this earlier. I think the industrial injury, in combination with the Workers' Compensation system, are the critical factors which brought about the different expression of his psychological difficulties, pre-existing."

Dr. Stolzberg also testified in the insurer's behalf. Her testimony echoed Dr. Yospe's. She opined that claimant had a preexisting personality problem with chronic depression, anxiety and tension. She opined that the compensation system had triggered claimant's severe psychological symptoms. She testified that claimant had a personality disorder prior to the industrial injury. She explained the distinction between personality traits and a personality disorder: "It becomes a disorder when the behavior life history and symptom reporting of an individual falls outside our cultural expectations."

Dr. Stolzberg further testified:

"Q. Considering the industrial injury itself, has the industrial injury affected the personality disorder at all?

"A. Well, I have to, there, get into a complicated discussion, similar to Dr. Yospe. I don't think there is a yes or no that would satisfy me. I don't think I would be satisfied with either of those answers. I think there is a complex interaction here of factors....A minor injury does not cause the kind of psychiatric symptoms we have seen here. A minor injury propels the individual into this kind of symptom, in my experience, certainly is well known to do just that. I think its unfolding in this case."

Dr. Stolzberg opined that, had claimant experienced a similar injury off the job, he would not have developed the symptoms he developed following the industrial injury. She opined that the industrial injury coupled with the compensation system to cause claimant's psychiatric symptoms: "It's basically the support system that triggers it. It's the injury that gives access to the system." She conceded, however, that but for the industrial injury, claimant would not have developed symptoms which required psychiatric care.

"Q. Of course, that psychiatric care, for all we know, would never be necessary but for his accident?

"A. I do not think it was the accident that makes it necessary, per se, but the interaction of this man's personality with all the things we have talked about.

"Q. There would have been no interaction but for the accident?

"A. That's correct.

"Q. So but for the accident, he would not need the psychiatric care?

"A. With that logical sequence, yes."

In order to establish the compensability of a psychological illness following an industrial injury, a claimant must prove that the industrial injury was a material cause of the psychological illness. Patitucci v. Boise Cascade, 8 Or App 503, (1972). In order to prove compensability of a psychological illness that preexisted the industrial injury, claimant must prove that the industrial injury was a material cause of a worsening of the preexisting condition. Partridge v. SAIF, 57 Or App 163 (1982). We are unsure on this record whether claimant had a preexisting psychological illness. It is apparent that claimant had a rigid personality prior to the industrial injury. Drs. Stolzberg and Yospe seem to consider this personality a preexisting psychological illness while Drs. Smith and Levine do not.

All four doctors believe that the industrial injury contributed to claimant's current psychological symptoms to some degree. The main issue then is whether the injury worsened the psychological illness. We find that it did. Prior to the injury, claimant had a stable work history and a stable marriage. Dr. Stolzberg defined a psychological disorder in terms of whether the patient had exhibited behaviors and symptoms outside cultural expectations. We find no evidence that prior to the injury claimant had exhibited behaviors or symptoms outside cultural expectations. However, even assuming that he had exhibited such behaviors, it is apparent that the magnitude and nature of those behaviors changed drastically after the industrial injury. Where he was a productive worker and had a stable marriage prior to the injury, he became suicidal and self mutilating following the industrial injury. This certainly constitutes a worsening. We conclude that claimant has sustained his burden of proving that the industrial injury was a material cause of a worsening of his preexisting psychological illness.

ORDER

The Referee's order dated April 1, 1983 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

ARNE A. LARSEN, Claimant
Peter Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-08045
May 9, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Neal's order which declined to reopen his claim as a compensable aggravation and refused to award a penalty and associated attorney fees for the insurer's alleged failure to accept or deny the claim within sixty days.

Claimant compensably injured his low back in June 1979. The claim was closed by a Determination Order dated August 19, 1980 which granted claimant an award for 5% (16°) unscheduled disability. Claimant returned to light work with the employer and worked successfully until April 1982. On April 11, 1982 claimant was transferred to a heavier job due to economic conditions. On April 13, 1982 he was examined by Dr. Goertz, a specialist in industrial medicine. On April 15, 1982 Dr. Goertz opined:

> "A fitness evaluation was performed on April 13, 1982 on [claimant] for the position of stand or floor grinder. This is a 26 year old man with a history of low back injury and probable disc pathology. He had been without problem until starting in the position of floor grinder two days ago. After two days in this position he noted a return of his low back pain with radiation into the left leg. Exam in that area showed tenderness without spasm and no neurological deficit. My recommendations for limitation would be no lifting greater than 10 pounds, prolonged standing, frequent bending, pushing or pulling. I did discuss the situation and findings with David Noall, M.D. who felt that the type of duties described for a grinder were likely to cause an exacerbation of [claimant's] problem and that this would most likely be progressive."

Approximately two days after his visit with Dr. Goertz, claimant reported to the employer's company nurse. The nurse testified at hearing that claimant appeared to be in pain. The nurse sent claimant home and arranged an appointment with Dr. Noall for claimant. She informed her employer and the insurer that claimant was sent home because he was physically unable to do the grinder job. The nurse testified that it was her understanding that claimant's job was terminated because he was physically unable to do the grinder job.

Claimant's job was terminated and he received no time loss benefits. He apparently reported to Dr. Noall who stated on October 1, 1982:

"He did well primarily because he was doing light-duty work until April, 1982 when his symptoms recurred after he was changed to a heavier work duty....I think his symptoms in April, 1982 were a result of his original injury in 1978, being made again symptomatic by the grinding job which he had recently started doing.

"If light duty is not available through his present employer, he may well need vocational rehabilitation to obtain another occupation."

Dr. Noall testified at deposition that he did not specifically authorize time loss because he understood that claimant had been laid off by the employer. He testified, however, that he would not have released claimant to the grinder job.

The Referee held that claimant had not satisfied his burden of proving that his compensable condition had worsened. We disagree. The undisputed evidence is that claimant worked successfully until April 1982 when he was required to do heavier work. The evidence is also undisputed that after two days of heavier work claimant experienced increased pain which precluded him from doing the heavier work. Claimant did not have a formal authorization for time loss because the employer had already terminated him. The experts agree that the increased pain was causally related to claimant's compensable injury. We find that had claimant still been employed by the employer, time loss would have been authorized by Dr. Noall. Accordingly, we reverse the Referee on the aggravation issue and order the claim remanded for processing pursuant to ORS 656.273.

Under the peculiar circumstances of this case, we agree with the Referee that a penalty and associated attorney's fee for late denial is not warranted. The insurer could reasonably have believed that all claimant was requesting was medical services under ORS 656.245.

ORDER

The Referee's order dated September 7, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which denied reopening pursuant to ORS 656.273 is reversed. The claim is remanded to the insurer for processing pursuant to ORS 656.273. The balance of the Referee's order is affirmed. Claimant's attorney is awarded a fee for his services at hearing in the amount of $850 and a fee for his services on Board review in the amount of $600, to be paid by the EBI Companies.

JEFFREY A. MILLS, Claimant
James P. O'Neal, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06423 & 83-06422
May 9, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee McCullough's order which set aside its denial of claimant's aggravation claim. SAIF contends that claimant failed to prove a worsening and/or that his present condition is related to his compensable back injuries.

Claimant is a 25 year old choker setter. He suffered two compensable low back injuries in September and November 1980. Claimant also has a preexisting spondylolisthesis condition. Both 1980 claims were ultimately resolved by a stipulation dated April 21, 1982, which awarded claimant 15% (48°) permanent partial disability for his two back injuries. That is the last award of compensation for purposes of this aggravation claim.

In his closing report of August 21, 1981, claimant's treating orthopedist, Dr. Woolpert, stated that claimant was experiencing low back pain and discomfort in the right leg, but he had no further treatment to offer claimant. Dr. Woolpert noted that claimant had some minimal daytime pain, but had more discomfort in the evening after work. Dr. Woolpert's examination revealed excellent range of motion, forward bending to six inches from the floor, normal lateral bending and 50% normal extension. There was no neurological deficit indicated. Dr. Woolpert opined that claimant's permanent partial impairment attributable to the industrial injury was in the minimal range. He recommended that it was in claimant's best interests not to return to work in logging.

After late 1981 claimant worked sporadically for several employers, including an oil drilling company in Texas and some Oregon logging companies. Between August 1981 and July 1983 claimant did not seek treatment concerning his low back.

In June 1983 claimant was again working as a choker setter. Late that month the pain in his back and right leg became severe enough to force claimant to leave his job. Claimant testified that he has had a lot more pain, tightness in his right leg, some numbness and increased tingling in his right foot since the last award of compensation in April 1982.

In July 1983 claimant was examined for the first time by Dr. Renaud, an orthopedist. Dr. Renaud reviewed claimant's x-rays which had been taken following the September 1980 injury. Dr. Renaud did not have copies of Dr. Woolpert's medical reports. Dr. Renaud's 1983 examination revealed that claimant's forward flexion was normal, but his back extension was essentially nil. Lateral bending was 20° and rotation was 30°, both in the normal range. Dr. Renaud's assessment was as follows:

> "1) Spondylolysis and spondylolisthesis. It is likely that this existed prior to his industrial accident. It is likely that his symptomatology was aggravated by the first industrial accident and also aggravated with the injury of Nov. 1980. It is

> impossible for me to allocate the percentage of symptomatology to one or the other injury at this time. There is no neurologic loss at this time, although he has paresthesias in the feet."

It was Dr. Renaud's opinion that claimant was unable to work. The doctor felt that a flexion jacket would be appropriate. He recommended claimant return in a month and sign a release so Dr. Renaud could obtain Dr. Woolpert's records.

The Referee found that the medical evidence was sufficient to support claimant's aggravation claim. We disagree and reverse.

The Referee correctly noted that Dr. Renaud never expressed the opinion that claimant's condition was worse during the summer of 1983 than it had been in April of 1982. Even if Dr. Renaud had so opined, the weight to be accorded any such opinion would have to take into account the fact that, with the exception of some x-rays, Dr. Renaud did not have the benefit of claimant's prior medical records when he wrote his reports that are in evidence. However, the Referee found a worsening by comparison of the range-of-motion findings in Dr. Woolpert's 1981 closing report and the range-of-motion findings in Dr. Renaud's 1983 reports. We disagree. With the exception of back extension, all other measured motions are reported to be substantially the same in 1983 as they were in 1981. Moreover, and more importantly, and particularly in regard to the change in back extension, we have often noted that range-of-motion tests are subjective and can vary from one day to the next and from one examiner to the next. E.g. Leonard Wonslyd, 34 Van Natta 230 (1982). For all of these reasons, we very much doubt that this record persuasively documents any worsening of claimant's back condition.

However, assuming a worsening for sake of discussion, the question next arises of the causal relationship between claimant's 1980 industrial injuries and his 1983 back symptoms. At the time of claimant's initial injuries, it was discovered that he had a preexisting degenerative spinal condition. It would be impossible to find on this record, if it is even claimed, that the 1980 injuries had any permanent impact on claimant's preexisting condition. Therefore, the possibility of a natural progression of this preexisting and noncompensable condition offers a possible explanation for claimant's 1983 back distress, including a reduction in back extension. It is also possible that claimant's 1983 back difficulties are materially related to the permanent impairment he suffered as a result of his 1980 industrial injuries. However, we find insufficient persuasive evidence to elevate that possibility to a probability and thus conclude that the preponderance of the evidence does not support a finding of a causal relationship between claimant's prior injuries and his possibly worsened condition in 1983.

ORDER

The Referee's order dated August 26, 1983 is reversed. The SAIF Corporation's denial of aggravation reopening made orally at the time of hearing is reinstated and affirmed.

ALEX M. BERG, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-02136
May 11, 1984
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Danner's order which upheld the SAIF Corporation's denial of claimant's aggravation claim. Claimant contends that his aggravation claim is compensable and that he is entitled to interim compensation and penalties and attorney fees for SAIF's unreasonable denial of the aggravation claim. Claimant also moves for remand of the case for consideration of additional evidence.

The Board affirms the order of the Referee. Because claimant did not raise the issues of interim compensation and penalties and attorney fees at the hearing when asked to list the issues to be determined, the Board has not considered those issues on review. Mavis v. SAIF, 45 Or App 1059 (1980). In addition, claimant's motion for remand is denied.

ORDER

The Referee's order dated October 7, 1983 is affirmed.

Board Member Barnes Concurring:

Claimant's opening brief includes a rather sharply-worded attack on the Referee; for example, arguing "it is clear that the record was incompletely developed by the Referee." I believe that criticism is unfair and unwarranted under these circumstances:

(1) A hearing was scheduled in this case in reliance on claimant's representation, filed in March 1983, that he "is ready for hearing and prepared with all medical reports and other evidence."

(2) In fact, the hearing record was not closed for more than two months after the July 1983 hearing, during which time Referee Danner allowed the parties inordinate latitude to develop additional evidence.

(3) In fact, the hearing record was closed at claimant's request stated in a letter dated September 12, 1983.

But assuming for sake of discussion that the Referee (as distinguished from the parties' attorneys) should have done something more or different to develop a complete record, I find it passing strange that claimant's reply brief "requests an attorney fee of $2,000 for the efforts of his attorney before the Referee and the Board." If it is really the duty of the Referees (as distinguished from the parties' attorneys) to develop a complete record, perhaps our awards of attorney fees should be made to the Referees.

BILL B. DAMERON, Claimant
William Mansfield, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
David Horne, Defense Attorney
Frohnmayer, et al., Defense Attorneys

WCB 81-06138, 81-06139 & 81-06140
May 11, 1984
Order on Reconsideration

On April 13, 1984 the Board entered its Order on Review herein, reversing the Referee's order in part. 36 Van Natta 592 (1984). The effect of our Order on Review is to assign responsibility for claimant's low back condition, presently diagnosed as arachnoiditis, to Hoffman Construction, insured by the SAIF Corporation. The Referee had found Peter Kiewit and Sons responsible for payment of claimant's compensation and, therefore, set aside the denial issued by Scott Wetzel Services in behalf of this employer. As part of our order assigning responsibility to Hoffman Construction/SAIF, we ordered SAIF to reimburse Peter Kiewit and Sons for compensation paid to claimant under the terms of the Referee's order. We further directed that, "The attorney's fee awarded by the Referee shall be paid by SAIF." The Referee awarded claimant's attorney a $1,000 insurer-paid fee.

Claimant has requested reconsideration of the above-quoted portion of our order directing that SAIF pay the attorney's fee awarded by the Referee. Claimant has provided the Board with a certified copy of an order entered by the Jackson County Circuit Court pursuant to ORS 656.388(2). That statute provides a procedure for Circuit Court review of an attorney's fee awarded by a Referee, the Board or appellate court. According to the Circuit Court order, the attorney's fee awarded by the Referee was increased from $1,000 to $1,500. Claimant requests reconsideration seeking modification of the Board's Order on Review to reflect the increased fee awarded by the Circuit Court.

The Board's review is limited to the record of the proceedings developed before the Referee. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). The Circuit Court order which was entered during the pendency of this proceeding on review is not part of the record before us and, therefore, cannot be considered as evidence which determines the outcome of any issue that may be properly before us, including an issue of attorney fees. We decline to modify our Order on Review as requested by claimant.

ORDER

On reconsideration of the Order on Review dated April 13, 1984, the Board adheres to its prior order, which hereby is readopted and republished.

RICHARD H. MILLER, Claimant
Peter Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03209
May 11, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Williams' order which: 1) Affirmed the SAIF Corporation's denial of claimant's alleged aggravation claim; 2) declined to award a penalty for late denial; and 3) declined to award a penalty for failure to pay interim compensation.

Claimant compensably injured his neck and back in July 1981. The claim was closed by Determination Order dated November 13, 1981 which granted claimant no award for permanent disability. He subsequently filed an aggravation claim which was ultimately accepted by a stipulation in which claimant was granted an award for 15% (48°) unscheduled disability.

On January 26, 1983 Dr. Eisendorf, claimant's treating physician, wrote the following letter to SAIF:

> "Reference is made to recent closing of the above claim when the patient was declared stationary and was given a PPD of 15%.
>
> "In the meantime he returned to driving his cab full time and has done fairly well until last week when during the course of an 8 hour day of driving he developed more low back pain.
>
> "On examination of the mid and low back, there is some paravertebral muscle guard with restriction of range of motion of the back. It appears that this represents an aggravation or worsening of his prior cervical and dorsal lumbar sprain of 7/7/81.
>
> "We are requesting that the above captioned claim be reopened for further treatment."

On March 3, 1983 Dr. Eisendorf wrote:

> "[Claimant] was seen in the office on March 2, 1983 and at that time stated that his back is better. He has been on full time duty for about 2 months. He needs no medication for his back."
>
> "On examination there is no paravertebral muscle guard and no flattening of the lumbar curve. The range of motion of the back has returned to normal.
>
> "He has been scheduled for a closing examination by Orthopedic Consultants on Mar. 3, 1983 which appointment he will keep. He is being discharged from active treatment at the present time."

Orthopaedic Consultants reported on March 16, 1983 that they found no evidence of worsening since an earlier examination in February 1982. On April 1, 1983 SAIF issued a formal denial letter refusing to accept claimant's "claim for aggravation." The denial specifically indicated that medical benefits due pursuant to ORS 656.245 would continue to be paid.

On August 23, 1983 Dr. Eisendorf filled out a questionnaire from claimant's attorney. He indicated that time loss was authorized from January 25, 1983 through February 1, 1983 and that in his opinion claimant became medically stationary on March 2, 1983.

The Referee concluded that Dr. Eisendorf's January 26, 1983 letter was not a claim for aggravation under ORS 656.273. The Referee acknowledged claimant's argument that Dr. Eisendorf's January 26, 1983 letter taken with his March 3, 1983 letter constitute a claim for aggravation. The Referee concluded they do not constitute a claim for aggravation. He noted that even if together the documents do constitute a claim for aggravation, no interim compensation was due because by the time the aggravation claim was made, claimant had already returned to work. He also concluded that SAIF's denial was not late because it was made within thirty days of the March 3, 1983 letter. The Referee also held that claimant had failed to prove an aggravation under ORS 656.273.

ORS 656.273(3) states: "A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." Dr. Eisendorf's January 26, 1983 letter is a claim for aggravation under that statute. Subsection (6) of the statute provides, however, that interim compensation shall be paid within 14 days after the employer has notice of "medically verified inability to work resulting from the worsened condition." We find that the first medical verification of inability to work due to the worsened condition was contained in the form Dr. Eisendorf filled out on August 23, 1983. By that time SAIF had already denied the aggravation claim, so it was not required to pay interim compensation pending a decision on the validity of its denial. Accordingly, no penalty is appropriate for failure to pay interim compensation because no interim compensation was due prior to the denial. SAIF's denial was late because it was not issued within 60 days of the aggravation claim. However, because no compensation was then due, there is nothing upon which a penalty may be assessed.

On the merits of the aggravation claim, we find that claimant has proven a compensable aggravation by a preponderance of the evidence. We base this finding on the reports of the treating physician, Dr. Eisendorf, as well as claimant's credible testimony.

ORDER

The Referee's order dated September 20, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which upheld the SAIF Corporation's denial is reversed. Claimant's aggravation claim is remanded to SAIF for processing pursuant to ORS 656.273. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $350 for services at hearing and $300 for services on Board review, to be paid by the SAIF Corporation.

JOSE G. PEREZ, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorney

WCB 81-08151
May 11, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Mannix's order which modified a Determination Order dated August 27, 1981 by awarding claimant additional compensation for temporary total disability and finding claimant permanently and totally disabled as of the date of the Determination Order. The principal issue on review is two-fold: (1) Whether a prior Referee's order establishes that impairment from claimant's ankylosing (rheumatoid) spondylitis condition is due to claimant's industrial injury, based upon res judicata reasoning; and (2) the extent of claimant's permanent disability attributable to his original industrial injury. See ORS 656.214(2). The secondary time loss issue also relates to the effect to be given the prior Referee's order.

I

Claimant sustained a low back injury on July 16, 1976 while lifting barrels. Dr. Howard, who became claimant's treating chiropractic physician, diagnosed a lumbar strain, which he treated by chiropractic manipulation and physiotherapy. Claimant subsequently was examined by Orthopaedic Consultants in September 1976, who diagnosed chronic recurrent cervical, dorsal and lumbar strain. X-rays taken at that time were interpreted as indicating a normal cervical spine, rather advanced degenerative osteoarthritis of the thoracic spine, and early degenerative changes at L5 and S1. The Consultants found that claimant's condition was medically stationary, that claimant was capable of returning to his pre-injury occupation with limitations, and that the total loss of function of claimant's back due to his injury was minimal. They expressed the opinion that claimant's dorsal spinal problem was actually a thromboid muscle soreness, with the loss of function attributable to claimant's injury being minimal.

Claimant continued to experience back symptoms, and he continued chiropractic care with Dr. Howard. In December 1976 claimant was examined by Dr. Robinson, an orthopedic surgeon, on referral by the insurer. Dr. Robinson diagnosed chronic dorsal and lumbar strain superimposed upon degenerative changes over these areas of the spine. He expressed the opinion that claimant was not capable of returning to heavy manual labor and recommended Callahan Center treatment and evaluation. Dr. Howard stated his agreement with Dr. Robinson's evaluation and opinion and subsequently reiterated the recommendation that claimant undergo a disability prevention evaluation. In March 1977 Dr. Howard opined that claimant could not return to any occupation requiring lifting, bending or stooping.

The claim was closed by a Determination Order dated April 1, 1977, as corrected by a second Determination Order on April 18, 1977, which awarded claimant compensation for temporary total disability and 80° for a 25% unscheduled permanent partial disability for injury to the mid and low back.

In June 1977 claimant was examined by another panel of the

Orthopaedic Consultants. They observed: "When he was examined . . . on September 16, 1976, he was very much better than he presents himself today." This panel of physicians diagnosed chronic dorsal strain and expressed the opinion that claimant's condition was not medically stationary. They expressed their agreement with Dr. Robinson's recommendation for an evaluation of claimant's work capabilities and a psychological evaluation as well. In September 1977 Dr. Howard opined that claimant's condition was medically stationary, and that claimant was capable of participating in modified work not requiring bending, stooping or lifting.

Claimant was admitted to the Callahan Center on September 14, 1977. He underwent a psychological workup which included findings that his I.Q. was 77 and his performance on non-reading aptitude tests was poor. X-ray findings of the thoracic and lumbosacral spine were noted to include hypertrophic degenerative disc disease at the T9-T10 level. The final diagnosis upon discharge from the Callahan Center on November 4, 1977 was chronic thoracic and lumbar strain with degenerative arthritis, especially in the thoracic spine. It was felt that vocational rehabilitation would be necessary in view of claimant's physical and mental limitations.

In February 1978 claimant was examined by Dr. Ho, an osteopathic physician, who diagnosed post-traumatic cervical, dorsal and lumbar myositis. Dr. Ho recommended that claimant not return to any work requiring strenuous or repetitive use of the spine. He administered manipulative treatment. Dr. Ho recommended serum studies for inflammatory disease.

In early May of 1978 Dr. Vigeland, an orthopedic surgeon, examined claimant. Dr. Vigeland expressed the opinion that claimant had a generalized arthritic condition or connective tissue disorder, including the possibility of ankylosing spondylitis, stating the impression that claimant was "in a somewhat older age group for this." On May 22, 1978 a third Determination Order closed the claim with an additional award for temporary total disability only.

Dr. Vigeland referred claimant for examination by Dr. Hakkinen, an internist, for further evaluation of the possible diagnosis of ankylosing spondylitis. Dr. Hakkinen found that claimant's history, physical findings and laboratory test results were compatible with an ongoing ankylosing spondylitis condition. He initiated a program of conservative treatment, including exercise and anti-inflammatory medication. After further evaluation Dr. Hakkinen reported that claimant definitely had ankylosing spondylitis, which he described as "a rather chronic condition which is usually progressive in its course, and although not caused by injury may certainly be exacerbated by same." Dr. Hakkinen indicated that the medication that he was administering to claimant had caused a marked decrease in claimant's back symptomatology. He expected that, with the combination of medication and back exercises, the disease process would be held under reasonable control. He also stated: "I must emphasize as this is a usually progressive disease that this treatment really is somewhat palliative, however, with this treatment program, patients can often have an extremely good course despite the otherwise chronic disease process."

A third Orthopaedic Consultants panel examined claimant on September 19, 1978. The diagnoses were chronic dorsal strain, superimposed upon degenerative osteoarthritis, ankylosing spondylitis and functional overlay, as previously documented. The Consultants stated:

> "This man has ankylosing spondylitis which was aggravated by an on-the-job injury in 1976 and which has probably been further aggravated since by ongoing chiropractic manipulations. The diagnosis of ankylosing spondylitis has only recently been established and appropriate therapy instituted. But before this patient can be considered stationary and his claim closed, it will first be necessary to see how he responds to appropriate therapy for his underlying disorder."

The Consultants "strongly recommended" that chiropractic treatment be discontinued. Due to claimant's "underlying medical problems," his low intelligence level and his "poor motivation," the Consultants found it unlikely that claimant would be retrainable for gainful employment; however, they also expressed the opinion that some effort to provide vocational assistance would be appropriate. A copy of the Orthopaedic Consultants' report was provided to Dr. Hakkinen, who indicated his concurrence by signing a form provided by the insurer.

A November 16, 1978 report was obtained by the insurer from Dr. Frink, whose specialty is in general surgery and thoracic surgery. Dr. Frink apparently reviewed the medical records contained in the insurer's claim file and, based thereon, stated his conclusions. He questioned whether claimant truly had ankylosing spondylitis or simply degenerative osteoarthritis, stating:

> "If the diagnosis of ankylosing spondylitis is accepted as a reasonable one -- and it has been by the Orthopaedic Consultants -- then I think there is a new factor interjected to be considered. This man is now 45 years of age and this is rather an advanced age for ankylosing spondylitis to develop. However, we note that his symptoms had been going back for several years.
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> * * *
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> "Ankylosing spondylitis is a slow, inexorably progressive, painful disease affecting largely the spine, that slowly and steadily progresses with increasing pain and stiffness. The very significant thing to me is that when this man was seen the first time by the Orthopaedic Consultants on September 20, 1976, which is two months following his injury, his objective findings were quite minimal and

ankylosing spondylitis was not even considered. It was not really considered by anyone until quite recently.

> "It is my personal opinion that the most probable cause of this man's slow progression of stiffness and pain is not related exclusively to his injury of July 16, 1976, but that the most likely cause of his present impairment is the result of the progression of the spondylitis. I think that if his injury of July 16, 1976 were the most probable cause of his present impairment, that it would have been manifest as such long before the past few months. Certainly his injury could and may possibly have aggravated his condition, but if such were the case I think that this would have been apparent by the objective findings, as well as the symptoms very shortly after his injury. This was not the case here. As a matter of fact, a short time after his injury, he himself felt that he was well enough to return to his usual work."

In a letter to the insurer dated March 19, 1979, Dr. Hakkinen stated that he had not seen claimant since December 8, 1978, at which time his medication had been changed. Although claimant had been instructed to return in two months, he had failed to keep his appointment. Dr. Hakkinen explained that he, therefore, was unable to state whether claimant's condition was stationary, "or anything else for that matter." He also stated that claimant "probably has rather permanent impairment secondary to his diagnosis of ankylosing spondylitis . . . " The insurer thereafter arranged for an examination with Dr. Hakkinen, which took place on April 10, 1979. In a report of that same date, Dr. Hakkinen characterized ankylosing spondylitis as a "chronic, slowly progressive disease of unknown etiology." He indicated that claimant stated that he had been taking his medication only on an irregular basis but had been performing his exercises. Dr. Hakkinen expressed doubt concerning the accuracy of claimant's history because, "I do not believe [he] really completely understands not only the language but the instructions given to him despite the fact that they have been carefully written out on every occasion." He stated his impression that claimant's condition was not medically stationary, and that "he will probably progress to slowly akylose his spine despite medical treatment."

> "As this medical condition is an underlying disease process that was only exacerbated by his industrial injury as indicated in previous correspondence from the Orthopedic Consultants, it is very difficult to say how much permanent injury has resulted as a result of the on-the-job injury."

Dr. Hakkinen further stated he believed it unlikely that claimant would be able to be retrained for gainful employment. Although most patients with this particular disease process are able to do

so, according to Dr. Hakkinen, he expressed significant doubt concerning claimant's ability in view of claimant's low education, low intelligence level, his poor motivation and "lack of really true understanding of what I am able to tell him." Dr. Hakkinen emphasized the importance of claimant's ongoing medical treatment and expressed the hope of conveying this understanding to claimant and his family.

A fourth Determination Order issued on June 1, 1979 awarding claimant additional compensation for temporary total disability from May 2, 1978 through April 10, 1979, less time worked, and an additional 80° for 25% unscheduled disability for injury to the low back. This Determination Order brought claimant's total unscheduled disability award to 160°, or 50% of the maximum allowable.

On April 17, 1980 Dr. Howard reported to the insurer that claimant was being treated on an "as needed" basis approximately once a week to once every two weeks. He stated that treatment was for the purpose of affording temporary relief of pain. He expressed his opinion that claimant should be considered permanently and totally disabled in view of his physical findings, lack of education, language difficulties and consequent communication problems.

Claimant again was examined by Dr. Robinson, who subsequently reported to the insurer by letter of May 14, 1980, his diagnosis of chronic dorsolumbar strain superimposed upon underlying rheumatoid spondylitis of the spine. He commented:

> "It is my opinion that this man has progressive evidence of rheumatoid spondylitis of the dorsolumbar spine. My examination on this date reveals further progressive stiffening of his spine with more limitation in bending ability, etc. This progression of the arthritic process
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> is not related to his industrial injury and unless remission is obtained by medical treatment by a rheumatologist, further progression can be expected. This latter treatment, in my opinion, is not the responsibility of the insurance carrier for the industrial injury. In my opinion, the industrial injury element here is stationary. Hopefully, with treatment for his arthritis, he could get back to some light activities such as managing a service station, etc.
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> "In my opinion, his overall disability, as it exists today, would be described as moderate, but that specifically due to his injury would probably be minimal."

Yet another Orthopaedic Consultants panel examined claimant on April 30, 1980 and produced a report dated May 12, 1980. X-rays of the dorsolumbar spine were interpreted as revealing degenerative spurring slightly increased in comparison with x-ray films taken in

1977 and 1978. It was noted that the sacroiliac joints revealed an increased amount of sclerosis (hardening) and lack of definition in comparison with previous films, characteristic of sacroiliitis. The Consultants diagnosed dorsolumbar strain and ankylosing spondylitis, unrelated to injury. They found claimant's condition medically stationary and recommended claim closure. They also recommended that claimant be followed by a rheumatologist or seen at the University of Oregon Health Sciences Center Rheumatology Clinic. They expressed the opinion that claimant was capable of performing some type of light work with restrictions in bending, lifting and twisting, and that claimant would require vocational assistance. They found the impairment of claimant's dorsolumbar spine to be in the moderate range, stating that the portion of the loss of function due to claimant's industrial injury was minimal.

The insurer provided a copy of this Orthopaedic Consultants report to Dr. Robinson, soliciting his opinion with regard to the Consultants' statement that claimant's ankylosing spondylitis was not related to his 1976 industrial injury. Dr. Robinson responded: "I agree that the ankylosing spondylitis is not related to the industrial injury."

On August 7, 1981 the insurer denied any claim for benefits related to claimant's ankylosing spondylitis for the stated reasons that:

> "1. There is no medical evidence to substantiate that the ankylosing spondylitis and any related disability or residuals are related to your industrial injury of July 16, 1976.
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> "2. There is no evidence to substantiate that your employment with our insured or your injury of July 16, 1976 caused a material worsening of the underlying disease process."

Claimant was examined by Dr. Martens for an orthopedic consultation in August 1980. As a result of his examination, x-ray findings and laboratory tests, Dr. Martens expressed the opinion that claimant did not suffer from ankylosing spondylitis. He diagnosed chronic strain of the cervicothoracic and lumbosacral spine, degenerative disc disease of the mid cervical spine and minor osteoarthritic spurring of the thoracic and lumbosacral spine. He concluded that these conditions were not a result of claimant's work, other than the chronic strain of the cervicothoracic and lumbosacral spine. He recommended that claimant continue with back stretching exercises and that he obtain vocational assistance for job placement consistent with his limitations regarding bending, twisting, lifting, prolonged standing, walking, sitting and driving.

On May 19, 1981 a hearing in a prior proceeding convened before Referee James pursuant to claimant's requests for hearing contesting the Determination Order dated June 1, 1979 and the insurer's August 7, 1980 partial denial. The issues at that hearing were the compensability of claimant's ankylosing spondylitis and/or the extent of claimant's permanent disability, including permanent total disability. Referee James concluded:

> "Claimant's underlying disease, ankylosing spondylitis, was aggravated by the industrial injury but . . . [s]omewhere along the line the aggravation may have ceased, leaving some 'permanent' injury as a result of the aggravation. When the aggravation ran its course, if it did, or how much damage was done by this is thus far unknown."

The Referee set aside the insurer's partial denial and remanded the claim for processing. He found it inappropriate to rate the extent of claimant's temporary or permanent disability at that time. He ordered:

> "[C]laimant's claim is remanded . . . to provide claimant temporary total disability and permanent disability benefits that may have resulted from aggravation of the ankylosing spondylitis as caused by the industrial injury of July 16, 1976 and further process the claim, as necessary, until the claim is again ready for closure, pursuant to ORS 656.268; to the extent that the above Order is contrary to the [insurer's] denial . . . the denial is reversed. * * * "

On the insurer's request for reconsideration, the Referee adhered to his original order, further stating:

> " * * * The referee did not discuss [Weller v. Union Carbide, 288 Or 27 (1979)] in his [order] because he believed discussion was not necessary in view of his ultimate conclusion that claimant's underlying ankylosing spondylitis was aggravated by the industrial injury -- leaving some permanent injury as a result of the aggravation.
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> * * *
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> "The remand was proper. The first issue in the hearing was that of the compensability of the ankylosing spondylitis. Having decided in claimant's favor it was incumbent upon the referee to remand the claim for appropriate processing rather than to attempt administration of the claim himself.
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> "Admittedly further processing of the claim could be difficult. However, in view of the fact that the referee's decision was greatly influenced by the opinion of Dr. Hakkinen, further processing may require no more than obtaining answers from Dr. Hakkinen as to how long, if ever, the ankylosing spondylitis kept claimant off work and how much permanent damage [it did]."

On July 27, 1981 the insurer's claims examiner discussed claimant's condition with Dr. Hakkinen, and the substance of this conversation was reduced to writing in a letter dated July 29, 1981, which was forwarded to Dr. Hakkinen for a statement of his concurrence. On July 30, 1981 Dr. Hakkinen signed the statement, which is aptly summarized in Referee Mannix's order in this case as follows:

> " * * * Dr. Hakkinen indicated that claimant's ankylosing spondylitis was probably aggravated or exacerbated by the July 16, 1976 industrial injury, but that the effect of this industrial injury (a back strain) had ceased to exist sometime prior to Dr. Hakkinen's first examination of claimant in June 1978. Dr. Hakkinen further indicated that claimant's ankylosing spondylitis was continuing to progress on its own, and that the chiropractic treatment claimant was receiving could aggravate the underlying ankylosing spondylitis."

On August 3, 1981 the insurer submitted the claim to the Evaluation Division for closure, indicating on its 1503 form that no compensation for temporary disability was due. On August 27, 1981 the claim was reclosed by a Determination Order which awarded no compensation for temporary total disability and no permanent partial disability in excess of that previously awarded by Determination Order, i.e., in excess of the previously awarded 160° for 50% unscheduled permanent partial disability.

In January 1982 this Board affirmed and adopted Referee James' order, which, as paraphrased in the Board's order, "remanded claimant's claim for ankylosing spondylitis to [the insurer] for acceptance and payment of compensation to which claimant is entitled." Jose G. Perez (WCB Case No. 80-01797), 34 Van Natta 419 (1982).

Claimant's attorney referred claimant for examination by Dr. Grossman, who also reviewed x-ray studies done in 1976, 1977 and 1978. He concluded that the 1976 films revealed relatively normal "sacroiliacs;" that the films taken in 1977 and 1978 revealed increasing sclerosis of the sacroiliac, osteoarthritis of the dorsal spine and straightening of the lumbar spine; and that these findings were consistent with ankylosing spondylitis and osteoarthritis. Dr. Grossman diagnosed ankylosing spondylitis, chronic back strain, chronic stress syndrome and osteoarthritis, concluding: "The injuries of 1976 probably accelerated the development of symptoms and x-ray findings of his condition." On June 17, 1982 Dr. Grossman reported to claimant's attorney that "there is no doubt that [claimant's] condition has progressed to the point where he is not capable of gainful employment. He is incapable of prolonged sitting or standing, and bending, twisting and lifting are to be avoided." Dr. Grossman indicated that he was unable to state whether claimant's condition would get worse. "It frequently does progress, but it does stabilize, too." Dr. Grossman expressly stated his opinion that claimant's current disability continued "because of the injury of July 1976, i.e.,

the strain superimposed upon and aggravating the ankylosing spondylitis."

The insurer referred claimant for examination by Dr. Fraback, whose specialty is rheumatology and internal medicine. Dr. Fraback examined claimant on July 6, 1982 and stated his impressions in a report dated July 9, 1982:

> "In summary, this man has long-standing low and mid back pain dating at least from the injury of July 1976. He has x-ray and clinical evidence of both osteoarthritis and ankylosing spondylitis. There is no x-ray evidence of the spondylitis involving anything above the sacroiliac joints. To answer your specific questions, it is impossible to state with any certainty whether the injury permanently aggravated the pre-existing condition of ankylosing spondylitis. It is generally accepted that trauma can aggravate spondylitis. The duration of the aggravation is based primarily on the patient's history and examination. His extensive osteoarthritic changes on x-ray complicate the picture. Much of his back pain may be due to the osteoarthritis and not the spondylitis. I suspect that the injury did aggravate the pre-existing spondylitis, but there is no way that I can say whether it did so permanently or if so to what extent. In regard to your second question, I doubt that he is capable of returning to some type of gainful employment based on his age, language barrier, educational level and degree of back pain."

Dr. Grossman's deposition was taken on August 31, 1982. His testimony was accurately summarized by Referee Mannix as follows:

> "It is his opinion that claimant's July 1976 industrial back strain made more rapid the development of the ankylosing spondylitis suffered by the claimant. The ankylosing spondylitis continues to be related to the July 1976 injury because of the more rapid development of the ankylosing spondylitis occasioned by the back strain. The back strain, now chronic, still exists. Claimant is a person predisposed to develop ankylosing spondylitis and may have developed it regardless of the July 1976 injury, but the July 1976 injury increased the speed of the progression of the underlying disease process.
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> * * *
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> "Dr. Grossman also opined that the July 1976 injury also 'probably contributed

> some' to the progression of another spinal condition suffered by claimant, which is osteoarthritis. Dr. Grossman could not say how much contribution there was, except to describe it as 'a little bit.' * * * Dr. Grossman could not be sure if the contribution had a 'significant' effect. * * * The doctor explained that his diagnosis of chronic stress simply describes a diagnosis of claimant's reaction to his situation, in which claimant is unable to cope with his problem as well as some others might. * * * "

At the hearing before Referee Mannix, a rehabilitation counselor testified, stating his opinion that claimant was not employable. Essentially, the counselor concluded that claimant presently has no work skills and would not be capable of performing any gainful employment. The Referee found, and we agree, that claimant's testimony regarding his physical condition is entirely consistent with the medical evaluations.

The hearing before Referee Mannix had convened pursuant to claimant's request for hearing after issuance of the August 27, 1981 Determination Order. The issues designated were temporary total disability, permanent partial disability, penalties and attorney fees for unreasonable resistance and/or delay in payment of compensation, permanent total disability and penalties for unreasonable claim closure. The contention that the insurer unreasonably resisted or delayed payment of compensation apparently arose as a result of its failure to pay temporary disability benefits upon receipt of Referee James' order, which, as noted by Referee Mannix, did not give any clear indication as to whether the insurer was required to provide temporary disability benefits pending further processing of the claim. "Rather the [prior order] established that, at some time, the ankylosing spondylitis was a compensable element of claimant's condition, and that the insurer was responsible for that portion of time and disability, whatever it may be."

Referee Mannix concluded that the prior Referee's order effectively reopened the claim for payment of temporary disability benefits until the insurer was able to further evaluate the claim and submit it for reclosure by the Evaluation Division. He, therefore, concluded that the insurer should have paid temporary disability benefits from the date of the Referee's order on reconsideration until the date that the Determination Order reclosed the claim. As previously mentioned, he also awarded claimant compensation for permanent total disability as of the date of the last Determination Order, based upon his conclusion that the medical evidence preponderated in favor of the finding that claimant's 1976 back strain caused claimant's ankylosing spondylitis to progressively worsen at a faster rate than it otherwise would have.

II

First we address the effect to be given Referee James' orders issued in June and July 1981, and the Board's affirmance of those orders. Claimant contends that the relationship between claimant's 1976 industrial injury, his ankylosing spondylitis, and his

entitlement to temporary and permanent disability compensation resulting from the ankylosing spondylitis condition involves a question concerning compensability that was adjudicated and finally determined in the prior proceeding before Referee James and the Board in WCB Case No. 80-01797.

We agree with Referee Mannix's analytical approach to this issue. His evaluation of the prior Referee's orders was that it established claimant's ankylosing spondylitis as an underlying condition which was, to some extent, "exacerbated" by the 1976 industrial injury. His conclusion that claimant was permanently and totally disabled was not premised upon the theory espoused by claimant, i.e., that Referee James' orders precluded a Referee in this proceeding from reexamining the interrelationship of claimant's injury and ankylosing spondylitis. Referee Mannix evaluated the question of the continuing effect of claimant's industrial injury vis-a-vis his ankylosing spondylitis condition on the merits, based upon the medical evidence bearing on that issue as it related to the extent of claimant's disability.

Although the hearing before Referee James included an issue concerning the extent of claimant's permanent disability, including the contention that claimant was permanently and totally disabled, it is fairly clear that, before considering the extent of claimant's disability, Referee James addressed the issue raised by the insurer's August 7, 1980 partial denial: The compensability of claimant's ankylosing spondylitis condition as a consequence of the 1976 industrial injury. Because Referee James found that claimant's injury had some effect upon the ankylosing spondylitis, he deemed it most appropriate to simply overturn the denial and remand the claim to the insurer for processing and payment of additional benefits, if any, that flowed from his finding that the injury interacted with the ankylosing spondylitis to result in some compensable consequences, the extent of which, based upon the record before Referee James, it was not then possible to determine.

There are situations in which a worker with an underlying condition experiences an exacerbation of that condition as a result of an industrial injury. If the underlying condition becomes symptomatic and the symptoms are disabling or require medical attention, then the underlying condition is a compensable consequence of the injury to some extent. E.g. Gerry W. Lowe, 35 Van Natta 1372 (1983); Betty L. Counts, 35 Van Natta 1356 (1983), as modified 36 Van Natta 18 (1984); Paul Scott, 35 Van Natta 1215 (1983); Jameson v. SAIF, 63 Or App 553 (1983); Boise Cascade v. Wattenbarger, 63 Or App 447 (1983). However, when the question of compensability arises, as it did in the prior proceeding before Referee James, the actual extent of the compensable consequences of the injury is usually not then in issue.

Sometimes an industrial injury merely results in a temporary worsening of symptoms of the non-industrial underlying condition, in which case the claimant is only entitled to compensation for the temporary consequences, that is, medical services and temporary disability compensation until the underlying condition returns to its premorbid status. On the other hand, sometimes an industrial injury causes a pathological change (acceleration, worsening, etc.) of an underlying condition or disease process, in which case all medical treatment for the underlying condition and all physical

impairment resulting from the underlying condition properly become part of the workers' compensation claim. Whether the industrial injury actually caused a pathological change in the underlying condition or whether it merely has caused a temporary worsening of the symptoms is not a determination generally made when the issue of compensability is initially litigated pursuant to a hearing request contesting a denial. Rather, such a determination of the extent of the compensable consequences of the injury generally must be reserved for a future hearing after the Evaluation Division has closed a claim pursuant to ORS 656.268.

Referee James' orders, although they are somewhat enigmatic, determined that claimant's industrial injury in 1976 caused a worsening of the non-industrial condition of ankylosing spondylitis to the extent that, at some point during claimant's very complicated medical history, claimant's ankylosing spondylitis became a compensable component of his claim. The question left unanswered by Referee James' order, and the question presently before us, is whether claimant's 1976 injury caused his underlying ankylosing spondylitis to become symptomatic, without contributing to a pathological change in that disease process; or whether the injury actually caused a permanent change in the underlying disease process, thereby making the underlying condition a component of the permanent residual effects of claimant's industrial injury. ORS 656.214(2). This obviously is a complicated factual determination, the proper resolution of which requires expert medical evidence.

Turning to the facts of this case, we find the medical evidence preponderates in favor of the conclusion that claimant's 1976 industrial injury merely caused the onset of symptoms of the underlying condition, ankylosing spondylitis, without causing a pathological change and without contributing to the further, continued progression of that disease process. Dr. Howard is a chiropractor and has not expressed an independent opinion concerning the causal relationship between claimant's original industrial injury and his ankylosing spondylitis. His statements regarding the extent of claimant's permanent disability, therefore, are not enlightening in this regard. The most recent Orthopaedic Consultants report states the opinion that the ankylosing spondylitis is not related to claimant's industrial injury. Dr. Robinson, who had examined claimant early in the history of this claim and before the diagnosis of ankylosing spondylitis was made, is of the firm opinion that the ankylosing spondylitis is not related to claimant's industrial injury. Like the most recent Orthopaedic Consultants panel, Dr. Robinson found claimant's overall impairment to be in the moderate range, but only minimal in relation to the original industrial injury.

Dr. Grossman's opinion is directly to the contrary. He firmly stated his belief that claimant's 1976 industrial injury accelerated the progression or development of the ankylosing spondylitis, and that all of claimant's present disability is thus the result of his industrial injury. Dr. Grossman aptly stated his reasons in support of this conclusion, which included the apparent medical fact that this disease process usually occurs in younger men between the ages of 20 and 30, and is seen less commonly in a man of claimant's age. Most of Dr. Grossman's depositional testimony, however, explains his conclusion that claimant's 1976 injury contributed to the onset of claimant's ankylosing

spondylitis without really explaining the basis for his conclusion that the industrial injury continues to play a material role in the further progression of the underlying disease process. To the extent that Dr. Grossman's testimony could be understood to explain the relationship between claimant's original industrial injury and further progression of the ankylosing spondylitis, his conclusions are largely based upon speculation, albeit, educated speculation. Dr. Grossman, who examined claimant on one occasion apparently for the express purpose of attempting to establish a causal relationship between claimant's original industrial injury and his present medical condition, clearly testified as an advocate in behalf of claimant, as opposed to a more objective medical examiner whose opinion was solicited on the basis of his examinations of, familiarity and relationship with the claimant and his medical history. It is in this light that we have considered Dr. Grossman's depositional testimony.

The opinions of Orthopaedic Consultants and Dr. Robinson, on the one hand, and Dr. Grossman on the other, are at opposite extremes. The remainder of the medical opinions contained in the record tend to fall somewhere in between.

Dr. Fraback is a rheumatologist and, therefore, presumably would know a good deal about the possible interrelationship of claimant's industrial injury and his ankylosing spondylitis. Dr. Fraback candidly admitted the uncertainty involved in determining whether the injury permanently worsened the underlying spondylitis. Although he stated that it is generally accepted that trauma can aggravate spondylitis, he indicated that the duration of the aggravation is based primarily on the patient's history and examination. Medical certainty is not required; however, medical probability is required. Dr. Fraback's opinion does not contribute significantly in establishing that, as a matter of medical probability, claimant's 1976 industrial injury caused or materially contributed to the development and further progression of claimant's ankylosing spondylitis.

Dr. Frink indicated in November of 1978 that the most likely cause of claimant's impairment was the progression of the spondylitis. Dr. Hakkinen, who had treated claimant's ankylosing spondylitis, indicated that since the time of his first examination of claimant in June 1978, he was treating claimant for the progressive spondylitis, as opposed to the effects of his back strain, and that the development and further progression of the ankylosing spondylitis could have been expected even in the absence of the industrial injury. This is entirely consistent with Dr. Hakkenin's earlier statements characterizing claimant's medical condition as a "slowly progressive disease," which would probably progress to "slowly ankylose his spine despite medical treatment," and the statement that claimant's medical condition is "an underlying disease process that was only exacerbated by his industrial injury."

Claimant is severely disabled. We agree with the Referee's finding that the major component of this disability is claimant's ankylosing spondylitis. We are unable to agree with the Referee's conclusion, however, that the progression of claimant's ankylosing spondylitis condition, which accounts for the present disability from which he suffers, is attributable in material part to claimant's 1976 industrial injury. Accordingly, we reverse the Referee's award of permanent total disability.

In evaluating the extent of claimant's permanent partial disability, we have considered the medical opinions which indicate that the residual impairment from which claimant suffers as a result of his 1976 industrial injury is in the mild category, in light of the pertinent social/vocational factors set forth in OAR 436-65-600 et seq. Considering these guidelines and other cases involving similarly situated injured workers, we find the prior awards claimant has received, which total 160° for 50% unscheduled permanent partial disability, adequately compensate claimant for the residual impairment attributable to his 1976 industrial injury. Accordingly, we affirm the August 27, 1981 Determination Order awarding no additional permanent partial disability.

III

We conclude that Referee Mannix's award of additional temporary total disability was in error. There is no indication that claimant's condition has been anything other than medically stationary since the last claim closure preceding Referee James' orders, which was by Determination Order dated June 1, 1979. Even considering the possibility that Referee James' orders may have imposed the obligation to pay additional compensation for claimant's ankylosing spondylitis condition, there was nothing in the medical reports dated before or after Referee James' orders to indicate that the spondylitis condition was other than medically stationary. There being no indication that claimant was entitled to additional temporary disability prior to June 1, 1979, or that claimant's condition had worsened sometime after that date, Referee James' orders imposed no obligation other than to require the insurer to further process the claim; i.e., to determine whether claimant was entitled to any further benefits as a result of the ankylosing spondylitis condition, possibly including payment of any outstanding medical bills submitted to the insurer in connection with treatment for the ankylosing spondylitis condition. We find no evidence to substantiate Referee Mannix's order awarding additional temporary disability from July 14, 1981 until the date of the Determination Order reclosing the claim on August 27, 1981. His rationale that Referee James' orders effectively reopened the claim for provision of time loss is simply wrong.

ORDER

The Referee's order dated November 12, 1982 is reversed. The Determination Order dated August 27, 1981, which awarded claimant no additional compensation for temporary total or permanent partial disability, is affirmed. Claimant's present awards for permanent partial disability total 160° for 50% unscheduled permanent disability.

OSCAR ROTH, Claimant
Michael Dye, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 83-04188
May 11, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests and the insurer cross-requests review of Referee Thye's order which awarded claimant 90% (288°) unscheduled permanent partial disability for injury to the right shoulder, that being an increase of 35% (112°) over and above the April 22, 1983 Determination Order. Claimant contends that he is entitled to an award of permanent total disability. The insurer contends that the Referee's award of 90% permanent partial disability is excessive.

We agree with the Referee that claimant is not entitled to an award for total disability. We agree with the insurer that the Referee's award of 90% permanent partial disability was somewhat excessive.

There is no question that claimant sustained significant impairment in his right shoulder as a result of his compensable injury. Claimant suffered a massive tear of the rotator cuff and underwent a right shoulder exploration with rotator cuff repair in January 1982. As a result of his injury, claimant has an essentially nonfunctioning right rotator cuff. Claimant's right shoulder has an anterior subluxation which causes difficulties in redeveloping good muscle strength and results in pain; this, in turn, limits claimant's ability to use his right arm. Claimant is unable to raise his right arm above the plane parallel to the ground, and is thus unable to perform any work requiring use of his right arm away from his side. Claimant is totally unable to perform any work requiring overhead reaching, is unable to push or pull things with his right arm unless it is braced against his body, has significantly limited lifting ability with his right arm, and has somewhat limited ability to manipulate objects with his right arm. Claimant also appears to have some preexisting tendinitis and/or bursitis in his left shoulder. Although claimant suffered a stroke approximately three years prior to his compensable injury, he apparently is now fully recovered from that incident.

With regard to the social/vocational considerations, claimant was 59 years of age at the time of the hearing. Claimant has a high school education and appears to be of average intelligence. Claimant has been a meat cutter all of his working life; he is no longer able to return to that occupation as a result of his compensable injury. Although claimant did participate in a direct employment program, the program was eventually terminated in July 1983 due to a lack of success.

Even though claimant does have a significant disability as a result of his injury, no physician who has examined or treated claimant since he became medically stationary in March 1983 has indicated that claimant is permanently and totally disabled. The medical consensus is that claimant is capable of performing light and sedentary work. Although claimant has limited ability to use his right arm, he has no actual disability in his right arm distal to his shoulder. Claimant was right handed prior to his injury, but is now able to perform most functions with his left hand.

Other than his right shoulder impairment, claimant has no disability to any other part of his body, except some apparent tendinitis and/or bursitis in his left shoulder, and is otherwise unrestricted from a physical standpoint. Claimant thus cannot be said to be permanently and totally disabled from a medical standpoint alone.

Although claimant's age and limited work experience are negative factors in his employability, we do not believe that these factors are sufficient, when considered with claimant's physical condition, to render him permanently and totally disabled. Claimant has a high school education, served in the army for two years and received an honorable discharge. Claimant has a steady work history, suffers from no psychological or emotional difficulties and is of at least average intelligence.

Claimant's participation in a direct employment program would appear to have been met with generally minimal enthusiasm. Various reports contained in the record from Comprehensive Rehabilitation Services, Inc. indicate that claimant had applied for social security disability, that he exhibited a self-concept of total disability, that he did not appear to be interested in rehabilitation because he had always intended to retire at age 62, and that claimant was resistant to relocating or considering jobs paying less than $10 per hour. Claimant testified at the hearing that he was receiving social security disability benefits.

Considering the record as a whole, we cannot conclude that claimant has established entitlement to permanent total disability. Moreover, we conclude that the Referee's award of 90% unscheduled disability is excessive. The evidence recited above indicates that the earning capacity claimant retains is somewhat greater than that found by the Referee. Considering the guidelines for the rating of unscheduled disability, OAR 436-65-600 et seq., and similar cases, we conclude that claimant would be adequately compensated with an award of 75% unscheduled permanent partial disability.

ORDER

The Referee's order dated October 14, 1983 is modified. Claimant is awarded 75% (240°) unscheduled permanent partial disability. This is in lieu of and not in addition to all prior awards. Claimant's attorney's fee should be adjusted accordingly.

DOUGLAS J. WINDRESS, Claimant
Williamson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01168
May 11, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Gemmell's order which set aside its denial of claimant's occupational disease claim for his hands, neck and shoulder condition.

SAIF contends the medical evidence fails to substantiate the presence of an occupational disease. Further, SAIF asserts that the medical opinions of a work relationship are solely based upon claimant's history and not upon objective evidence. Inasmuch as claimant's credibility has been seriously discredited, SAIF contends these opinions are of questionable value. Consequently,

SAIF argues that claimant has failed to meet his burden of proving compensability. We agree.

We do not find the medical opinions of a work relationship persuasive. Neither claimant's family doctor nor his treating chiropractor-naturopath provide an analysis or an explanation for their conclusions that claimant's condition was work-related. The diagnoses ranged from overuse myalgia syndrome to chronic cervical-upper thoracic compression sprain. These opinions are apparently based upon claimant's description of his job as a trim puller at a sawmill. There is no indication that either doctor was aware of the specific physical demands entailed in the job. Furthermore, when claimant's testimony is compared with the contradictory testimony of his foreman and co-worker, there is reason to believe claimant significantly exaggerated the physical duties required in his trim puller job.

Prior to the date of claimant's termination, both doctors had released claimant to regular work without restrictions. The only evidence that indicated claimant was not released for regular work is a checked box on an 827 form signed by claimant's chiropractor-naturopath. Coincidentally, this form is dated the same day claimant was terminated. We do not find this evidence persuasive.

The Orthopaedic Consultants diagnosed bilateral shoulder, arm and hand pain, by history, and functional overlay. They noted a "total absence of objective findings." Dr. Stolzberg, psychiatrist, felt claimant was a "somewhat hypochondriacal individual" who tended to "over-value physical sensations and somatic symptoms." No doctor reports any objective findings. This absence of objective findings we find particularly noteworthy since claimant testified that during this time period his knuckles became so swollen that he could hardly move them.

Our review of the record reveals that claimant's primary concern appears to be frustration with his job and particularly, his foreman. Claimant's family doctor acknowledged claimant's rising frustrations with his situation. Claimant's subsequent claims for unemployment compensation and discrimination tend to substantiate this conclusion.

Finally, there are several discrepancies and contradictions in claimant's testimony, any one of which would call claimant's credibility and, therefore, his medical histories, into question. The most damaging revelation in our mind is the testimony of claimant's co-worker. The co-worker testified that claimant attempted to influence the co-worker's testimony concerning claimant's unemployment compensation hearing. The unemployment compensation issue, which stemmed from claimant's termination, coincided with claimant's workers' compensation claim. When the co-worker refused to change his recollection of the events surrounding claimant's dismissal, claimant became upset. The co-worker testified he was forced to "run him off" the co-worker's property.

Under these circumstances, we find that claimant has failed to sustain his burden of proving the compensability of his occupational disease claim.

ORDER

The Referee's order dated October 25, 1983 is reversed. The SAIF Corporation's denial dated January 13, 1983 is reinstated and affirmed.

THOMAS L. LEARY, Claimant
Erickson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
William Stockton, Defense Attorney

WCB 82-07057, 82-02405, 82-02406, 82-02407 & 82-02408
May 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Galton's order which held that claimant had sustained a compensable aggravation under ORS 656.273.

SAIF argues that the aggravation question was not an issue at hearing. We agree.

Claimant compensably injured his right elbow in June 1978. The claim was closed by a Determination Order which granted no award for permanent disability. Claimant sustained three other right elbow injuries during the next year. In January 1982 SAIF issued a partial denial which specifically reaffirmed that SAIF had accepted claimant's June 1978 injury and the other three elbow injuries. However it stated:

> "[A]fter careful examination of all information in your claim file, we find that we are unable to accept responsibility for your current right elbow tendinitis and/or right shoulder bursitis. Medical information in your file indicates your current and recent right sided problems are not the direct result of any of the industrial injuries of 1978 or 1979 while employed by Mercer Industries, but are probably related to more current activities."

Claimant was working for another employer, also insured by SAIF, at the time. He, therefore, filed a claim against the second employer. SAIF denied both compensability and responsibility on behalf of the second employer. Claimant filed a request for hearing on the denial related to the June 1978 injury and the other three injuries at the same employment which stated:

> "The issue to be presented for resolution is the appeal of the denial of responsibility for claimant's current right elbow tendinitis and/or right shoulder bursitis...."

Claimant later requested a hearing on the denial related to the claim against the second employer which framed the issue exactly the same. At hearing, the Referee framed the issues:

> "The first four case numbers deal with a protest to the SAIF Corporation's denial of January 21, 1982 insofar as only, as claimant is protesting denial of compensability and responsibility for his

right elbow claim. Claimant requests the denial be set aside and SAIF Corporation requests that it be affirmed.

"The latter case arises out of a denial entered by SAIF Corporation on June 29, 1982 which claimant is also requesting be set aside and SAIF Corporation is requesting be affirmed."

Claimant's attorney agreed with the Referee's statement of the issues. He made the following opening statement:

"I am not waiving any claims against any of the matters we have appealed here today, but I will be emphasizing after reading all the medical reports submitted here, it is my opinion this appears to be an aggravation of a Mercer Claim...date of injury June 1st, 1978.

"[Claimant] will testify at that time, June 1, 1978, he did incur an injury and has had ongoing problems with his right elbow ever since that time including up to the present time. There appears to have been no new injury at his current employer...."

The Referee found that claimant's current condition was caused by the June 1, 1978 injury. In addition, he found that claimant's condition had aggravated so that he is entitled to reopening of the claim pursuant to ORS 656.273. SAIF concedes that claimant's current condition was caused by the June 1978 injury. However, it argues that the issue of a reopening for an aggravation claim under ORS 656.273 was never raised.

We find that the issue of whether claimant had sustained an aggravation which requires reopening under ORS 656.273 was never properly raised. No claim for an aggravation was ever presented to SAIF, either by claimant or any physician. The requests for hearings do not raise the issue of aggravation. The Referee's statement of the issues does not raise an aggravation issue. Finally, we agree with SAIF's attorney that claimant's attorney:

"[U]sed 'aggravation' in his opening statement to mean that an earlier injury had caused claimant's condition. In context [claimant's attorney's] remarks could not be interpreted to mean that claimant believed his condition had worsened as a result of an earlier injury."

We have previously said that Referees should not decide issues not properly before them. Michael R. Petkovich, 34 Van Natta 98 (1982). Accordingly, we reverse that portion of the Referee's order which found that claimant had sustained an aggravation which required reopening under ORS 656.273. We note that even if this issue were properly raised, we would find that claimant failed to prove that he sustained a compensable worsening which would require reopening under ORS 656.273.

ORDER

The Referee's order dated October 14, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which remanded the claim for processing under ORS 656.273 is reversed. The balance of the Referee's order is affirmed.

CHARLES MADDOX, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 79-09937
May 15, 1984
Order on Remand

This matter is before us again for a determination of the extent of claimant's disability. There has been considerable prior litigation involving this claim, both in this proceeding and in another case which involved the question of whether claimant's psychiatric illness is compensable as an occupational disease. The history of the prior proceedings is set out in SAIF v. Maddox, 295 Or 488 (1983), and need not be repeated here.

In the other case, claimant's claim for psychiatric illness was ultimately found compensable. In this case the Referee concluded that claimant was permanently and totally disabled due to his psychiatric illness. Although we adopt the Referee's summary of the background facts as our own, we conclude that claimant has not proven that he is totally disabled.

There are very few medical reports in the record which address the question of the extent of claimant's disability. What few reports there are come from only two physicians -- Dr. Parvaresh, a psychiatrist who examined claimant at the request of SAIF, and claimant's treating psychiatrist, Dr. Paltrow. After examining claimant and reviewing his medical records, Dr. Parvaresh reported on April 10, 1980:

> "It is my further clinical opinion that the psychiatric impairment is in the range of [the] upper limits of mild and that considering [claimant's] experience and training in the past, should not interfere with his ability to gain employment in the field of vocational counselling. In terms of disability rating, I believe his psychiatric disability should not be greater than 20% maximum allowed for unspecified injury."

Dr. Paltrow's opinions seem to vary. On November 2, 1979 Dr. Paltrow reported that claimant would be unable to return to his employment as a vocational counselor, or any job similar in nature because, "The professional demands and the stress would create decompensation." Dr. Paltrow felt that this was a permanent condition. However, Dr. Paltrow reported on February 13, 1980 that: "I have strongly encouraged [claimant] to look for a possible opening in his professional field, particularly as a vocational counselor, even if it were in a remote area of this, or any other state." When asked for an opinion on the extent of claimant's disability based on the American Medical Association's Guidelines to the Evaluation of Permanent Impairment, Dr. Paltrow responded in his February 28, 1980 report as follows: "[I] would

describe [claimant] as coming under aegis of psychoneuroses, Class II-Impairment of Whole Man-10%-45%."

Confusing matters further, Dr. Paltrow testified at that hearing that, in his opinion, claimant would be unable to hold down a job. Apparently the basis of Dr. Paltrow's new opinion was that, "if an individual has to live with depression, anxiety and the fear for his food, shelter and clothing, he can't hold down a job." However, on cross examination Dr. Paltrow testified that he continued to advise claimant to seek and obtain employment if possible because he felt that working would be good therapy for claimant because it might enable claimant to regain some of his lost self-esteem. Dr. Paltrow testified that he would have encouraged claimant to continue working at a part-time job he previously obtained at Herfy's, had the job not terminated when the company was sold.

Dr. Paltrow was also questioned concerning his use of astrology in his medical practice. The following exchange took place at the hearing between defense counsel and Dr. Paltrow:

> "A: When you asked me if I used astrology to come to a diagnosis in my evaluation, I answered, 'No.' Then you presented this [a deposition given by Dr. Paltrow in a prior case] to the [Referee]. This does not indicate that I use astrology to come to any psychiatric diagnostic conclusion.
>
> "Q: I am sorry if I mischaracterized your position. What do you use astrology for, then?
>
> "A: There are many patients who are interested in the field of metapsychology, akin to metaphysics. In psychiatry today metapsychiatry is a new field. It is the subject of exorcism, hexes, astrology, reincarnation, telepathy, and there are about 4,000 psychiatrists now who would like to form the American Metapsychiatric Association; and I am one of them. There are many patients who come in and they have had precognition, they believe in reincarnation, they have had their horoscopes done and they are interested in astrology. I tell them if I can relate it to psychiatry to help them, I will: but it is not part of any official American Psychiatric Association diagnosis.
>
> "Q: So it is a fair statement . . . that you use astrological signs to sometime help speed up therapy in some of your patients?
>
> "A: Yes.
>
> "Q: Was that done in this case, when you indicated that Pisces was the astrological sign of [claimant], was that your intent?

> "A: My intent was to give myself more provocative thought to help this person. One of the major cornerstones of a Piscian, if you are interested in astrology, is the belief, and I have struggled to get him to believe in himself, in his adaptability. I don't believe astrology was mentioned at any other time except for my own note that, that fit in with a Piscian."

This raises some doubts, to say the least, in our minds concerning how much weight, if any, to accord Dr. Paltrow's opinions, and we are thus puzzled how the Referee could have found Dr. Paltrow's analysis to be "succinct, plausible and entirely understandable."

Since we find no convincing evidence in the record that claimant is permanently and totally disabled from a medical standpoint alone, we turn to the relevant social/vocational considerations. Claimant was 58 years of age at the time of the hearing. He has a Bachelor's degree in psychology and a Master's degree in social psychology and counseling. Claimant did post-graduate work and completed more than 12 months of a psychiatric internship at the psychiatric hospital in Rosemead, California. Claimant worked as a fraternal counselor with the Lutherean Aid Association from 1960 to 1963 and then in a public relations position for the Mossy Rock Dam project in Washington. Claimant worked for the State of Alaska as a counselor from 1970 to 1971 and worked for the Oregon Department of Vocational Rehabilitation from 1972 through 1977.

Claimant's extensive educational and employment history indicates that he is probably above average from an intellectual standpoint, and that he has numerous transferrable skills. Subsequent to the termination of his employment with DVR in 1977, claimant went into business on his own as a private vocational consultant. Although claimant found it not economically feasible to continue this business, we understand his hearing testimony to be basically to the effect that he was able to do this work despite his psychiatric illness. Claimant later obtained employment as a clerk in the Portland Merchant's Exchange. Claimant handled the telephones which consisted of 35-40 lines for shipowners and brokers, and monitored two or three radio channels as well. Claimant left this job by mutual agreement with his employer because he was unable to keep up with all of the necessary paperwork.

Following his employment with the Portland Merchant's Exchange, claimant obtained employment with Herfy's restaurant on a part-time basis. Claimant lost this job when Herfy's sold out to Arctic Circle. As we previously noted, Dr. Paltrow testified that he would have encouraged claimant to continue working at Herfy's had the restaurant not been sold. Although such employment does not correspond very well with claimant's educational background, it nevertheless indicates that claimant is capable of gainful employment from a physical and mental standpoint.

Having concluded that claimant is not totally disabled, the question becomes: What is the extent of claimant's permanent

partial disability due to his compensable psychiatric illness? Considering the record as a whole, the guidelines stated in OAR 436-65-600 et seq., and similar cases, we conclude that claimant would be adequately compensated by an award of 40% unscheduled permanent partial disability.

ORDER

The Referee's order dated June 30, 1980 is reversed. Claimant is awarded 40% (128°) unscheduled permanent partial disability, that being an increase of 25% over and above the Determination Orders of March 14, 1978 and April 20, 1979. This award is in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly.

WESLEY G. MARQUIS, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-09658
May 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests and claimant cross-requests review of Referee Howell's order which set aside SAIF's denial of claimant's psychiatric condition and upheld SAIF's denial of claimant's low back injury claim. SAIF contends that claimant's psychiatric claim is not compensable. Claimant contends that his low back claim is compensable. Claimant also moves for a remand in the event the Board finds the record was not adequately developed in light of McGarrah v. SAIF, 296 Or 145 (1983).

We find that both claimant's psychiatric claim and low back claim are compensable, we reverse the Referee's order with regard to the low back claim and we affirm the Referee's order with regard to the psychiatric condition.

Claimant is a 43-year-old male who, at the time of the events leading to his workers' compensation claims, worked as a line maintenance man for the City of Roseberg, Sewer Division. Claimant encountered several stresses on his job, as outlined in the Referee's following findings of fact, which we adopt:

> ". . . Based upon preliminary discussions with the superintendent of the Sewers Division, claimant understood the job to be that of a 'foreman.' He also understood that he would be provided the use of a pickup to drive to and from work.
>
> "Claimant quit work with the City of Klamath Falls to accept the job with the City of Roseburg. On November 1, 1981, the day before claimant was to begin his new job, he discovered that the job was actually that of 'lead man' of a two person crew. He also found that no pickup was then available for his use. Claimant accepted the job nonetheless.
>
> "When claimant first began working he and his supervisors discussed various problems

with past and present Sewer Division employees. Claimant understood from those discussions that his supervisors had devoted considerable effort into 'getting rid of' the employee whom claimant had succeeded. He also understood that his supervisors were out to get two or more remaining employees. He understood that management intended to get rid of one particular employee, who supposedly caused considerable trouble, by promoting him to a supervisory position within the division. Claimant believed that he was taken into his supervisors' confidence for the purpose of spying on other employees.

"After three to four months on the job, claimant became friends with his fellow employees. He then felt 'caught in the middle' between the pressures he perceived from management and his concern for fellow employees. He began to feel insecure and felt management might be interested in terminating his job, just as he understood they had his predecessor's.

"On August 11, 1982 claimant and another employee were directed to go into a 42-inch diameter sewer line which was then in service. Claimant and the other individual were to locate a stub in the trunk line which they had been unable to locate from above ground or with the use of a television camera. Using a 50-foot tape, hip waders and a gas detection meter, claimant and the other individual moved down the line. While in the sewer claimant had difficulty breathing and, on one occasion, had to stop to catch his breath. While in the sewer line claimant was in a squatting position. His back began to hurt and he sat in about 12 inches of water for some time to relieve that pain. Claimant went a total of 100 feet into the line and was in the sewer about 10 minutes.

"Later, claimant developed increased concern over the possible dangers to which he had been exposed in the sewer. He believed the procedures he had followed were in violation of safety standards and presented a risk of exposure to methane or other toxic gases. He also felt that he was subject to injury from materials moving down the sewer line. Claimant began to suspect that the employer had been trying to kill him.

"On August 12, 1982 claimant reported to his supervisor that his back had been painful since the previous day. The

supervisor filled out an accident report. Claimant made no further complaints of back pain to his supervisor. . . .

"Shortly after the August 11, 1982 sewer incident claimant met with a union representative and his supervisor concerning his use of sick leave and his entitlement to overtime pay. Claimant became extremely upset as a result of that meeting.

"During the next two weeks claimant was observed by several co-employees to be emotionally upset. On, or shortly before, August 31, 1982 claimant submitted a resignation (Ex. 12A). His immediate supervisor attempted to dissuade claimant from resigning, but during one or more of those conversations claimant was loud and abusive. He was characterized by one observer as wild and violent and by the supervisor himself as irrational and paranoid.

"On September 3, 1982 claimant saw Dr. Williams complaining of back pain since the August 11, 1982 sewer incident. Dr. Williams diagnosed as work-related lumbo-sacral strain and treated claimant for both his back pain and boils (Exs. 11 & 13). Claimant was not considered disabled from work during that treatment (Ex. 13). Claimant had undergone a laminectomy in 1969 and had multilevel degenerative disc disease. In 1975 he suffered a compensable back injury and as late as 1981 claimant had back problems which SAIF denied as being related to the 1975 injury (Ex. 12). . . .

* * *

"On February 28, 1982 Dr. Henderson testified that claimant had experienced depression as a result of his perception of work-related matters such as safety concerns, his supervisor's behavior and conflicts between his loyalty to management and fellow employees. Dr. Henderson felt claimant had no personality disorders, nor any other source of stress outside his employment which could have accounted for his depression. Dr. Henderson also doubted that claimant had filed a false claim to obtain revenge against his former employer. Claimant's progress during treatment from October 1982 until February 1983 tended to confirm Dr. Henderson's original diagnosis of work-related depression (Ex. 26)."

Psychiatric Claim

Regarding the psychiatric claim, the Referee stated, "The possibility that claimant's perceptions of management pressure, danger, etc. were distorted or unrealistic is irrelevant. . . . See, McGarrah v. SAIF, 59 Or App 448 (1982)." The Referee then found that claimant had proven he suffered from depression, that the major contributing cause of that condition was his employment and that his depression, therefore, is compensable.

Since the date of the Referee's order, the Supreme Court has decided McGarrah v. SAIF, 296 Or 145 (1983). The court held:

> "The stress conditions must actually exist on the job. That is, they must be real, not imaginary. The views of an average worker or average person or the perceptions by the claimant may be relevant, but are not determinative. The existence of legal cause of stress-related occupational disease must be determined objectively." 296 Or at 165. (Footnotes omitted.)

Subsequently, the Court of Appeals decided Elwood v. SAIF, 67 Or App 134 (1984), in which the court stated that McGarrah poses the following four questions:

> "1. What were the 'real' events and conditions of plaintiff's employment?
>
> "2. Were those real events and conditions capable of producing stress when viewed 'objectively,' even though an average worker might not have respond [sic] adversely to them?
>
> "3. Did plaintiff suffer a mental disorder?
>
> "4. Were the real stressful events and conditions the 'major contributing cause' of plaintiff's mental disorder?" 67 Or App at 137.

We first examine the record to determine whether it was adequately developed in light of the legal standard established by McGarrah. We find that the record contains adequate evidence of whether the job stresses alleged by claimant actually existed. Therefore, we do not find it necessary to remand for further development of the record.

Next, in accordance with McGarrah and Elwood, we review the record to determine whether the events and conditions described by claimant were real, if so, whether those real events and conditions were capable of producing stress when viewed objectively, whether claimant suffered a mental disorder, and whether the real stressful events and conditions were the major contributing cause of claimant's mental disorder. Claimant contends that he became depressed and that his depression was caused by the concerns he had about the safety of entering the sewer line, the conflicts he had

with management regarding the terms of his employment and the conflicts he had regarding his loyalty to management and fellow employes.

Based on the testimony of claimant, the testimony of claimant's co-workers and some of the testimony of claimant's supervisor, we find that the events and conditions alleged by claimant actually existed and were capable of producing stress when viewed objectively. We also find that claimant suffered depression which required psychiatric treatment. Further, we find that these real work-related stresses were the major contributing cause of claimant's depression. Therefore, we agree with the Referee that claimant's psychiatric claim is compensable.

Back Claim

Regarding claimant's low back claim, the Referee stated:

> "Dr. Williams felt claimant had suffered a lumbosacral strain as a result of that incident in the sewer. However, it cannot be determined from the record whether Dr. Williams was aware of claimant's previous history of back problems (from the record it appears unlikely). Consequently, it cannot be determined whether Dr. Williams would have attributed claimant's back problems in any material way to the incident in the sewer had he been aware of his preexisting condition."

The record, however, contains a letter dated January 11, 1983, written by claimant's attorney to Dr. Williams, asking Dr. Williams to answer some questions in light of claimant's history of preexisting low back problems. In this letter claimant's attorney gave Dr. Williams claimant's history of a back injury in 1968 or 1969, subsequent hospitalizations and surgery, a 1975 industrial back injury and an exacerbation of back pain in 1981. In a "check the boxes" format signed on February 1, 1983, Dr. Williams indicated that at claimant's initial visit on September 3, 1982 and subsequently, Dr. Williams did not inquire about and claimant did not volunteer the history of his preexisting back problems. In addition, Dr. Williams indicated that assuming claimant's history of preexisting back problems as outlined by claimant's attorney, the August 1982 incident aggravated claimant's preexisting back condition, caused claimant to experience additional pain and caused claimant to require medical treatment for his back strain.

Based on this opinion of Dr. Williams, given after obtaining claimant's history of prior back problems, we find that claimant has proven that he suffered a compensable low back injury on August 11, 1982 while squatting in the sewer line.

ORDER

The Referee's order dated May 27, 1983 is affirmed in part and reversed in part. The Board affirms that portion of the Referee's order which set aside SAIF's denial of claimant's psychiatric claim. The Board reverses that portion of the Referee's order which upheld SAIF's denial dated October 15, 1982

and that denial is set aside and claimant's low back injury claim is remanded to SAIF for acceptance. Claimant's attorney is awarded $500 as a reasonable attorney's fee for services at hearing with regard to claimant's denied low back claim and $650 for services on Board review, to be paid by the SAIF Corporation.

JOHN W. ROBB, Claimant
Evohl Malagon, Claimant's Attorney
Schwabe, et al., Defense Attorney

WCB 82-11626
May 15, 1984
Order on Review

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Quillinan's order which set aside its November 24, 1982 denial of compensability of claimant's hearing loss claim, and assessed penalties against the employer in the total amount of 20% of whatever amount of permanent partial disability might be awarded by the Evaluation Division upon closure of the claim. The employer contends that the Referee erred on all counts.

Claimant, who was 43 years of age at the time of the hearing, had been employed by Weyerhaeuser Company since February 1960. Claimant worked primarily as a sawmill and planing mill foreman in various Weyerhaeuser mills. Claimant was exposed to mill noise in varying degrees of intensity.

An audiogram taken in December 1962 indicated that claimant had some high frequency hearing loss.

Sometime in the 1970's, claimant began to notice a gradual hearing loss. Claimant thereafter began wearing ear protection devices. Another audiogram taken in January 1977 revealed further erosion in claimant's hearing.

In April 1982 claimant was examined by Dr. Echevarria. On April 26, 1982 Dr. Echevarria reported that claimant had a 20 year history of gradual hearing loss which claimant believed to be work related. Testing by Dr. Echevarria revealed that claimant had a severe high frequency sensory neural hearing loss. Dr. Echevarria further stated, "I feel that it is probable that his work has played some role according to the history. . . ."

Claimant was thereafter referred to Eugene Speech Center. In a report dated May 14, 1982 Lynn Elliot, an audiologist, reported that claimant suffered from a mild to severe bilateral hearing loss in the mid to high frequency range. It was expected that claimant would experience difficulty understanding a conversation with any amount of noise in the background, but that amplification could significantly improve the situation.

On May 25, 1982 claimant filed a claim contending that his hearing loss was work related. The claim was not denied until November 24, 1982. There is no contention in this case that any interim compensation was owed, or if owed, was unpaid.

The only other medical evidence in the record is an undated report from Dr. Echevarria. Dr. Echevarria reported:

> "When I examined [claimant] on April 26, 1982, my diagnosis was that of severe high

> frequency sensory neural hearing loss. I also felt that it was probable that his work played some role in the hearing loss, however, I arrived at this conclusion by history only. I have no pre-employment or inter-employment audiograms upon which to base my opinion. * * *
>
> "If you could obtain [claimant's] audiograms through the years which have been performed at Weyerhaeuser, and if they have been consistent with the medical history, it would then be likely that [claimant's] employment was a substantiali contributing factor in his current permanent hearing loss."

The evidence with regard to off the job noise exposure consists of the following. Claimant owns an ocean-going fishing boat that has twin 40 horsepower outboard motors. Claimant has owned a rifle for the past twenty years and a shotgun until about six years before the hearing. Claimant goes deer hunting yearly. Claimant uses a chain saw from time to time to cut wood.

The Referee concluded that based on claimant's testimony regarding the nature and quality of his on-the-job noise exposure versus his off-the-job noise exposure, the fact that what audiograms were in existence showed a progressive hearing loss, and the "fact" that, "It is reasonably well-established that individuals have differing sensitivities and tolerance to noise," the claim was compensable. We disagree.

We understand this claim to be based on occupational disease rather than injury. That being the case, claimant must establish that his employment exposure was the major cause of his hearing loss. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570 (1982). There is simply no evidence in this record which would allow us to conclude that claimant's employment was the major cause of his hearing loss.

A case very similar to the current case is Williams v. SAIF, 22 Or App 350 (1975). The facts of Williams involved a 66 year old claimant who had been employed for Bingham-Willamette Company for over 20 years. In 1945 the claimant was told he had a slight hearing loss. The claimant noticed a definite worsening of his hearng in 1971, and he filed a claim in 1973. The only medical evidence consisted of two audiograms and a single medical report. The audiograms revealed only a loss of hearing, which was not a contested issue. The medical report stated that claimant's hearing loss was "compatible" with noise exposure. 22 Or App at 352. The only other evidence consisted of claimant's testimony that he was exposed to tremendous noise levels at work. The court concluded:

> "[T]he evidence does not establish that clamant's hearing loss is related to his employment. Claimant did not produce noise level studies on his own behalf. Claimant presented no testimony from fellow workers regarding noise in the plant. No attempt was made to show that claimant had ever

> complained to anyone, including his doctor, fellow employes and his employer, that his hearing loss was related in any fashion to his employment. . . . We do not suggest that any one of these types of evidence is particularly required. We merely note that the non-medical evidence actually presented in this case was insufficient to establish a causal relationship between claimant's employment and his hearing loss." 22 Or App at 353.

We find the current case to be virtually a carbon copy of Williams. As in Williams, there is no question that the claimant in the current case has a hearing loss. The question is, the relationship between that hearing loss and claimant's employment. The only medical evidence claimant has presented consists of a report which says that it is "probable" that the employment played "some role" according to claimant's history, and another report which says that there is really no way of determining what role claimant's employment played in his hearing loss in the absence of additional audiograms. The only other evidence consists of claimant's testimony with regard to the noise he was exposed to. Although it might be tempting from a lay standpoint to find a causal connection, under Williams, Dethlefs and Gygi, the evidence in this case is insufficient.

On the issue of penalties, we also reverse. A portion of the penalties assessed by the Referee against the employer was based on the employer's failure to issue its denial within 60 days of notice of the claim. ORS 656.262(6). Subsequent to the hearing in this matter, we concluded in Ray A. Whitman, 36 Van Natta 160 (1984), that even if a denial is untimely, no penalties can be imposed if there is no compensation "then due." ORS 656.262(10). Since there is no contention that there was any compensation "then due" prior to the issuance of the denial in this case, it follows that the Referee's assessment of a penalty on that basis must be reversed.

Even in the absence of our decision in Whitman, the Referee's award of penalties against the employer would have to be reversed. As there was no compensation "then due" claimant prior to the denial, the Referee assessed a penalty against the employer based on a percentage of whatever future permanent partial disability claimant might receive at the time of closure. Since we have found the claim not compensable, there will, of course, be no valid award of permanent partial disability forthcoming. Additionally, prior to the issuance of the Referee's order in this case, we stated in Gary L. Clark, 35 Van Natta 117 (1983) and Alfred M. Norbeck, 35 Van Natta 802 (1983), that the compensation a claimant might receive in the future, such as in a future closure of his or her claim, is not compensation that is "then due" within the meaning of ORS 656.262(10) and, therefore, penalties cannot be assessed on that basis. See also Daniel J. Cannon, 35 Van Natta 1181 (1983). Thus, that portion of the Referee's order which assessed a penalty against the employer based on future compensation, as a result of the employer's failure to furnish medical reports in accordance with the provisions of OAR 436-83-460, must also be reversed. Claimant does not argue that a penalty can or should be assesed

against the employer on any other basis for its failure to adequately comply with the administrative rule.

ORDER

The Referee's order dated June 29, 1983 is reversed in its entirety. The employer's November 24, 1983 denial is reinstated and affirmed.

Board Member Barnes Dissenting in Part:

I disagree with that portion of the Board majority's decision which concludes that no penalty should be assessed because of the employer's admitted failure to timely comply with its discovery obligations under the Board's procedural rule.

I agree that the manner in which the Referee expressed the penalty she imposed because of this violation was erroneous under our prior decision in Gary L. Clark, 35 Van Natta 117 (1983). But the fact that there was an error in the manner in which the Referee expressed the penalty does not necessarily lead to the conclusion that no penalty should be assessed in any other manner.

The majority dismisses the simple alternative of our modifying the manner in which the penalty is expressed in a single sentence: "Claimant does not argue that a penalty can or should be assessed against the employer" in any other manner. In my opinion, claimant's only responsibility is to frame the penalty issue with reasonable precision and to offer evidence on the relevant facts. See Richard Pick, 34 Van Natta 957, 959 (1982). If the evidence is persuasive in establishing unreasonable employer/insurer conduct, it then becomes primarily our responsibility to assess and express a penalty in the proper manner.

We recently considered, at some length, the question of the proper manner in which to express a penalty for violation of discovery obligations in Stella Phillips, 35 Van Natta 1276, 1277 (1983):

> "* * * [W]e have often assessed penalties for noncompliance with OAR 436-83-460 that were not expressed as a percentage of compensation 'then due.' E.g., Rose E. Pederson, 34 Van Natta 1658 (1982); Ronald D. Blackwell, 29 Van Natta 629 (1980). The Supreme Court has concluded that this Board had the authority to create the discovery rights stated in OAR 436-83-460. Morgan v. Stimson Lumber Company, 288 Or 595, 599 (1980): 'The discovery provision embodied in the first sentence of OAR 436-83-460 is plainly a rule of practice and procedure to expedite the effective disposition of claims for which the Board is responsible.' In our opinion, authority to create a right necessarily includes authority to create a remedy for breach of that right. As this case illustrates, the alternative of linking the only possible remedy for breach

> of OAR 436-83-460 to compensation 'then due' would create a class of cases in which there would be no possible remedy and would 'invite the parties to speculate on such after-the-event litigation about the actual consequences of noncompliance [with OAR 436-83-460] in the particular case.' Morgan, 288 Or at 604. We conclude that we have authority to assess a penalty and attorney fee in this case and that it is appropriate to do so."

Based on Phillips, in this case I would assess a penalty of $300 and an attorney fee of $300 because of the employer's unreasonably delayed compliance with the obligation to provide discovery.

If the rest of the Board is not going to follow Phillips in this or other similar cases, then I would respectfully suggest that the Board cease adopting rules that create rights without remedies and impose duties without sanctions.

CARLOS IGLESIAS, Claimant
Marvin S. Nepom, Claimant's Attorney
Roberts, et al., Defense Attorney

WCB 82-06774
May 18, 1984
Second Order on Reconsideration

The Board issued an Order on Review dated January 13, 1984 in which it reduced claimant's award of temporary total disability from that approved by the Referee and increased the award of permanent partial disability granted by the Referee. The insurer requested clarification of our order, requesting that we specifically authorize it to offset the overpaid temporary total disability against the increase in permanent disability awarded. It relied on Forney v. Western States Plywood, 66 Or App 155 (1983). We abated our Order on Review in order to give claimant an opportunity to respond to the insurer's motion. Claimant responded arguing that Forney does not permit the Board to authorize an offset against future compensation without the employer first requesting a hearing on the offset issue. Claimant did not contest the amount of overpayment, only the Board's authority to authorize an offset.

On reconsideration the Board declined to allow an offset on the ground that the insurer sought to offset compensation paid pending a Referee's order. The insurer has again requested reconsideration pointing out that the overpaid benefits were actually paid prior to a Determination Order and not pursuant to a Referee's order. The insurer is correct. We, therefore, rescind our Order on Reconsideration dated April 25, 1984.

We turn again to the merits of the insurer's original request for an authorization to take an offset. We note at the outset that this case does not concern an offset against future compensation, but an offset against compensation payments currently due under our Order on Review.

We do not read Forney to preclude us from authorizing an offset in this situation. The court characterized its holding in Forney in the companion case of Mesa v. Barker Manufacturing, 66 Or App 161 (1983), as follows:

> "[E]mployers and carriers are not allowed unilaterally to deduct overpayments from current amounts due under compensation awards without prior approval from the referee or Board." 66 Or App at 163.

This is exactly what the insurer now requests -- prior approval from the Board to deduct overpayments from current amounts due under a compensation award. We do not believe that the court intended that, in a situation such as this in which the Board's order creates an overpayment, the insurer be required to initiate the hearing process in order to obtain authorization to deduct the overpayment. This is analogous to the situation in Hicks v. Fred Meyer Inc., 57 Or App 68, modified, 58 Or App 18 (1982), in which the Referee, on reconsideration, allowed the insurer to offset previously overpaid temporary disability benefits against an increased award of permanent disability benefits. In that case the court relied on Wilson v. SAIF, 48 Or App 993 (1980), and stated:

> "Wilson did not change the law but merely applied a previously-existing principle requiring resolution of all issues at an adjudicative hearing rather than by unilateral action.
>
> "However, we conclude that the referee's action was not improper. Although employer did not raise the issue at the hearing, neither did it act unilaterally. Employer brought the issue to the referee's attention; and had claimant contested the issue, the referee could have reopened the hearing. The procedure was not unfair to claimant, and the policy favoring an orderly compensation process was satisfied." 57 Or App at 71.

Likewise, in this case, the insurer does not seek to act unilaterally. If claimant contested the amount of overpayment, the Board could remand to the Referee to decide the issue. Allowing the insurer to take an offset is not unfair, and the policy favoring an orderly compensation process is satisfied.

We, therefore, amend our Order on Review dated January 13, 1984 to include express authorization for the insurer to offset overpaid temporary total disability benefits against the increased award for permanent disability.

ORDER

The Board's Order on Review dated January 13, 1984 is amended to authorize the insurer to offset overpaid temporary total disability benefits against the increased award for permanent partial disability benefits. The Board's Order on Reconsideration dated April 25, 1984 is rescinded. The Order on Review is adhered to and republished in all other respects.

CANDELARIO REYNAGA, Claimant
Kenneth Peterson, Claimant's Attorney
Larry Dawson, Defense Attorney

WCB 82-10833
May 18, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Danner's order which upheld the insurer's denial of claimant's out-of-state chiropractic treatment. Claimant contends that: (1) Rivers v. SAIF, 45 Or App 1105 (1980), upon which the Referee based his decision, is distinguishable from the facts of this case; (2) Rivers should be overruled; and (3) the Referee's decision is inconsistent with Evans v. SAIF, 62 Or App 182 (1983).

We, of course, lack authority to overrule Rivers. Thus accepting that decision as binding, we agree with the Referee's analysis and conclusion that the denial of out-of-state treatment here in issue is valid under Rivers, and that nothing in Evans is to the contrary.

ORDER

The Referee's order dated October 25, 1983 is affirmed.

CHARLOTTE A. CLEMMER, Claimant
Welch, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-09118
May 23, 1984
Order on Review

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Howell's order which set aside its denial of claimant's aggravation claim and awarded claimant temporary total disability benefits from September 3, 1982 through November 7, 1982. The specific issue is whether claimant is entitled to reopen her claim pursuant to ORS 656.273, or whether she is only entitled to continued medical treatment pursuant to ORS 656.245.

Claimant experienced a sharp pain in her neck on October 15, 1980 while working as a green chain puller. Claimant was examined by Dr. Smith on May 8, 1981 who reported that he had performed a cervical laminectomy on claimant about 10 years earlier, and that claimant's current condition was diagnosed as cervical nerve root compression syndrome aggravated or precipitated by her work. A subsequent discogram and myelogram revealed a defect at C5-6.

In June 1981 Drs. Smith and Berkeley performed an anterior diskectomy and posterior decompression at C5-6. On October 9, 1981 Dr. Smith reported that claimant was released to return to her regular work on October 12, 1981 and that her cervical impairment was minimal, in the range of 0-10%.

A November 3, 1981 Determination Order awarded claimant 5% (16°) unscheduled permanent partial disability.

Claimant returned to work in November 1981. After only two weeks of employment, she returned to Dr. Smith with complaints of suboccipital pain and headaches, nausea and vomiting. Dr. Smith did not feel that claimant's complaints were related to her neck injury or surgery, but to a hypoglycemic reaction or intracranial process. Dr. Smith stated that claimant could return to work.

On December 16, 1981 the employer partially denied the compensability of claimant's headaches and related complaints.

In December 1981 claimant was examined by Dr. Zivin who diagnosed recurrent acute cervical strain. Dr. Zivin reported that, "Continued major physical stresses upon [claimant's] shoulder and cervical anatomy will do nothing more than continue her discomfort." Dr. Zivin reported he had nothing in the way of treatment to offer, but that claimant should protect her neck from additional excessive stresses.

On January 21, 1982 Dr. Martin reported that he had seen claimant on December 17, 1981 with complaints of neck and shoulder pain. Dr. Martin placed claimant on light duty work and instituted physical therapy. Dr. Martin reported that claimant was much improved by January 4, 1982, but that she had a further increase in pain on January 15, 1982 which she attributed to pulling heavier than normal wood at work. Dr. Martin reported:

> "[Claimant] has been seen in this office for multiple episodes of back, shoulder and neck pain. Associated with the neck pain are headaches. Her present type of employment aggravates this pain. She improves with rest and muscle relaxant. The only possible long term solution is to remove the causative factors."

On June 1, 1982 the employer and claimant executed a stipulation which relieved the employer of responsibility for claimant's headaches and awarded claimant an additional 40° unscheduled disability in relation to her neck condition.

Approximately three weeks after the stipulation was signed, claimant returned to Dr. Zivin complaining of continued neck pain associated with her work. Claimant was also examined by Dr. Grewe, who reported on August 30, 1982 that, "Obviously, the simplest disposition would be to find some light physical activity within the jurisdiction of her present employer to lessen the stresses on her upper extremities and neck area."

Claimant returned to Dr. Martin on September 3, 1982. Dr. Martin reported that claimant was doing some heavy lifting at work recently and that this had increased her neck and shoulder pain. Claimant informed Dr. Martin that the pain was too severe to continue working. Dr. Martin reported:

> "[Claimant's] problem is an ongoing problem. This is not a new injury. This is the basic problem which has been occurring for the last several years. In my . . . letter from January 21, 1982, I outlined what my feelings were then. This has not changed. My discussion with [claimant] reached the following conclusion then. 1. The pain and muscle spasm in the right neck and shoulder interfere with her normal living. 2. The muscle spasm and pain was secondary to repetitive exertion. 3. The only way this exertion could be avoided is by changing to another occupation."

Dr. Martin further reported that he had little to offer claimant in the way of treatment other than muscle relaxants and physiotherapy which was only palliative in nature. Dr. Martin concluded: "The only curative treatment, in my opinion, would be change in occupation."

On September 27, 1982 the employer denied reopening of claimant's claim on the grounds that her condition had not actually worsened.

On September 29, 1982 claimant went to a hospital emergency room where she received an injection for neck pain.

On October 19, 1982 Dr. Martin reported that claimant should not return to her job. He noted that claimant did not follow this recommendation when it was previously made in January 1982 and that there had been basically no change since that time.

On October 27, 1982 Dr. Grewe performed a myelogram on claimant. No defects were found. Dr. Grewe released claimant to return to work on November 8, 1982. Although vocational rehabilitation services had previously been initiated, claimant reported to her counselor that she would not participate in any vocational assistance program because Dr. Grewe released her to return to mill work.

On November 29, 1982 claimant was examined by Dr. Rosenbaum, a neurosurgeon. Dr. Rosenbaum reported that he had released claimant to return to her regular mill work without restrictions. Dr. Rosenbaum felt that claimant would continue to experience further difficulty with her neck and that the best alternative would be a different job.

On April 7, 1983 Dr. Grewe reported that claimant's condition had not materially worsened since November 3, 1981.

The Referee stated:

> "I conclude that claimant's condition after June 1982 became worse (both as to severity and duration/continuity) than before that date. I also conclude that claimant's condition from September 3, 1982 until November 8, 1982 was more severe than any of the expected exacerbations which were contemplated as being compensated by the June 1982 stipulation."

The Referee, therefore, set aside the employer's denial of aggravation. We disagree.

The thrust of the employer's argument is that ORS 656.273 requires claimant to establish a worsening of her condition since the last award or arrangement of compensation. The employer contends that the medical evidence fails to demonstrate that claimant's condition has actually worsened since her last arrangement of compensation, which was the June 1982 stipulation.

We agree with the employer. We find that the evidence fails

to establish that claimant has suffered a worsening of her condition. The medical evidence establishes, in near unanimity, that claimant is currently experiencing the same symptoms she was experiencing prior to the execution of the June 1982 stipulation.

Claimant has been experiencing shoulder and neck pain in varying degrees ever since her release to return to regular work following her surgery in June 1981, and it does not appear that her current symptoms are any different now than they were at that time. In December 1981 Dr. Zivin reported that claimant had some restriction in cervical ranges of motion, and that she experienced increased pain whenever she was required to do heavier lifting and pulling at work. Dr. Zivin had no specific treatment to recommend, and advised that the only real curative treatment was for claimant to obtain employment that would not continue to put stress on her shoulders and neck.

Dr. Martin, who has perhaps treated claimant more than any other physician, reported in January 1982 that claimant exhibited a pattern of exacerbation in her symptoms after a period of work with subsequent remission with rest and muscle relaxant. Dr. Martin felt that this pattern would continue and that the only possible curative "treatment" would be for claimant to simply engage in some form of less strenuous work. When further questioned concerning this matter, Dr. Martin consistently referred the questioning party to his January 21, 1982 report. In his report of September 17, 1982 Dr. Martin stated that claimant's problem was ongoing, that nothing had changed since the time of his January 1982 report and that his opinion in September 1982 remained the same as it had been in January 1982. In his October 1982 report Dr. Martin once again referred to his January 1982 report and stated that there had been no change in claimant's condition in the last year.

Dr. Grewe's reports also fail to establish that claimant experienced a worsening of her condition. Dr. Grewe believed that claimant would continue to experience exacerbation and remission of her symptoms so long as she continued working in her present capacity, and he reported on April 7, 1983 that he did not feel that claimant's condition represented a worsening since the date of the issuance of the November 1981 Determination Order.

In addition to arguing that claimant's condition has not actually worsened since the June 1982 stipulation, the employer also argues that the stipulation and the additional permanent disability awarded claimant pursuant to that stipulation contemplated that claimant would have a certain amount of continued difficulties with her condition if she continued to work. We agree with this argument also. There are medical reports prior to the execution of the June 1982 stipulation which predict that there will be waxing and waning of claimant's cervical symptomatology. In fact, claimant began experiencing such symptoms shortly after her release to return to work by Dr. Smith in October 1981. Dr. Zivin reported on December 17, 1982 that claimant was continuing to experience neck and related shoulder pain whenever she had to engage in pulling and pushing heavy wood at work, and that the only real treatment for her condition was to simply avoid doing work which would put stress on claimant's neck. Dr. Martin's January 1982 report also is dated prior to the execution of the June 1982 stipulation, and clearly

indicates that claimant's condition is chronic and that she will continue to experience symptomatic flare-ups and remission of her condition so long as she continued to work in the mill.

As we stated in Jo Wanda Orman, 35 Van Natta 650 (1983), reversed on other grounds, Orman v. SAIF, 68 Or App 260 (May 9, 1984):

> "Finally, and possibly most importantly, it must be remembered that claimant has received awards that total 30% unscheduled disability. Since no other forms of permanent impairment are mentioned in this record, we assume these awards were based on chronic pain. Claimant's cervical pain has 'waxed and waned' over the years since her 1976 injury. There was admittedly a flare-up of that pain in February-April of 1982 because of claimant's work as a data entry operator. It appears to us, however, that claimant has experienced a fluctuating level of cervical pain since 1976 and that it is exactly this form of impairment that was the basis of the prior awards for permanent disability. Under these circumstances, we do not think that every flare-up of pain can or should be the basis of an aggravation claim when cycles of pain were reasonably to be expected and were the basis of prior awards of permanent disability."

The same is true in the current case. See also, Harmon v. SAIF, 54 Or App 121 (1981); Francis Knoblauch, 35 Van Natta 218 (1983). Claimant's condition may be treated pursuant to ORS 656.245, but there is no basis in the record for reopening the claim at this time.

ORDER

The Referee's order dated May 10, 1983 is reversed. The employer's denial of September 27, 1982 is reinstated and affirmed.

Board Member Lewis Dissenting:

I would affirm the Referee's order which set aside the self-insured employer's denial of claimant's aggravation claim.

I cannot agree with the majority's statement that claimant's continued difficulties were contemplated by the June 1982 stipulation, and therefore, do not constitute an aggravation. Instead, I agree with the Referee's following statement:

> ". . . The question is, what degree of difficulty was contemplated [by the June 1982 stipulation and permanent disability award]. At the time of the stipulation claimant was working. She had missed several weeks of work in late 1981 and a few days in 1982 because of her compensable condition.

"Claimant testified credibly that since June 1982, under generally the same work conditions, her symptoms became more continuous and more severe. She was disabled from work beginning September 3, 1982 and continuing until November 8, 1982 because of her neck. She required emergency room treatment and Demerol on one occasion during that period, because of neck pain.

"I conclude that claimant's condition after June 1982 became worse (both as to severity and duration/continuity) than before that date. I also conclude that claimant's condition from September 3, 1982 until November 8, 1982 was more severe than any of the expected exacerbations which were contemplated as being compensated by the June 1982 stipulation."

Furthermore, I find that the medical evidence shows that claimant's condition worsened after June 1982 causing claimant to miss work starting September 3, 1982. After his December 1981 examination, Dr. Ziven reported that claimant's neurological examination was entirely normal. Dr. Martin examined claimant on December 17, 1981 and reported that claimant denied pain radiating down into her arm or into her hands and that no neurological deficit was demonstrated. Again, on January 15, 1982, Dr. Martin examined claimant and reported that no neurological deficit was demonstrated. Dr. Ziven saw claimant again on June 28, 1982 and reported that claimant had no sensory abnormalities.

On August 30, 1982, however, claimant saw Dr. Grewe complaining of pain in the neck and right arm with numbness in the right shoulder, elbow, thumb and lateral forearm. Dr. Grewe reported marked sensory loss in the right thumb, some sensory loss in the index and middle fingers, questionable sensory loss in the fourth and fifth fingers and slight sensory loss in the lateral forearm. Dr. Grewe opined that claimant's recent intermittent numbness in the right arm was due to muscle contraction, which probably was aggravated by claimant's work activities.

Although Dr. Grewe later stated that claimant's condition had not "materially worsened" since November 1981, I cannot rely on that opinion in light of his sensory loss findings in August 1982. I find those sensory loss findings, when considered with Dr. Martin's decision to take claimant off work on September 3, 1982 and claimant's emergency room treatment later that month, to be sufficient evidence of an aggravation.

Moreover, Dr. Martin stated that claimant's problems in late 1982 were "ongoing," and that his feelings about claimant's condition and his recommendations had not changed. I do not interpret that to mean that Dr. Martin believed that claimant's condition had not worsened. Dr. Martin did not address the question of whether claimant's condition had worsened.

I would affirm the Referee's order setting aside the self-insured employer's denial of claimant's aggravation claim and, therefore, I respectfully dissent.

TIMOTHY J. NELSON, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04002
May 23, 1984
Order on Further Reconsideration

The Board entered its Order on Review on March 30, 1984. Claimant requested reconsideration and the Board entered its Order on Reconsideration on April 25, 1984. Claimant then moved the Board for remand of the case for a determination of appropriate attorney fees.

The SAIF Corporation originally denied claimant's aggravation claim and claimant's entitlement to ongoing medical treatment. The Referee set aside SAIF's denial and awarded claimant's attorney $1000 as reasonable attorney fees for prevailing on both prongs of SAIF's denial. On review, only the denial of the aggravation claim was at issue. In its Order on Review, the Board reversed the Referee's order and reinstated SAIF's denial. On reconsideration, the Board corrected its prior order to state that the Referee's order was reversed only insofar as it set aside SAIF's denial of the aggravation claim, but the balance of the Referee's order was affirmed. Consequently, SAIF's denial of medical benefits continues to be set aside.

In his motion for remand, claimant notes that the Referee awarded $1000 attorney fees for prevailing on both the aggravation and medical benefits issue. The Referee did not apportion the award between the issues. Now that the Board reversed on the aggravation issue, claimant asks for a determination of the appropriate attorney fee award for prevailing on the medical benefits issue only at hearing.

We find it unnecessary to remand for determination of an issue that we can determine on reconsideration. Accordingly, we find that of the $1000 originally awarded by the Referee, the appropriate amount to apportion to claimant's attorney for prevailing on the medical benefits issue is $500. Therefore, we modify our Order on Review and Order on Reconsideration to state that the Referee's order of an attorney fee award is modified to award claimant's attorney $500 for services at hearing in connection with prevailing on the medical benefits issue.

ORDER

On reconsideration of the Order on Review dated March 30, 1984 and the Order on Reconsideration dated April 25, 1984, we modify our prior orders and modify the Referee's order of June 20, 1983 to award claimant's attorney $500 for services at hearing in connection with the medical benefits issue. Except as modified herein, we adhere to our prior orders which hereby are readopted and republished.

PATRICIA J. DAILEY, Claimant
Magar & Magar, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01824
May 25, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Gemmell's order which affirmed the SAIF Corporation's denial of her right leg (ankle) injury. Claimant contends her injury arose out of and in the course of her employment.

With her appellant's brief, claimant has enclosed additional proposed exhibits. We treat this submission as a motion to remand for the taking of further evidence.

The additional exhibits are copies of affirmative defense pleadings made by claimant's employer in a civil court proceeding. Apparently, claimant had brought a civil suit against her employer for negligence stemming from the circumstances surrounding her ankle injury. The pleadings note a court filing date of November 1983, a date subsequent to claimant's hearing. As one of several affirmative defenses, the employer alleged that the sole and exclusive remedy for claimant was through the workers' compensation system. Claimant contends this evidence was not available at hearing and amounts to a "conclusive judicial admission" attributable to SAIF.

We deny the motion for remand. Our review of the record reveals that this case has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Furthermore, although this particular exhibit was not available until after the hearing, the record indicates that similar "judicial admissions" were in existence before the hearing. Although these prior pleadings are not in the record, letters from both claimant's and the employer's attorneys are. These letters indicate that approximately 10 months before the hearing the employer moved to dismiss the civil court matter on the basis that claimant's sole and exclusive remedy was through the workers' compensation system.

Granted, this particular affirmative defense pleading was unavailable at the time of hearing. However, we are persuaded that other pleadings filed on the employer's behalf, which espoused the identical "workers' compensation" theory, were available. Thus, evidence of civil pleadings documenting the employer's "workers' compensation" theory could reasonably have been discovered and produced at the hearing. Therefore, this case does not merit remand. Bailey v. SAIF, 296 Or 41 (1983).

Finally, assuming these proposed exhibits were admitted into evidence, and assuming we considered them "conclusive judicial admissions" attributable to the workers' compensation insurer (who was not a party in the civil court proceeding), we would reach the same result as we do today.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated September 30, 1983 is affirmed.

MERCEDES A. EVANS, Claimant
Garrett, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Schwenn, et al., Defense Attorneys

WCB 82-04068 & 82-10141
May 25, 1984
Order on Reconsideration

The Board entered its Order on Review herein on March 9, 1984. The self-insured employer, Fred Meyer, Inc., thereafter requested reconsideration of that order, and in order to allow a sufficient opportunity for response and for consideration of the employer's request, we entered an Order of Abatement on March 30, 1984. We have now received the response of United Pacific Insurance Company and claimant, stating their opposition to the motion for reconsideration.

On reconsideration of the Board's above referenced Order on Review, the Board adheres to its prior order which is hereby readopted and republished.

IT IS SO ORDERED.

FREDERICK D. OXFORD, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01496
May 25, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Daron's order which assessed a 15% penalty and $750 attorney fee against it for SAIF's delayed payment of temporary disability benefits pursuant to a Referee's order in a prior proceeding. SAIF contends that the delay was reasonable because it was due to the need to obtain medical verification of claimant's continued inability to work and information from claimant about possible earnings -- all information SAIF argues it is entitled to obtain before paying benefits.

While we generally agree that an insurer should be allowed a reasonable time to obtain this kind of information following issuance of a Referee's order that merely remands a claim for processing, in this case we conclude that the delay of about 39 days from the prior Referee's order to the date that benefits were paid in full was unreasonable. Cf. Rick E. O'Dell, 35 Van Natta 1169, 35 Van Natta 1238 (1983), aff'd, O'Dell v. SAIF Corp., 68 Or App 383 (May 9, 1984).

ORDER

The Referee's order dated October 26, 1983 is affirmed. Claimant's attorney is awarded $350 for services on Board review, to be paid by the SAIF Corporation.

GLEN RAGER, Claimant
Emmons, et al., Claimant's Attorneys
Horne & Tenenbaum, Defense Attorneys

WCB 83-02590
May 25, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Baker's order which awarded claimant a total of 30% (96°) unscheduled permanent partial disability for his low back injury, which was an increase of 25% (80°) over and above the March 8, 1983 Determination Order. On review, the insurer contends the award was speculative and excessive.

Claimant was 22 years old at hearing. On October 26, 1982 claimant felt a popping sensation in his low back when he and several co-workers lifted a heavy power pole. At the time of the injury claimant had been working as a construction laborer for approximately three weeks. He experienced immediate pain, with slight radiation into his buttocks. The following day claimant was unable to straighten up and experienced severe radiation of pain from his lower back into the back of both legs.

Claimant sought treatment from Dr. Ray, a chiropractor. X-rays revealed a bilateral fracture of the pars interarticularis at L5, grade I spondylolisthesis of L5 on S1; accentuation of lumbar lordosis, marked reversal of cervical curve, compensatory "C" scoliosis and multiple static intersegmental disc relationships. Dr. Ray diagnosed "acute traumatic L5 pars interarticularis fracture with resultant grade I spondylolisthesis, bilateral S1 radiculitis and associated lumbosacral sprain." Dr. Ray also detected a marked degree of lumbosacral edema as well as bilateral erector spinae muscle splinting.

Dr. Ray noted that claimant had undergone one osteopathic manipulation in April 1982 which relieved lower back pain. Claimant also reported that for several years he had experienced intermittent episodes of lower back pain brought on by prolonged bending and pulling from his seasonal job as a tree planter. In addition, the doctor noted that claimant had sustained a slight concussion and neck pain in two motor vehicle accidents. Apparently, both conditions had resolved without residuals.

Dr. Ray opined that claimant's injuries were the direct result of his on-the-job injury. The doctor felt that claimant was not a suitable candidate to resume his previous employment.

The insurer referred claimant to Dr. Scheinberg, an orthopedist. An x-ray consultation was also performed by Dr. Kimmel, who opined that there was a mild loss of normal lumbar lordosis, with no definite fractures, spondylolysis or spondylolisthesis identified. Dr. Scheinberg concluded that it was doubtful that claimant's x-ray findings were attributable to an acute injury, although he conceded it was possible. Dr. Scheinberg felt that it was probable that claimant had preexisting pars interarticularis defects. Assuming the defects were preexisting, Dr. Scheinberg opined that claimant's present condition was substantially worsened by his preexisting impairment.

Dr. Ray disagreed with Dr. Scheinberg's opinion. As support for his opinion, Dr. Ray referred to the popping sensation, the

immediate pain and the marked amount of edema following the incident. Apparently overlooking the previous history he had obtained from claimant, the doctor also stated that claimant had no past history of lower back pain or injury. Finally, Dr. Ray noted the orthopedic texts he had recently reviewed listed trauma as the major etiology for pars defects and spondylolisthesis.

A Determination Order issued on March 8, 1983 awarding claimant 5% unscheduled disability. Claimant requested a hearing.

Claimant testified that he experienced numbing pains in his lower back if he sat or bent over for too long a period of time. The pain also radiated into his legs, mostly his right leg. Due to the pain he has curtailed his physical activities.

A progress note, dated June 1, 1982, from either Dr. Kauffman or Dr. Schmidt, osteopaths, records that claimant sought treatment concerning lumbar pain which he had been experiencing intermittently for two months. Claimant testified he sought treatment, likely from Dr. Schmidt, but insisted that this pain emanated from his mid-back. He admitted he had experienced back pain in the past, but insisted the pains pertained to his mid-back and not his low back.

Claimant's father testified that to his knowledge claimant had no difficulties or limitations concerning his back until the incident at work.

At the time of hearing, claimant was employed in a subsidized job at his father's catalog and clearinghouse store. His duties included counter work, answering the phone and taking customer orders. The job was specifically designed to meet claimant's limitations. Normally the position would have required loading and unloading packages as well as stocking merchandise.

Claimant has an eleventh grade education and a GED certificate. He has work experience as a construction laborer (for three weeks), seasonal tree planter, and part-time shoe salesman as well as his specially modified job as a catalog clearinghouse clerk. Dr. Ray has placed claimant under a 15 pound weight limitation and advised him to refrain from prolonged forward bending or twisting. His restrictions limit him to primarily light duty.

The Referee increased claimant's award to 30%. He found that claimant's prior symptoms did not emanate from the same point and were not of the same nature and intensity as those noted following the work injury. The Referee stated there were several objective findings suggestive of an acute, substantial trauma. It was the Referee's conclusion that it was more likely than not that the work injury materially caused the back condition requiring the work activity restrictions.

We agree that the evidence preponderates in favor of finding that claimant's restrictions are attributable to his compensable injury. We are particularly persuaded by the uncontradicted description of the popping sensation, immediately followed by pain and a marked amount of edema in the low back.

We agree that the Determination Order's award should be increased. However, we find the Referee's award excessive.

Pursuant to OAR 436-65-600 et seq., we consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings, and physical impairment, including residual pain, in rating the extent of claimant's disability. Considering the above guidelines and comparing this case to similar cases, we conclude that a total award of 20% would more appropriately compensate claimant.

ORDER

The Referee's order dated September 26, 1983 is modified. In lieu of the Referee's award, and in addition to the 5% (16°) unscheduled disability awarded by the March 8, 1983 Determination Order, claimant is awarded 15% (48°) unscheduled disability for a total award to date of 20% (64°) unscheduled disability for his low back injury. Claimant's attorney's fee shall be adjusted accordingly.

RANDAL J. SLONECKER, Claimant
Gatti & Gatti, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 83-03647
May 25, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Daron's order which: (1) Set aside the insurer's denial of responsibility for ongoing medical and temporary disability benefits; (2) awarded penalties and attorney fees for the insurer's unreasonable denial; and (3) set aside the April 19, 1983 Determination Order as being premature. The insurer contends that claimant's ongoing back and neck problems are related to claimant's 1978 injury, and not to the January 1983 injury for which it is responsible, that the Determination Order was not premature, and that in any event, penalties and attorney fees are not warranted in this case. Also, claimant moves for remand for consideration of additional evidence.

The Board affirms the order of the Referee to the extent that it set aside the insurer's partial denial and set aside the Determination Order. The Board reverses the Referee's award of penalties and attorney fees, however.

We make the following findings of fact. Claimant suffered a compensable injury to his head, neck, upper and lower back on January 23, 1983. In 1978 claimant suffered injury to his mid and low back. On March 17, 1983 claimant's treating doctor, Dr. Martens, reported that claimant had only suffered a temporary worsening of the back and neck and that claimant was medically stationary regarding the January 1983 back injury. On March 24 Dr. Martens reported that claimant's present restrictions were due to his 1978 injury and not to the 1983 injury. The insurer terminated time loss benefits on March 24 and requested determination of claimant's claim on April 6, 1983. Then, on April 14, 1983 the insurer denied continuing responsibility of claimant's medical care and temporary disability, although reaffirming its acceptance of claimant's January 1983 injury. A Determination Order issued on April 19, 1983.

Although we agree with the Referee's determination that the partial denial was erroneous and should be set aside on the merits, we note an additional reason for setting aside the denial. After

the Referee issued his Opinion and Order, the Court of Appeals held that a partial denial of an originally accepted condition, issued before claim closure under ORS 656.268, is invalid and of no force and effect. Safstrom v. Riedel International, Inc., 65 Or App 728 (1983); Roller v. Weyerhaeuser, 67 Or App 583 (April 11, 1984); Maddocks v. Hyster Corp., 68 Or App 372 (May 15, 1984). Although the employer is not precluded from litigating the partial denial at the time of claim closure or from denying continuing responsibility after closure, Roller, supra slip op at 4, the extent to which claimant's present symptoms indicate compensable continuation of temporary or permanent injury is to be decided in the first instance by proceedings under ORS 656.268, Safstrom, supra n. 2. Therefore, the insurer's partial denial was invalid as a matter of law.

The Referee awarded penalties and attorney fees, finding that the insurer's denial was unreasonable. The insurer, in denying claimant's present inability to work and present medical expenses, apparently relied on Dr. Martens' March 24, 1983 report, which stated that claimant's continuing problems were related to the 1978 injury and not to the 1983 injury. We share the Referee's doubts about Dr. Martens' opinion in light of claimant's lengthy asymptomatic period before the January 1983 injury and the fact that the January 1983 injury involved the previously non-involved neck area. Nevertheless, we find the insurer's reliance on Dr. Martens' opinion in issuing the denial to have been reasonable. Therefore, we find a penalty and attorney fee not to be warranted. Furthermore, although penalties might be appropriate with regard to a partial denial issued after Safstrom, Roller, and Maddocks, supra, the denial here was issued before the Court of Appeals spoke on this question. Therefore, we do not believe penalties for unreasonable denial are appropriate. Penalties may have been proper for the insurer's unilateral termination of temporary disability benefits prior to claim closure, but that issue was not raised.

The Board affirms the Referee's order setting aside the Determination Order as being premature. In addition, the Board denies claimant's motion for remand.

ORDER

The Referee's order dated October 6, 1983 is affirmed in part and reversed in part. The Referee's award of penalties and associated attorney fees for unreasonable denial is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

CHARLES SPARKMAN, Claimant
Pozzi, et al., Claimant's Attorneys
David Horne, Defense Attorney
Foss, Whitty & Roess, Defense Attorneys
Marcus Ward, Attorney

Own Motion 82-0087M
May 25, 1984
Own Motion Order

Claimant requested that the Board exercise its own motion authority and reopen his 1967 industrial injury claim for a worsened condition allegedly related to that injury. By an order dated December 20, 1982, the Board referred claimant's request for own motion relief to the Hearings Division for consolidation with claimant's pending hearing requests involving claims filed with three more recent employers. The hearing was held on March 9, 1983 before Referee Foster, who recommended that the Board grant

claimant's request for own motion relief, finding claimant's current medical condition compensable as a consequence of his 1967 injury. We have this date issued a separate Order on Review addressing the claims filed with claimant's more recent employers, affirming the Referee's conclusion that claimant has failed to establish either a more recent industrial injury or a compensable occupational disease claim. Charles Sparkman, WCB Case Nos. 82-05888, 82-08694, 82-08695, 36 Van Natta 768 (decided this date). In making our determination whether to exercise our authority pursuant to ORS 656.278, we have reviewed the evidentiary record developed before the Referee, and we have considered the written arguments submitted by counsel for the parties to the consolidated hearing proceedings. For the following reasons, we decline to adopt the Referee's recommendation, and we deny claimant's request for own motion relief.

Claimant's 1967 injury with Griffey & Laird Logging Co. occurred while he was cutting timber. The injury at that time was diagnosed as intervertebral disc syndrome, grade one protrusion at L5-S1. Claimant was treated by chiropractic manipulation, and because his symptomatology did not resolve, he was referred to a neurologist, Dr. Luce, who diagnosed a protruded intervertebral disc at the L4 interspace on the right and performed a laminectomy at the L4-5 level with removal of a free intervertebral disc fragment. The claim was closed by Determination Order in January 1969, which awarded compensation for temporary total disability and 20% unscheduled permanent partial disability.

After recovering from his 1967 injury, claimant continued to work as a bucker and faller. We understand this type of employment to involve a good deal of vigorous physical activity, strength and endurance. Claimant testified that he continued to experience symptoms of low back pain during the 12 years of this work activity subsequent to closure of his 1967 injury claim, but did not seek medical attention for his back problem during this 12-year period. As he testified: "[The pain] wasn't anything I couldn't live with. It just over the years got gradually worse."

In our companion Order on Review we have quoted at length the medical opinions of Drs. Whitney and Coletti concerning the relationship between claimant's employment in the logging industry, his 1967 industrial injury, and the present state of his degenerative spinal disease. It is apparent from those medical opinions that claimant's entire employment history has been a factor in the progression of his underlying degenerative condition, although we have been unable to conclude that claimant's employment is the major factor. The Referee found that claimant's 1967 injury caused his back condition to continue to worsen, and that, "[i]t is clear that claimant's condition dates back to the original 1967 industrial injury while employed with Griffey & Laird Logging Co."

Although it is clear that the onset of claimant's back problems relates back to his 1967 injury, it is less clear whether, as a result of that injury, claimant's degenerative spinal disease continued to progressively worsen. If the question of compensability of claimant's current condition as a natural progression of his 1967 injury-related condition was before us in the context of a claim pursuant to ORS 656.273, we would be inclined to find this "aggravation claim" compensable. Indeed, in our companion Order on Review, we have determined that claimant has satisfied his burden of proving, although only by a slight preponderance of the

evidence, a sufficient causal connection between his 1967 injury and his present back condition for purposes of establishing his entitlement to medical services pursuant to ORS 656.245. It is in this context that one of the significant differences between establishing entitlement to compensation as a matter of right, on the one hand, and obtaining the discretionary remedy of own motion relief, on the other hand, becomes apparent.

The issue now before us is whether claimant's 1967 injury claim should be ordered reopened for payment of temporary disability benefits and, possibly, additional permanent disability pursuant to ORS 656.278. In order to persuade us that he is "entitled" to such discretionary relief, we believe that claimant is required to adduce more evidence of a direct causal relationship between his 1967 injury and his present claim for relief than might be required when claiming entitlement to benefits as a matter of right. We were presented with a similar situation in Michael R. Fischer, 35 Van Natta 2028, 35 Van Natta 2040 (1983). On review of a Referee's order which set aside the insurer's denial of claimant's low back surgery, we affirmed, finding that the evidence "slightly preponderate[d]" in favor of finding claimant's surgery compensable. In a companion Own Motion Order, we declined to exercise own motion relief, stating:

> "Claimant has established that his 1981 surgery is compensably related to his original injury by the slimmest margin of the evidence. Because the evidentiary scale tips ever so slightly in claimant's favor, we have agreed with the Referee's finding that claimant is entitled to the medical services in issue, compensation to which claimant is entitled as a matter of right. ORS 656.245(1). In deciding whether to exercise our discretionary authority pursuant to ORS 656.278, however, we deem it appropriate to require more persuasive evidence of a causal connection than is presented by the evidentiary record before us."

We find that the evidence in this case, as in Fischer, is sufficient to establish claimant's right to benefits pursuant to ORS 656.245, but insufficient to warrant the exercise of the Board's discretionary own motion authority.

Claimant was able to work as a bucker and faller twelve years subsequent to closure of this 1967 claim. The work entailed vigorous physical activity. The medical evidence indicates that subsequent employment activity probably contributed to the current condition of claimant's back, as well as other factors, such as claimant's age, weight and congenital factors. The recent herniation of a disc at the L3-4 level (which, in Dr. Whitney's words, "was a new injury unrelated to [claimant's] previous operative procedure and injury"), appears to be too attenuated from claimant's 1967 injury to persuade us that claimant is entitled to the relief requested. Accordingly, claimant's request for own motion relief is denied.

ORDER

Claimant's request that the Board exercise its own motion authority and reopen his 1967 industrial injury claim with Griffey & Laird Logging Company, insured by Wausau Insurance Companies, for payment of additional temporary and permanent disability is denied.

CHARLES SPARKMAN, Claimant
Pozzi, et al., Claimant's Attorneys
David Horne, Defense Attorney
Foss, Whitty & Roess, Defense Attorney
Marcus K. Ward, Attorney

WCB 82-05888, 82-08694 & 82-08695
May 25, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests and Wausau Insurance Companies cross-requests review of Referee Foster's order which found that claimant sustained neither a recent injury nor an occupational disease during his employment with Bohemia, Inc. (Bohemia), W & R Construction (W & R), or Moore Mill & Lumber (Moore). The Referee found claimant's current condition attributable to a 1967 injury sustained while claimant was working for Griffey & Laird Logging Company, insured by Wausau Insurance. The Referee recommended that the Board exercise its discretionary authority pursuant to ORS 656.278 and grant claimant's request for own motion relief in connection with this injury. The Board had referred claimant's request for own motion relief to the Referee for consolidation with claimant's pending hearing requests contesting the denials issued on behalf of the more recent employers, all of which are insured by the SAIF Corporation. Claimant's request for Board review is designated as a "protective matter" in the event that the Board declines to grant own motion relief as recommended by the Referee. See Charles Sparkman, Own Motion No. 82-0087M (decided this date).

We adopt the Referee's findings of fact and affirm his conclusion. We agree that there is no evidence to substantiate a conclusion that claimant sustained a more recent industrial injury during his employment with Bohemia, W & R, or Moore. Whether claimant has established a compensable occupational disease claim is a closer question.

The condition which has given rise to the claims filed with the three employers herein has been diagnosed by Dr. Coletti as chronic degenerative lumbar spine disease, including intervertebral disc disease. In order to establish the compensability of this condition as an occupational disease, claimant must establish that the condition has arisen out of and in the scope of his employment and is one to which he was not ordinarily subjected or exposed other than during a period of regular actual employment. ORS 656.802(1)(a). Claimant's employment must be the major cause of his degenerative disease condition. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570 (1982). The medical opinions bearing on the issue of compensability of claimant's degenerative condition as an occupational disease are contained in reports from Dr. Whitney, who became claimant's treating physician in 1981, and Dr. Coletti, an orthopedic surgeon who reviewed claimant's medical records at SAIF's request.

On June 25, 1981 Dr. Whitney performed a decompressive laminectomy at L3-4 and L4-5 and discectomy at L3-4. Dr. Whitney's

office note dated March 8, 1982 indicates that the condition of claimant's spine at the L3-4 level "is what brought him to surgery at this point. This is probably what happened during his fishing episode," referring to an incident that occurred while claimant was surf fishing for three days. Dr. Whitney's office note continues: "The L4-5 level was probably related to his previous surgeries and stenosis is somewhat congenital judging from his previous operative notes and somewhat due to hypertrophy secondary to the surgery and work. Other factors include his age and his weight."

An April 29, 1982 letter from Dr. Whitney addressed to claimant's attorney indicates his impression that:

> "[Claimant's] problem at the L3-4 level was a new injury unrelated to his previous operative procedure and injury. However, his problem of stenosis at L4-5 level was related to the old injury.
>
> "His problems at the old L4-5 level were just primarily scarring and stenosis, whereas the L3-4 level showed an acute herniation.
>
> "Necessity for the most recent operation was probably a combination of both of them in that the ruptured disc into a previously narrowed and tightened down area of the previous area of surgical scarring [sic]."

In a June 23, 1982 interoffice memorandum, Dr. Coletti expressed the following "opinion regarding claimant's condition as a result [of], or related, to his employment," after reviewing claimant's medical records:

> "After reviewing the information contained in this chart, it is obvious this patient has suffered from chronic degenerative lumbar spine disease, including intervertebral disc disease, documented by x-rays, treating physicians and two myelograms, since 1967. There has been no new injury and the disease process, treated by A. L. Whitney, M.D., represents a natural progression of this lesion. It is rather evident from the chart that the lumbar spine disc disease problem became evident subsequent to the injury incurred while the patient was employed and insured by Employers Mutual of Wausau. I cannot see any reason why there should be a new injury considered in this case for, in essence, there has been none reported by anyone and the disease process has been associated with a gradual increase in the symptoms which the patient has apparently had all along. I would therefore conclude that the patient's present condition is the result of his underlying basic medical problem, i.e., lumbar spondylosis with

degenerative disc disease aggravated by his initial injury and necessitating surgery. This lumbar spondylosis (a degenerative condition of the spine) is the primary etiologic factor in his present condition. I would further add that a secondary factor, I feel operative from a medical standpoint, has been his work history as he has essentially performed heavy work in the woods no doubt exacerbating his back condition. In essence, a man with this type of spine should probably be sheltered from the type of work this man has performed and irrespective of which insurer covers this patient, there is no question that his work, from a medical standpoint, has severely aggravated his basic underlying condition. This would include his entire work history and, in particular, the work history which I have since 1967, related to employment in the lumber industry."

In a February 14, 1983 letter addressed to counsel for SAIF/Moore, Dr. Coletti attempted to clarify his earlier statement concerning the relationship between claimant's current condition and his employment history:

" * * * [T]he patient did have chronic degenerative disc disease of the lumbar spine and had been treated for this problem. Apparently he has had a gradual increase in symptoms, but he had performed heavy work in the woods for some period of time.

" * * * In all fairness to the patient, I might indicate that the claimant did have underlying disc disease which dates back many years. This degenerative change was aggravated by the patient's heavy work and necessitated in fact, further treatment possibly to include surgery by Dr. Whitney [on] June 25, 1981. I do not have any information to suggest that this is not the case and it is my feeling after reviewing your report, that if this claimant had done only light bench type work, it is rather unlikely that he would develop difficulties as severe as he apparently has.

"I hope I am being clear in pointing out that the patient did have pre-existing problems, but that the work activities as I understand them, have exposed him to considerable stress in terms of his lumbar spine and that they have probably caused an advance in his pain and symptoms in excess of what might ordinarily be construed to be

natural progression of the disease. As such then, I feel that there is considerable validity in relating his work activities over the years to his problem. At least, I believe this is the way I understand his history on the basis of the information supplied."

Claimant has worked in the logging industry, primarily as a bucker and faller, since 1955, except for a period from 1971 through 1974 when he was self-employed as a dairy owner. He testified that since his injury in 1967 he has experienced continuing problems with his low back. During the years that he worked with Moore, his back and leg pain gradually worsened, and claimant began to miss some time from work as a result of these difficulties. There is no indication that claimant sought medical attention after his 1967 injury claim was closed in January of 1969, and prior to his hospitalization in early May of 1981 for acute low back strain and degenerative spinal disease. Claimant was 53 years of age at the time of hearing.

The Referee found that claimant's current condition relates back to his initial industrial injury in 1967 and, on that basis, recommended that the Board exercise its authority and grant claimant's request for own motion relief in relation to that injury. For the reasons stated in the companion Own Motion Order we have issued this date, we do not find it appropriate to adopt the Referee's recommendation. It, therefore, has been necessary for us to consider whether claimant's current condition is compensable as the result of either a more recent injury or occupational disease. Although Dr. Coletti has on two occasions expressed the opinion that claimant's work history as a faller and bucker is related to his current medical condition, we do not understand his opinion to be that claimant's employment has been the major cause in the development and progression of his degenerative spinal disease. Dr. Whitney indicated that the condition of claimant's spine at the L4-5 level, in addition to being related to claimant's prior injury and surgery, was "somewhat congenital"; other factors are claimant's age and his weight.

Assuming it is appropriate to consider claimant's degenerative disease as a "pre-existing condition," a term frequently used by Dr. Coletti, and assuming further that claimant's employment activities over the course of his years as a faller and bucker have actually contributed to a worsening of that underlying disease process, as opposed to merely causing symptoms associated with that underlying disease process, we nevertheless are unable to conclude that claimant's work activities were the major cause of that worsening, as opposed to other non-employment factors as mentioned by Dr. Whitney. See Beaudry v. Winchester Plywood Company, 255 Or 503 (1970); Weller v. Union Carbide, 288 Or 27 (1979); see also Dethlefs v. Hyster Company, supra; cf. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).

For the foregoing reasons, we affirm the Referee's order upholding the denials issued by the SAIF Corporation in behalf of Bohemia, Inc., W & R Construction and Moore Mill & Lumber.

Claimant's 1967 injury claim with Griffey & Laird Insurance Company carries with it the right to receive reasonable and necessary medical services for treatment of conditions related to

the original industrial injury. This is a lifetime right. ORS 656.245(1). A claim for such medical services is not the proper subject of a request for own motion relief, and the insurer has the obligation, in connection with injuries occurring on and after January 1, 1966, to accept/pay or deny medical service claims after expiration of the claimant's aggravation rights; and the claimant has the corresponding right and obligation to request a timely hearing in the event of a denial. ORS 656.245(2); Dwayne G. Cary, 36 Van Natta 265 (1984); Donald L. Lentz, 35 Van Natta 1084 (1983); Max D. Cutler, 34 Van Natta 1480 (1982); see William A. Newell, 35 Van Natta 629 (1983).

It could not be more apparent that this case includes a claim for medical services pursuant to ORS 656.245, and that all of the potentially responsible employers/insurers herein, including Griffey & Laird Logging Company and its insurer, Wausau, the "own motion" employer/insurer, anticipate that the responsible paying agent will be required to pay claimant's medical services, including claimant's surgery in June of 1981.

Although the Referee had jurisdiction to order Wausau to pay claimant's medical services, pursuant to the provisions of ORS 656.245, 656.283 and 656.289, he failed to do so. Apparently, the Referee assumed, as do the parties, that, in the event the Board adopted the Referee's own motion recommendation, the relief granted by the Board pursuant to ORS 656.278 would include medical services. For the reasons stated, this is an erroneous assumption.

It is appropriate, therefore, to order payment of claimant's medical expenses by Wausau Insurance Companies in the event that a preponderance of the evidence establishes that claimant's back condition is materially related to his 1967 injury with Griffey & Laird Logging Company. See ORS 656.295(6); cf. Thomas v. SAIF, 64 Or App 193 (1983). We note that, in any event, because there are medical services being claimed in connection with claimant's request for own motion relief with Wausau Insurance and its insured, it would have been preferable for the insurer to have issued an appropriate denial, for the claimant to have requested a hearing contesting this denial, and for the Referee to have included, as part of his order entered pursuant to ORS 656.289, an appropriate ruling concerning the employer/insurer's liability for payment of claimant's medical expenses.

We find and hold that the evidence slightly preponderates in favor of finding that claimant's back condition in 1981 is causally related to his 1967 industrial injury; therefore, Wausau Insurance Companies is responsible for payment of claimant's medical expenses pursuant to the provisions of ORS 656.245. Claimant's attorney is entitled to a reasonable attorney's fee for prevailing on a de facto denial of medical services. Although the litigation at hearing and on Board review primarily involves issues of employer/insurer responsibility, there are certain compensability issues present, and counsel's services in this regard warrant an award of a reasonable attorney's fee.

ORDER

The Referee's order dated May 2, 1983 is modified to provide that Wausau Insurance Companies shall pay claimant's medical expenses for treatment of his back condition, including those costs associated with claimant's June 1981 surgery. Claimant's attorney

is awarded $900 for services at hearing and $400 for services on Board review, to be paid by Wausau Insurance Companies. Except as modified, the Referee's order is affirmed.

DAVID E. SITTON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05753
May 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests and claimant cross-requests review of Referee Thye's order which awarded claimant 12.5% (40°) unscheduled permanent disability, whereas the Determination Order awarded no permanent disability. SAIF contends that claimant's low back condition is not related to his compensable injury and, therefore, should not be considered in evaluating claimant's disability. SAIF concurs with the amount of the permanent disability award, but asks for a ruling that the award is for claimant's upper back only. Claimant contends that the low back condition is related to his compensable injury and that the permanent disability award is insufficient.

The Board affirms the order of the Referee with the following comments.

In his order, the Referee stated:

> "The employer urges that claimant's low back condition is unrelated to the industrial accident and should therefore not be considered. I am unable to comply with this request as it appears that there has never been a partial denial of that condition, and compensability of claimant's low back condition was not specified as an issue at the hearing."

We do not agree with the Referee's apparent refusal to make an independent determination of whether claimant's low back condition is related to his compensable injury. At a hearing requested by a claimant on the issue of permanent disability, the claimant has the burden of proving permanent disability "due to the compensable injury." ORS 656.214(5). At the hearing in this case, SAIF denied that claimant's low back problems were related to his compensable injury and claimant offered evidence showing that his low back condition was related to the injury. We find it to be appropriate for the finder of fact to determine what permanent disability is "due to the compensable injury."

Furthermore, had SAIF issued a partial denial prior to claim determination, that partial denial may have been invalid. Safstrom v. Riedel International, Inc., 65 Or App 728 (1983); Roller v. Weyerhaeuser, ___ Or App ___ (April 11, 1984); Maddocks v. Hyster Corp., ___ Or App ___ (May 15, 1984). These cases were decided after the date of the Referee's order.

Accordingly, we find that claimant has proven that his low back condition is related to the compensable injury and, therefore, is compensable. The medical evidence does not persuade us, however, that any permanent disability has resulted from the

low back condition. Therefore, we affirm the permanent disability awarded by the Referee, but we hold that that award is for permanent disability resulting from the upper back, neck and shoulder conditions and not from the compensable low back condition.

ORDER

The Referee's order dated September 13, 1983 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the SAIF Corporation.

DONALD B. ANDERSON, Claimant
Moomaw, et al., Claimant's Attorneys
Beers & Zimmerman, Defense Attorneys

WCB 83-01070
May 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Pferdner's order which set aside its denial of aggravation for claimant's lower abdominal muscle strain. The insurer contends that claimant suffered an intervening injury while working for a subsequent employer or, in the alternative, the insurer requests that, if the Board finds claimant did suffer an aggravation of the prior compensable abdominal injury, we should clarify that the only medically verified time loss on this record is from August 31, 1981 through September 14, 1981.

We agree with the Referee that the medical evidence supports a claim for aggravation of the original lower abdominal injury rather than a new intervening injury. Further, we agree with the insurer that, on this record, the only medically verified time loss is for the period specified above. Claimant had to leave work on August 31, 1981 but was authorized to return to work with no limitation on September 14, 1981 by his treating physician, Dr. Kim. Therefore, the insurer is only required to pay temporary disability benefits for that period unless and until claimant's physician authorizes further time loss.

ORDER

The Referee's orders dated September 8, 1983 and October 10, 1983 are modified. Claimant is entitled to temporary total disabilty benefits from August 31, 1981 through September 14, 1981. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

LORRAINE ANGLIN, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-08689
May 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Johnson's order which dismissed her requests for hearing.

Claimant originally petitioned the Board to exercise its own motion jurisdiction pursuant to ORS 656.278 and reopen her claim

for a worsened condition related to her June 11, 1972 industrial injury as her aggravation rights had expired.

On April 3, 1981 SAIF issued a denial of certain medical treatment being recommended for claimant by Dr. Dunn. Specifically, Dr. Dunn requested authorization for insertion of a Pisces device in claimant.

On May 4, 1981, the Board issued an order instructing the Referee to hold a hearing on the issue of medical care and treatment. Our order stated:

> "Upon receipt of the Referee's Opinion and Order the Board will make a decision on claimant's request for the Board to exercise its own motion jurisdiction."

The hearing convened on November 23, 1983. By that time, however, Dr. Dunn had determined not to proceed with the Pisces device insertion. Therefore, since there were no viable issues with regard to ORS 656.245, the Referee dismissed claimant's request for hearing.

It would appear that claimant has requested review of the Referee's order merely as a precautionary measure. On this date, we have also issued an Own Motion Order with regard to claimant's request for reopening of her claim. We, therefore, affirm and adopt the Referee's order in this case.

ORDER

The Referee's order dated December 5, 1983 is affirmed.

ANNIE L. BOUNDS, Claimant
Pozzi, et al., Claimant's Attorneys
Beers & Zimmerman, Defense Attorneys

WCB 83-04989
May 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which declined to grant claimant any award for scheduled leg disability in excess of the 37.5° for 25% previously granted by Determination Order.

The sole issue is extent of scheduled disability. Rating extent is particularly difficult in this case because claimant's knee was reinjured in an automobile accident before it had become medically stationary following her compensable injury.

The Evaluation Division, in rating extent of disability, apparently considered only loss of range of motion and atrophy. Claimant also testified that she experienced disabling pain as a result of her compensable injury, and we so find. We, therefore, consider that disabling pain in rating the extent of claimant's disability. See Harwell v. Argonaut Insurance Company, 296 Or 505 (1984). We hold that claimant is entitled to an award of 52.5° for 35% scheduled disability to her left leg.

ORDER

The Referee's order dated November 29, 1983 is modified. Claimant is awarded 15° for 10% scheduled disability in addition to the 37.5° for 25% previously awarded. Claimant's attorney is allowed 25% of the increased compensation.

RICHARD S. INGRAM, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-09558
May 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Williams' order which upheld the SAIF Corporation's denial of claimant's claim for coronary artery disease.

The Board affirms the Referee's order with the following comment. Claimant argues that SAIF must overcome the so-called fireman's presumption found in ORS 656.802(2) by clear and convincing evidence rather than by a preponderance of the evidence. That argument is premised on the fact that in 1983 ORS 656.802(2) was amended to require the higher "clear and convincing" standard. We hold that the 1983 amendment is not to be given retroactive effect because it concerns eligibility for coverage and because of the presumption against retroactive application of workers' compensation statutes. See Miner v. City of Vernonia, 47 Or App 393, 398 (1980).

ORDER

The Referee's order dated October 12, 1983 is affirmed.

MICKEY L. KING, Claimant
Steven Yates, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 83-06651
May 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Howell's order which declined to award penalties and attorney's fees for unreasonable delay by the insurer in providing claimant with copies of medical reports pursuant to OAR 436-83-460 (currently OAR 438-07-015(2)).

Claimant states in her brief that:

> "On May 9, 1983 [claimant's] counsel wrote to the insurer requesting medical reports. None were forthcoming. Claimant's attorney again on June 27, 1983 wrote requesting medical reports; again, none were forthcoming."

On July 18, 1983 claimant, through her attorney, filed a request for hearing. That request set forth the only issue as being penalties and attorney's fees for unreasonable refusal, resistance or delay by failure to provide medical reports in a timely manner. Under cover letter of July 20, 1983 counsel for

the insurer forwarded a group of 66 exhibits to claimant's attorney. Under cover letter of August 31, 1983 the employer forwarded additional exhibits to claimant's attorney.

Claimant contends that she is entitled to penalties and attorney's fees as a result of the insurer's failure to provide her with copies of medical reports following the prehearing requests for such reports made by her attorney. We disagree.

As the insurer correctly notes, although claimant argues in her brief that her attorney wrote to the insurer on May 9, 1983 and June 27, 1983 requesting copies of medical reports, there is no such evidence in the record. Neither claimant nor her attorney testified at the hearing, and the alleged letters of May 9 and June 27, 1983 were not submitted as evidence. As the Referee stated:

> "Claimant argues that she should have been provided medical reports prior to her July 18, 1983 request for hearing. There is no evidence that such reports were ever requested nor, in fact, is there any evidence that they were not provided to claimant."

Even assuming that OAR 436-83-460 granted claimant the right to medical reports prior to the time she filed a request for hearing, which it does not, there is no evidence that such a prehearing request was made in this case. We, therefore, agree with the Referee and affirm his order.

ORDER

The Referee's order dated November 29, 1983 is affirmed.

DAVID R. PATTERSON, Claimant
SAIF Corp Legal, Defense Attorney

WCB 83-04696
May 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of those portions of Referee Leahy's order which set aside its backup denial and failed to grant SAIF authorization to offset amounts of temporary total disability compensation paid claimant during July and August of 1982.

Despite the fact that this claim was probably not compensable to begin with because it did not arise out of or in the course of claimant's employment, Richmond v. SAIF, 58 Or App 354 (1982), we find that SAIF's backup denial must be set aside pursuant to Bauman v. SAIF, 295 Or 788 (1983). We agree with claimant that the record fails to establish that there was any fraud, misrepresentation or other illegal activity in connection with his assertion of this claim; thus, under Bauman, a backup denial is not permitted.

We disagree with the Referee's failure to grant SAIF authorization to offset temporary total disability benefits paid to claimant during July and August of 1982. Claimant admitted at

the hearing that he was paid his regular salary during July and August 1982, in addition to benefits for temporary total disability that he was paid for those same months. Such "double recovery" is normally not allowed. Candee v. SAIF, 40 Or App 567 (1979). Such "double recovery" is normally avoided by reducing temporary disability benefits by the amount of wages earned. Fink v. Metropolitan Public Defender, 67 Or App 79 (1984). There is no reason in this case to depart from those norms. SAIF should be allowed to offset temporary total disability benefits paid during July and August against any future award of compensation relative to this claim.

ORDER

The Referee's order dated December 5, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which refused the SAIF Corporation's request for authorization to offset temporary total disability benefits paid claimant from July 14, 1982 to August 31, 1982 are reversed, and SAIF is granted authority to offset said benefits. The remainder of the Referee's order is affirmed.

GLEASON W. RIPPEY, Claimant
Steven Yates, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-11441
May 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of that portion of Referee Daron's order which awarded claimant's attorney an insurer-paid attorney's fee of $500 pursuant to the provisions of ORS 656.382(2). The issue for review is the propriety of that attorney fee award.

On December 16, 1982 claimant filed a request for hearing. The request specified several issues, including extent of permanent disability in relation to the November 4, 1982 Determination Order. The insurer filed no cross-request for hearing. When the hearing convened on April 28, 1983, all issues were eliminated other than the question of the extent of claimant's disability. The following exchange took place between the Referee and the insurer's counsel:

> "Referee: All right. Then that leaves us down to the issue of unscheduled permanent partial disability, fine then. Let me back up one moment. Is the employer contending any issues, Mr. Terrall?
>
> "Mr. Terrall: No, we agree that the only issue is extent of unscheduled PPD. Essentially, all we will be asking for is a modification to reduce the award.
>
> "Referee: Well, are you or aren't you? Are you asking that the award be reduced?
>
> "Mr. Terrall: Yes. My understanding of the law in regards to issues raised, is that they don't just get raised by the other parties raising something new."

Although the Referee affirmed the November 4, 1982

Determination Order, he nevertheless awarded claimant's attorney an insurer-paid attorney's fee of $500. The Referee apparently felt that the above-quoted exchange constituted a cross-request for hearing on the Determination Order by the insurer and that an attorney's fee was therefore warranted pursuant to ORS 656.382(2). We disagree.

ORS 656.382(2) provides in part:

> "If a request for hearing . . . 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's fee . . . ." (Emphasis added.)

As the insurer argues, ORS 656.382(2) requires the employer or insurer to initiate the hearing before an insurer- or employer-paid attorney fee may be awarded. Attorney fees in workers' compensation cases may be awarded only when expressly authorized by statute. Korter v. EBI Companies, Inc., 46 Or App 43, 52 (1980). Since it did not initiate the hearing, no attorney fee may be awarded against the insurer in this case.

We believe that ORS 656.382(2) would require the award of an insurer-paid attorney fee where the insurer's cross-appeal necessitates litigation of an issue separate from or additional to the issues raised in the litigation initiated by the claimant. Teel v. Weyerhaeuser Co., 294 Or 588 (1983); Ralph J. Bencoach, 36 Van Natta 681 (May 3, 1984). Although we do construe the request by the insurer's counsel as a cross-request for hearing, we do not believe in any event that any new issues were raised at the hearing when insurer's counsel indicated that the Determination Order's permanent partial disability award should be reduced. Claimant's request for a hearing on the Determination Order necessarily exposed him to attack on the basis that the Determination Order's award was excessive. As we stated in Lesley L. Robbins, 31 Van Natta 208 (1981):

> "When the claimant appealed the Determination Order, he opened the issue of extent and nothing in logic, law, or rule says that the Referee's only options are to determine whether its award should be affirmed or increased." 31 Van Natta at 209.

An employer or insurer is not required to file a cross-request for hearing on a Determination Order in order to contest the amount of the award. Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983). The Referee's award of an insurer-paid attorney fee must, therefore, be reversed.

ORDER

The Referee's order dated June 7, 1983 is affirmed in part

and reversed in part. That portion of the Referee's order which awarded claimant's attorney a fee of $500 to be paid by EBI Companies is reversed. The remainder of the Referee's order is affirmed.

DANNY V. STANGLAND, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Beers & Zimmerman, Defense Attorneys

WCB 83-05129 & 83-05130
May 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Knapp's order which affirmed the SAIF Corporation's denial for claimant's hernia condition.

The Referee held that SAIF had proved it was prejudiced by claimant's untimely filing of his injury claim and, further, that it was not barred from waiving the defense of untimely claim notice under 656.265(4)(b), even though it had begun paying interim compensation. The Referee relied on our decision in Inez Van Horn, 35 Van Natta 432 (1983), which held that payment of interim compensation did not constitute a waiver of the defense of untimely notice of injury. Subsequently, the Board's opinion was reversed in Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984). In Van Horn, supra, the court held that the insurer must raise the defense of untimely claim notice within 14 days of notice of claim or waive that defense. Here, claimant gave notice of claim on April 4, 1983. On May 6, 1983 SAIF reported that it had paid interim compensation within 14 days of that claim notice. Also, on May 6, 1983 the claim was denied.

Except for the defense of untimely notice, the Referee found the claim compensable:

> "Claimant is a credible witness. I accept his statements concerning the accident and injury as true. Dr. O'Connell's opinion of the causal relationship between the hernia and claimant's work activities satisfies the requirements for expert medical testimony. Uris v. Comp. Dept., 247 Or 420 (1967). Claimant sustained his burden of proof that he suffered a compensable injury."

There was no medical opinion contained in the record contrary to the above treating physician's opinion and we find no reason to discount that opinion. Based on the above, we find that claimant's hernia claim was not time barred and that claimant has proven the claim to be compensable on its merits.

ORDER

The Referee's orders dated October 10, 1983 and November 1, 1983 are reversed in part. The SAIF Corporation's denial dated May 6, 1983 is reversed. The remainder of the orders is affirmed. Claimant's attorney is awarded $1,000 for services at hearing and $600 for services on Board review, to be paid by the SAIF Corporation.

RONALD L. WAGGENER, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-01476
May 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Podnar's order which found that claimant's claim had been prematurely closed by Determination Order dated February 2, 1982 and which awarded penalties and attorney fees for SAIF's failure to accept or deny claimant's aggravation claim within 60 days and for SAIF's failure to pay interim compensation within 14 days of notification of claimant's aggravation claim. SAIF contends that the claim was properly closed by the Determination Order and that penalties and attorney fees are not warranted.

The Board affirms the Referee's order on the issue of premature closure, but modifies the award of penalties.

The Referee assessed penalties on the basis of temporary disability benefits from March 9, 1983 to July 6, 1983, the date of SAIF's aggravation denial. The Referee based the starting date of this temporary disability period on Dr. Redfield's March 9, 1983 letter, which authorized time loss for claimant. As SAIF notes, Dr. Redfield's March 9 letter also stated that claimant had a recurrence of the old injury which was "not materially worse." SAIF contends that since it had been notified that claimant's condition was not worse, an aggravation claim had not been made that it had to accept or deny.

We agree with SAIF's argument as to the March 9, 1983 letter. On April 18, 1983, however, SAIF received another letter from Dr. Redfield dated April 15 which stated that, although claimant's basic condition was not worse, claimant's present complaints represented another flare-up and the symptoms were definitely disabling and were no doubt more severe than at the time of claim closure. Dr. Redfield stated that he could not say whether this was grounds for reopening the claim. We find this April 15, 1983 letter was sufficient to notify SAIF of claimant's aggravation claim.

Therefore, we modify the penalty awarded by the Referee. SAIF is ordered to pay a penalty of 25% of the temporary disability benefits due for the period from April 18, 1983 through the date of its denial, July 6, 1983. We affirm the attorney fee awarded by the Referee in connection with the penalty.

ORDER

The Referee's order dated October 12, 1983 is modified in part and affirmed in part. The SAIF Corporation is ordered to pay claimant a penalty of 25% of the temporary disability benefits due from April 18, 1983 through July 6, 1983, in lieu of the penalty ordered by the Referee. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by SAIF.

ROBERT E. BECKER, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-08636 & 81-08637
May 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies, the insurer for E. W. Eldridge, Inc. (hereinafter "Eldridge"), requests review of Referee Braverman's orders which set aside EBI's denial of claimant's industrial injury claim based upon his conclusions that claimant was an Oregon subject worker and that, by operation of ORS 656.029, EBI was responsible for payment of claimant's compensation. The issues on review are claimant's status as an Oregon subject worker at the time of his injury, and Eldridge/EBI's liability as a statutory employer pursuant to the provisions of ORS 656.029(1). The parties have conceded that claimant's injury is otherwise compensable.

The Board's review of the Referee's order in this case has been coordinated with review of the Referee's order in Terri E. Becker, WCB Case Nos. 81-08635, 81-08634, in accordance with claimants' request that these cases be reviewed in tandem. Both claims arise out of the same set of facts and circumstances and involve similar issues of law and fact. We have issued a separate Order on Review in Terri E. Becker, 36 Van Natta 788 (decided this date).

Claimant and his wife, Terri Becker, were employed by D & F Trucking (hereinafter "D & F") as dump truck drivers. D & F was a corporation engaged in the business of general subcontract work and had its main offices in Beaverton, Oregon. Claimant and Terri Becker were, at all times material herein, Oregon residents. D & F performed subcontract work in Oregon and Washington.

In November of 1980, D & F entered into a standard subcontract agreement with Eldridge whereby D & F agreed to furnish materials and perform work for a Corps of Engineers contract involving excavation and placement of levee materials at a site on the Cowlitz River at Kelso, Washington. Claimant's and Terri Becker's primary job responsibilities in connection with D & F's performance of this subcontract agreement involved transporting loads of rocks from a rock quarry in Goble, Oregon, to the job site in Kelso, Washington. During one period of this job, rocks were being hauled from a site in Washington, apparently near Longview. The following additional facts are based upon the parties' stipulation that claimant and Terri Becker would testify accordingly:

> "That Robert Becker was employed by D & F Trucking as a 'truck boss,' with the responsibilities of assigning drivers to jobs on a day-to-day basis as jobs were obtained by the company and assuring that maintenance on the trucks was done as needed;
>
> "That both Robert and Terri Becker would from time to time perform maintenance on the trucks themselves and that prior to the commencement of the Kelso, Washington job the trucks were kept at the Becker

residence in Oregon;

"That upon commencement of the Kelso, Washington job, the trucks were kept at or near a rock quarry in Goble, Oregon at which quarry the rock for the Kelso, Washington job was obtained;

"That most truck maintenance during the Kelso, Washington job was done at the Goble, Oregon site, but that truck maintenance would be done at the time and place it became necessary, whether in Washington or Oregon;

"That during the entire term of their employment with D & F Trucking they were both Oregon residents and that during the term of the Kelso, Washington job they lived in Oregon and commuted daily from their Oregon residence to Goble, Oregon to pick up their trucks and a load of rock before proceeding to the Kelso, Washington site;

"That the Kelso, Washington job involved making as many round-trip runs from Goble with rock to the Kelso job site and back to Goble for another load of rock;

"That at the end of each work day during the Kelso job the trucks would be returned to the rock quarry in Goble, Oregon and the Beckers would return to their Oregon residence;

"That Robert Becker would, from time to time, make calls to various construction companies to line up jobs;

"That Terri Becker did some bookkeeping for D & F Trucking at her home and was paid for the service by adding a couple of extra hours per week to her time sheets as truck maintenance."

At the time that the contract was formed between Eldridge and D & F, D & F had workers' compensation insurance in full force and effect through the SAIF Corporation. This coverage apparently lapsed at the end of 1980, and when claimant sustained his injury on March 31, 1981, D & F no longer had workers' compensation coverage. It is apparent that D & F obtained workers' compensation coverage in the State of Washington, and that this coverage was in effect on the date of claimant's injury.

Claims were filed with EBI as the insurer for Eldridge, with the SAIF Corporation as the processing agent for the noncomplying employer D & F, and with the State of Washington. EBI denied the claim for the stated reasons that it would be more appropriate to consider the claim as one arising under the workers' compensation

provisions of the State of Washington, that EBI was not the workers' compensation insurer for D & F, and that claimant's condition did not arise out of and in the course of employment with EBI's insured, Eldridge. The SAIF Corporation denied the claim, under instruction from the Workers' Compensation Department, for the reason that coverage was in effect under ORS 656.029 at the time of claimant's injury and, therefore, claimant would not be deemed a subject worker of D & F. The State of Washington denied the claim for the reason that claimant was an Oregon worker at the time of his injury and, therefore, was not covered under the industrial laws of Washington.

The Referee concluded that claimant was an Oregon subject worker temporarily out of the state at the time of his injury and, therefore, was entitled to receive workers' compensation benefits under the provisions of the Oregon Workers' Compensation Law. He further determined that the subcontract agreement between Eldridge and D & F was "a contract involving the performance of labor" within the meaning of ORS 656.029 and that, because at the time of claimant's injury D & F had no workers' compensation coverage in effect, claimant was deemed to be Eldridge's subject worker for purposes of this industrial injury. Eldridge contends that each of the Referee's findings and conclusions are erroneous.

We believe that the record clearly and convincingly establishes that claimant's interstate employment activities, and the injury arising therefrom, fall within the provisions of ORS 656.126(1):

> "If a worker employed in this state and subject to ORS 656.001 to 656.794 temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of his employment, he . . . is entitled to the benefits of ORS 656.001 to 656.794 as though he were injured within this state."

The Referee correctly concluded that claimant was an Oregon subject worker entitled to receive benefits under the Oregon Workers' Compensation Law.

We also agree with the Referee's determination that the subcontract agreement entered into between Eldridge and D & F constitutes a contract involving the performance of labor within the meaning of ORS 656.029(1). Eldridge has attempted to characterize the contract as one for the delivery of materials, as opposed to a contract for labor, in view of the fact that the primary purpose of the agreement was to obtain rocks for delivery at the levee site. However, as the Referee correctly observed, the contract contemplated the performance of labor as well as the delivery of materials. Virtually every subcontract agreement involves the performance of labor and provision of materials by the subcontractor. This subcontract is no different. Transporting loads of rocks from one location to another by means of a dump truck is clearly "the performance of labor."

The most intriguing argument advanced by Eldridge is that the facts and circumstances existing at the time the parties enter into

their agreement, i.e., at the time the "contract is let," as opposed to the facts and circumstances existing at the time an injury occurs, should determine whether ORS 656.029 operates to assign liability to the "prime contractor."

The statute provides in pertinent part:

> "If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let has qualified either as a carrier-insured employer or a self-insured employer." ORS 656.029(1).

This portion of ORS 656.029 has been substantially the same at all times material herein.

Eldridge argues that because D & F had qualified as a "carrier-insured employer" and had workers' compensation coverage in effect at the time the contract was formed in November of 1980, the requirements of ORS 656.029(1) have been satisfied. Eldridge argues that, as the prime contractor, its only obligation should be to ensure that the subcontractor has coverage in effect when the contract is executed; and that any other construction imposes an onerous burden upon Oregon employers that enter into subcontract agreements because, in effect, each such employer is required to monitor every one of its subcontractors in order to assure that the subcontractors maintain their respective workers' compensation insurance policies in full force and effect. Eldridge contends that this is the statutory duty and function of the Compliance Division of the Workers' Compensation Department, and it is a duty which should not be imposed upon employers.

Although we previously have not had the opportunity to consider the particular issue presented in this case (time of contract versus time of injury as determinative), we have considered other, related issues concerning the breadth and scope of ORS 656.029. See Richard F. Erzen, 36 Van Natta 218 (1984); Richard O. Hampton, 36 Van Natta 230 (1984); Dennis P. Cummings, 36 Van Natta 260 (1984).

In Erzen we discussed at length the legislative history of ORS 656.029. Erzen involved application of the 1981 version of subsection (2) of the statute because the "person" (a partnership) in that case performed work "without the assistance of others." This case involves subsection (1) because D & F was the "person" to whom this contract was let by Eldridge, and D & F performed the contract, "with the assistance of others," including claimant. Hampton was a subsection (1) case, as was Cummings. In Cummings we found that ORS 656.029 did not operate to create a "statutory employer" under the facts and circumstances presented therein; in Erzen and Hampton we held to the contrary.

In reviewing the legislative history in Erzen, we found that

a primary goal of ORS 656.029 was the elimination of "phoney partnerships" and other business entities organized to avoid the costs of workers' compensation insurance. We also determined, however, that there were other concerns addressed and considered by the legislature, such as establishing a means of identifying who was performing services as an independent contractor at the front end of a business relationship. It is also clear that the legislature intended to encourage persons performing services as independent contractors to obtain workers' compensation insurance by indirect means. That is, once employers became aware of the exposure they faced in hiring an "independent contractor" who employed other workers (if the independent contractor failed to provide workers' compensation insurance in its own right), it was contemplated that the employer (prime contractor) would refuse to hire the independent contractor unless the independent contractor purchased its own workers' compensation insurance. This, then, would have the salutary effect of encouraging legitimate business concerns to obtain workers' compensation insurance. There was also some indication of a desire to avoid the administrative costs of processing claims as noncomplying employer claims, pursuant to ORS 656.054. See Erzen, supra, 36 Van Natta at 222.

We believe that the legislature did intend to impose a policing function upon employers that enter into subcontract agreements and are in the position of prime contractor. Furthermore, we believe that consideration of the circumstances existing at the time a worker is injured, rather than at the time the subcontract is entered into (i.e. whether the subcontractor's workers' compensation insurance is in effect), is consistent with and in furtherance of this apparent legislative intent.

The Referee correctly identified the practical solution available to the prime contractor that needs to be assured that the subcontractor will keep workers' compensation coverage in effect: "The contractor merely must exercise prudent business judgment in seeing to it that the subcontractor secures a certificate of insurance evidencing workers' compensation coverage until performance of the contract is complete." Although a certificate of insurance may not, in and of itself, guarantee that the subcontractor will keep its workers' compensation insurance in full force and effect, we believe that this procedure, commonly used in other spheres of the insurance industry, will go a long way toward answering the problems theorized by Eldridge's argument.

Eldridge contends that, in situations such as this, where coverage in effect at the time the contract is let has lapsed, the claim should be processed under the noncomplying provisions of the Act, rather than under the coverage provided by the prime contractor. Two reasons advanced by Eldridge in support of this contention are: First, the assessment paid by Oregon employers includes monies that are earmarked for the payment and administration of noncomplying employer claims. It, therefore, is inappropriate to require employers to pay this assessment and, in addition, pay the costs of claims that otherwise would be paid out of the Administrative Fund. Second, Eldridge contends that by requiring it to pay claimant's compensation, it must assume the costs of this claim without any possible recourse for recovery. With respect to the first point, as previously mentioned, the

legislature apparently contemplated that there would be a reduction in the number of noncomplying employer claims by enactment of ORS 656.029. Therefore, the possible inequity of requiring employers to pay claim costs by operation of ORS 656.029 in addition to the assessments paid into the Administrative Fund appears to be a policy consideration already addressed by the Legislative Assembly. This consideration applies equally in all cases arising under ORS 656.029 and is not peculiar to this situation, where coverage was once in effect but had lapsed by the time of claimant's injury. With respect to the second point, concerning Eldridge's (or EBI's) ability to recoup the costs of this workers' claim, we stated in Richard L. Hampton, supra:

> "We find it quite conceivable in this type of case that the 'prime' contractor or its industrial insurer (as a third party beneficiary or based on subordination rights) would have a contractual or quasi-contractual cause of action against the noncomplying subcontractor. That question will ultimately be determined in some forum other than this agency; we only note that, in answering the questions that are now properly before us, we are not willing to join (the insurer) in the assumption that there is no possible recourse against a noncomplying subcontractor in this kind of situation." 36 Van Natta at 233.

Finally, we find unpersuasive Eldridge's argument that the result we reach today will encourage subcontractors to allow their workers' compensation insurance to lapse once the subcontractor has been successful in obtaining a contract with a prime. The legislature obviously anticipated that a prime contractor would be able to encourage a subcontractor to obtain workers' compensation insurance, in order to be eligible for performance of a contract. For the same practical reasons, we believe that the prime contractor is in a position to require the subcontractor to maintain a policy of insurance in effect during the period that the contract is performed. Where the subcontractor has subject workers but no workers' compensation insurance, it presently appears as though such a noncomplying subcontractor would be subject to the sanctions provided by ORS 656.735. See also ORS 656.052. The possibility of being subject to a civil penalty for noncompliance with the law would appear to be some inducement to provide workers' compensation insurance, in addition to the practical considerations involved in being unable to obtain (or being able to lose) a subcontract in the absence of having workers' compensation insurance in full force and effect.

For the foregoing reasons, we agree with the Referee's determination that ORS 656.029(1) operates to make claimant Eldridge's subject worker for purposes of this industrial injury. Therefore, EBI Companies, as the insurer for Eldridge, is liable for payment of claimant's workers' compensation benefits.

ORDER

The Referee's orders dated August 27, 1982 and September 7, 1982 are affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by EBI Companies.

TERRI E. BECKER, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 81-08635 & 81-08634
May 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies, the insurer for E. W. Eldridge, Inc., requests review of Referee Braverman's order which set aside EBI's denial of claimant's claim for "a tension condition." The issues on review are: (1) Whether claimant was, at the time of her injury, an Oregon subject worker; (2) whether an incident which occurred on March 31, 1981, has been established as the legal and medical cause of claimant's condition; (3) and whether, if the claim is otherwise compensable, E. W. Eldridge, Inc. and its insurer are responsible for payment of claimant's compensation pursuant to ORS 656.029.

In accordance with this claimant's request, the Board has coordinated its review of the Referee's order in this case with its review of the Referee's order in Robert E. Becker, WCB Case Nos. 81-08636 and 81-08637, in view of the fact that both cases involve the same or similar legal and factual issues concerning both claimants' status as Oregon subject workers and employer/insurer responsibility for processing the respective claims. We have entered a separate Order on Review in Robert E. Becker, 36 Van Natta 782 (decided this date), in which we have held that the claimant was an Oregon subject worker at the time of his injury and that E. W. Eldridge, Inc., by and through its insurer, EBI Companies, is responsible for payment of that claimant's compensation pursuant to the provisions of ORS 656.029(1). Our holding on those issues in Robert E. Becker, is dispositive of those issues in this case as well.

With respect to the issues concerning the causal connection between the March 31, 1981 incident involving claimant, her husband and a third party assailant, we find that claimant's condition has been diagnosed by her treating physician as a psycho/physiologic gastrointestinal disorder which manifested itself as an acute peptic ulcer followed by a chronic irritable (spastic) colon. We find that the evidence preponderates in favor of concluding that claimant has established the March 31, 1981 incident as the legal and medical cause of this condition. Accordingly, we agree with the Referee's determination of compensability.

ORDER

The Referee's order dated December 16, 1982 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by EBI Companies.

RICHARD DAVIES, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Mitchell, et al., Defense Attorneys

WCB 80-05224 & 80-02635
May 31, 1984
Order on Remand

On review of the Board's order dated January 18, 1983 the Court of Appeals reversed the Board's order and found that claimant sustained a new injury for which the SAIF Corporation is responsible.

Now, therefore, the above-noted Board order is vacated and this claim is remanded to the SAIF Corporation for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

MARILYN KOLB, Claimant
Des Connall, Claimant's Attorney
Noreen Saltveit, Defense Attorney
John Snarskis, Defense Attorney

WCB 82-09022 & 81-11764
May 31, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of those portions of Referee Knapp's order which awarded claimant 32° for 10% unscheduled disability in addition to the 32° for 10% unscheduled disability previously awarded. We do not understand any party to have raised any objection to the Referee's decision on an employer/insurer responsibility issue.

Claimant's argument on extent of disability focuses on that portion of the Referee's analysis which concluded that some of claimant's impairment was due to obesity rather than due to her industrial injury or injuries, and which declined to take the obesity-related impairment into account in rating the extent of her compensable disability. The Referee relied on Nelson v. EBI, 64 Or App 16 (1983), in support of that analysis. Since the Referee's order, the Supreme Court's decision in Nelson has issued. Nelson v. EBI, 296 Or 246 (1984). The Supreme Court agreed with the Court of Appeals that a disability award may be reduced if a claimant has unreasonably failed to follow medical advice to lose weight. However, the Supreme Court stated that the burden of proof in this regard is on the employer/insurer, rather than on the claimant.

We have reviewed this case with the burden of proof, as defined by the Supreme Court, in mind and agree with the result reached by the Referee: The insurer has satisfied its burden of proving that claimant unreasonably failed to follow medical advice to lose weight.

ORDER

The Referee's order dated September 13, 1983 is affirmed.

JOHN PARKS, Claimant
Robert L. Burns, Claimant's Attorney
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01044
May 31, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Williams' order which upheld EBI Companies' denial of claimant's claim that he sustained a new injury in May 1981. Claimant argues that he established a new injury claim and requests that the Board impose a penalty and associated attorney's fee for EBI's failure to promptly accept or deny this claim.

Claimant also requested that the Board exercise its own motion authority in connection with a 1972 injury which occurred when this employer's workers' compensation coverage was provided by the SAIF Corporation. Claimant's request for own motion relief was assigned Own Motion No. 82-0282M, and by an order dated November 9, 1982, the Board referred that request to the Hearings Division for consolidation with claimant's pending hearing request contesting EBI's denial of his alleged 1981 injury. The Referee conducted a consolidated hearing and made an own motion recommendation to the Board as requested in addition to entering the appealable order that is the subject of this review. Claimant's request for own motion relief is the subject of a separate order entered this date in Own Motion No. 82-0282M.

On the issue of whether claimant has established that he sustained a new injury in May 1981, we agree with the Referee's conclusion that the evidence simply does not preponderate in favor of so finding. Accordingly, we affirm this portion of the Referee's order.

On the issue of EBI's liability for payment of a penalty and associated attorney's fee, we agree with the Referee's conclusion, although in part for different reasons. The incident which claimant alleges constitutes a new injury occurred on May 19, 1981. A form 801 was not completed by claimant and the employer until September 23, 1981. Part of this form indicates that the employer had notice of this incident on the day it occurred, which is consistent with claimant's testimony. EBI denied the claim on December 16, 1981. Claimant suffered no time loss during the period between the date of his alleged injury and the date of EBI's denial. On the question of the delay between the date of the claim and the date of the denial, the Referee seemingly focused on the September 23 to December 16 period.

To the extent that the Referee relied on the date of the 801 form as the critical date for purposes of the insurer's liability for a penalty, claimant correctly points out that the date of the 801 form is not necessarily dispositive. ORS 656.262(6) provides that an insurer shall issue written notice of acceptance or denial within 60 days after the employer has notice or knowledge of the claim. As indicated on the 801 form, here the employer knew of claimant's alleged injury on the date of its occurrence. Therefore, the denial was issued well beyond the permitted 60-day period.

We nevertheless agree with the Referee's conclusion with respect to the penalty issue because the only compensation claimed during the pertinent period of time, i.e. during the period of EBI's delayed denial, was compensation in the form of medical services; and we have determined that claimant sustained no injury during EBI's period of coverage; thus, there are no "amounts then due" which can provide the basis for imposition of a penalty pursuant to ORS 656.262(10). See Darrel W. Carr, 36 Van Natta 16 (1984); Gary L. Clark, 35 Van Natta 117, 119 (1983); EBI Companies v. Thomas, 66 Or App 105 (1983).

The Referee determined that no issue was presented of whether claimant is entitled to payment of medical bills pursuant to the provisions of ORS 656.245 by the SAIF Corporation as insurer on the risk at the time of the 1972 injury. Claimant makes no contention concerning the propriety of this determination, and, therefore, we have not considered it as an issue before us on review.

ORDER

The Referee's order dated November 10, 1983 is affirmed.

HERBERT E. RICHARDS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-09437
May 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which, in effect, upheld the SAIF Corporation's de facto denial of claimant's medical services claim. Claimant's aggravation rights have expired, and claimant has made a related request for own motion relief, requesting claim reopening for payment of additional temporary and/or permanent disability benefits. We have this date issued a separate own motion order in Own Motion No. 82-0084M. Because of some apparent confusion on the part of the Referee, we deem it appropriate to discuss the pertinent factual and procedural background of this case. The primary issue is the compensability of claimant's bilateral varicose veins.

Claimant sustained a compensable industrial injury on May 18, 1976 when he was moving a load of plywood on a dolly, the dolly tipped and the plywood fell onto his leg. As a result, claimant sustained a severe contusion and abrasions of his right lower leg with severe redness, swelling and hematoma. Claimant's physician, Dr. Smith, prescribed rest, medication (apparently by topical application), elevation and ice pack. Although claimant was off work for a day or two, he suffered no compensable time loss. See generally ORS 656.210(3).

Claimant continued to work as a cabinet maker, and he continued to experience difficulties with his right leg. In August of 1976 claimant bumped his leg and, as a result, the wound from his original injury became ulcerated. Claimant sought treatment with a similar problem in November of 1976. Physicians' records from these office visits refer to an April injury; however, we infer that these are mistaken references to claimant's May 1976 industrial injury. Physicians' records from June and October of 1977 do not appear to be related to claimant's leg injury.

Claimant's injury was accepted and processed as a nondisabling injury, and no determination of the claim was made. Accordingly, claimant's aggravation rights expired five years after the date of claimant's injury, or May 18, 1981. ORS 656.273(4)(b). Claimant's sole remedy beyond that time, in order to obtain claim reopening for payment of additional temporary and/or permanent disability, was by application to the Board pursuant to ORS 656.278; however, claimant had the continuing right to receive medical services for conditions related to his original industrial injury. ORS 656.245.

In September of 1981, claimant's physician, Dr. Smith, reported to SAIF that, as a result of claimant's May 1976 injury, he sustained contusions and abrasions to the right lower leg with vascular injuries. Dr. Smith related a history of claimant's subsequent development of cellulitis and ulceration of the right lower leg. Dr. Smith also reported that, since the injury, claimant had developed recurring thrombophlebitis, varicosities and stasis dermatitis of the right lower leg. He attributed the stasis dermatitis and swelling of the right lower leg to vascular damage resulting from claimant's original May 1976 injury. He recommended varicose vein stripping in the near future in order to avoid further dermatitis and ulceration of the leg, as well as continuing periodic thrombophlebitis problems. Dr. Smith subsequently advised SAIF that he was referring claimant to Dr. Jefferson for consultation and arrangement of surgery. Dr. Smith is a family practitioner, and Dr. Jefferson apparently specializes in general, thoracic and vascular surgery.

In a November 23, 1981 report to Dr. Smith, Dr. Jefferson reported that claimant had "rather significant bilateral greater saphenous varices" and that surgery was scheduled for the middle of December.

The report of a venogram obtained by Dr. Jefferson revealed bilateral varicosities. Claimant's deep venous system was found to be patent, i.e. open or unobstructed. The impression stated in this report was: "Bilateral varicose veins with identical four groups of incompetent perforators, one immediately above and one below the knee and the others in the lower extremities."

On December 4, 1981 Dr. Smith reported to SAIF and explained his theory of the causal relationship between claimant's 1976 right lower leg injury and his subsequent development of bilateral varicose veins. Essentially, it is Dr. Smith's opinion that, as a result of claimant's right leg injury, he favored this leg and, therefore, stood with most of his weight on his left leg during long periods of work activity, which in turn led to "aggravation" of the veins in the left lower leg, thereby causing varicosities of that leg. Dr. Smith noted, however, that the varicosities in the right lower leg were "much worse," and that, in addition, claimant had a considerable amount of "coppery pigmentation" of the right lower leg secondary to the varicosities. Dr. Smith also reported that claimant had been his patient since July of 1972 and that at no time prior to claimant's May 1976 injury had he experienced any of these medical problems with reference to his legs.

SAIF referred claimant for examination by Dr. Rogers, a physician apparently specializing in thoracic and cardiovascular surgery. The results of the venous angiogram (venogram) were not

made available to Dr. Rogers in conjunction with his examination of claimant. Dr. Rogers diagnosed chronic venous insufficiency of both lower legs, secondary to superficial varicosities and stated: "By history it appears that the bump in 1976 was the primary contributing factor . . . "

A report from SAIF's medical consultant, Dr. Girod, an internist, dated February 22, 1982, states his impression of the possible causal relationship between claimant's 1976 injury and subsequent development of varicose veins. This opinion was rendered based upon Dr. Girod's review of claimant's medical file. He did not have the opportunity to examine claimant. Dr. Girod stated that all the changes in claimant's right lower leg "could be secondary to the trauma to the right leg." With respect to the left leg, however, he stated:

> "The changes in the left leg could be attributed to the trauma to the right leg only if he had developed clots in the inferior vena cava at the time of his right leg injury in 1976. This is extremely unlikely as he would have been very ill and would have had swelling of the left leg at that time. This is an extremely uncommon occurrence and is only a remote possibility. Therefore, I feel that the changes in the left leg cannot be attributed to the trauma to the right leg. If the changes in the right leg are no more marked than the changes in the left leg, one could then question the contribution of the injury to the changes in the right leg. The bilateral venograms reveal similar disease in veins of both legs. It is very likely that the claimant would have varicose veins had he not injured his right leg."

Dr. Girod suggested that an opinion be solicited from Dr. Porter at the University of Oregon Health Sciences Center, who is a vascular surgeon.

Dr. Porter's opinion, in fact, was obtained. He is Professor of Surgery and Head of the Division of Vascular Surgery at the Center. Dr. Porter's report to SAIF, dated March 30, 1982, begins by stating that he failed to see a "clearly demonstrated relationship" between claimant's May 1976 injury and his subsequent development of varicose veins in both legs. Dr. Porter was aware that the 1981 venogram disclosed no evidence of deep vein thrombosis, from which he drew the conclusion that it was likely that claimant did not sustain any deep vein thrombosis in 1976. He stated: "Accordingly, there would have been no explanation whatsoever for thigh to foot varicose veins following a tibial injury. Under no circumstances would any injury to his right leg have any affect on varicose veins on his left leg." Dr. Porter's report continues:

> "The patient apparently has significant varicose veins of the greater saphenous systems of both legs. It is my assumption that the soft tissue injury in May of 1976 has had no relationship whatsoever to the

> subsequent development of varicose veins, and I think there is a high degree of medical probability that these varicose veins would have been equally developed at the present time had the patient had no trauma whatsoever.
>
> "As stated above, I find no plausible relationship between any injury to the patient's right lower leg and the subsequent development of saphenous vein varicosities in his left leg."

Dr. Jefferson (the vascular surgeon claimant saw on referral from Dr. Smith) completed a Form 827 (first medical report) dated June 1, 1982. Dr. Jefferson indicated that his examination revealed rather severe varices of the greater saphenous system bilaterally with venous stasis changes of the lower legs which were more pronounced on the right side. Dr. Jefferson indicated that he had reviewed the venogram. In response to the question whether the condition was work-related, Dr. Jefferson marked the "undetermined" box and explained that claimant's injury to the right leg "certainly could have aggravated or brought on problems with varicose veins," but that he apparently had not experienced injury to the left leg, "and only prolonged standing at work [had] aggravated his condition." Dr. Jefferson recommended surgery for treatment of claimant's condition.

Claimant testified, consistent with the history reported by Dr. Smith, that he continued to experience problems periodically with his right leg subsequent to the injury, that he began to favor his right leg while working, and that he eventually began to experience problems with both legs in the form of cramping and pain. Claimant testified that, subsequent to his 1976 injury, he experienced no other trauma or injury to either leg, other than the minor bumps previously mentioned.

Because claimant's aggravation rights had expired by the time Dr. Smith communicated with SAIF in September of 1981 concerning the condition of claimant's right leg, Dr. Smith's recommendation that surgery be performed at that time was processed by SAIF as a request for own motion relief pursuant to ORS 656.278. SAIF had indicated, however, by a November 2, 1981 letter to claimant, that the medical bills received up to that date (presumably the recent billings from Dr. Smith in connection with further evaluation and treatment of claimant's leg injury) would be paid. SAIF referred claimant's request for additional temporary and/or permanent disability to the Board for consideration, and, by an order dated May 10, 1982, the Board denied claimant's request for own motion relief. It is apparent, from the terms of the Board's order, that it considered much of the medical information submitted to the Referee, including the reports of Drs. Rogers, Porter and Girod.

After the Board issued its Own Motion Order denying claimant's request for relief, claimant petitioned for reconsideration. As a result, by order dated December 3, 1982, the Board entered another Own Motion Order, by the terms of which any further action with respect to claimant's own motion request was deferred pending resolution of the litigation that had been initiated by claimant's hearing request in this proceeding, which claimant had filed in

September of 1982. By the terms of this more recent Own Motion Order, the Board requested that the Referee provide a copy of his order upon resolution of the litigation.

The Referee concluded that a preponderance of the persuasive evidence failed to establish the compensability of claimant's varicose veins. In reaching this conclusion, however, it is quite apparent that the Referee somehow felt bound by the Board's May 10, 1982 Own Motion Order denying relief. The Referee expressed uncertainty concerning his "jurisdiction" to consider claimant's request, by and through his physicians (Drs. Smith and Jefferson), that SAIF authorize payment for surgical treatment of his varicose veins.

The Referee had jurisdiction to consider claimant's request for relief by virtue of the fact that claimant presently seeks compensation in the form of medical services; i.e., claimant's physicians have presented, in claimant's behalf, a claim for medical services in the form of a request that SAIF authorize a recommended surgical procedure. See generally Billy J. Eubanks, 35 Van Natta 131 (1983). Although the Board previously denied own motion relief -- compensation in the form of additional temporary and/or permanent disability benefits -- and although the same questions of medical causation may be present with respect to both forms of relief (additional disability benefits pursuant to ORS 656.278 and additional medical services pursuant to ORS 656.245), there are additional factors frequently considered by the Board in deciding whether the discretionary remedy of own motion relief should be granted. See, e.g., Vernon Michael, 34 Van Natta 1212 (1982). Furthermore, the Board generally will not consider the merits of a claim for medical services in the exercise of its own motion authority where the claimant has the continuing right to receive injury-related medical services under the provisions of ORS 656.245. See generally Dwayne G. Carey, 36 Van Natta 265 (1984); William A. Newell, 35 Van Natta 629 (1983). For these reasons the Board's initial Own Motion Order was not binding upon the Referee with respect to claimant's entitlement to medical services pursuant to ORS 656.245.

Having attempted to clarify this apparent confusion, we turn to the merits of this claim for medical services based upon the evidence of record, including claimant's testimony. The question of the causal relationship between claimant's 1976 right lower leg injury and the subsequent development of varicose veins in both of claimant's legs is a complicated question of fact requiring expert medical evidence. There are medical opinions aplenty in this record; however, the only medical opinion that explains the possible relationship between claimant's original injury and the subsequent development of bilateral varicose veins is the opinion rendered by Dr. Smith. It is not necessary for the evidence to "clearly demonstrate" a relationship between claimant's original injury and his varicose veins, as apparently sought by Dr. Porter; however, it is necessary for a preponderance of the evidence to establish a reasonable medical probability that claimant's 1976 industrial injury materially contributed to the development of his bilateral varicose veins. Our de novo review of the record fails to convince us that such a medical probability exists in fact.

Claimant asserts that Dr. Smith's opinion is entitled to considerable weight due to the fact that he treated claimant at the time of his 1976 injury and thereafter. Although we have considered this factor in our evaluation of the evidence,

resolution of the medical causation issue presented in this case requires expertise in understanding and analyzing the etiology and development of varicose veins, which is not necessarily enhanced by the opportunity to personally observe and examine claimant. See Hammons v. Perini Corp., 43 Or App 299 (1979). For this reason, we do not give Dr. Smith's opinion special deference. Because Dr. Porter is a vascular surgeon, whose station indicates that he is well-versed in this area of medical science, we find his opinion particularly persuasive. He found a "high degree of medical probability" that claimant's varicose veins would have developed to the same extent independently of trauma to claimant's right lower leg. He reached this conclusion based upon his review of the medical records pertinent to claimant's 1976 injury and subsequent development and diagnosis of varicose veins, including the venogram performed by Dr. Jefferson. Neither Dr. Smith nor Dr. Rogers had the opportunity to review the results of the venogram, which, significantly, disclosed that the varices of the greater saphenous system were rather severe in both legs.

No physician other than Dr. Smith appears to subscribe to the theory that claimant developed varicosities in the left leg due to his favoring the right leg during the post-injury period of recuperation and thereafter. Dr. Rogers, a thoracic and cardio-vascular surgeon, may be understood to endorse this theory by his statement to the effect that claimant's history appears to indicate that the 1976 "bump" was the primary contributing factor to the varicose veins; however, he offered absolutely no explanation in support of this apparent premise. It is obvious that Dr. Rogers was more concerned with the proper diagnosis of claimant's condition, the extent of claimant's medical problem and the appropriate treatment thereof, as opposed to the possible causal connection between claimant's injury and his varicose veins.

We would expect that, since Dr. Smith referred claimant to Dr. Jefferson for treatment of his varicose veins, Dr. Smith would defer to Dr. Jefferson's opinion concerning the causation question. In any event, we give greater deference to Dr. Jefferson's opinion for that reason. Dr. Jefferson, after viewing the venogram, indicated that it was "undetermined" whether claimant's varicose veins were related to his industrial injury. Like Dr. Girod, Dr. Jefferson stated that claimant's right leg injury "could have" contributed to the development of varicose veins in that leg; however, we believe that both physicians were doubtful of the causal connection between claimant's right leg injury and the varicose veins in the left leg. We do not consider Dr. Jefferson's statement that "only prolonged standing at work has aggravated this condition" to be a statement of his opinion, to a medical probability, that claimant's 1976 injury materially contributed to the development of varicose veins in the left leg. We consider this statement to be more in the nature of a possible, not probable, explanation, particularly in light of Dr. Jefferson's indication that the work connection was "undetermined" in his mind.

Viewing the evidence in the light most favorable to claimant, we find that, at most, claimant has established the possibility that his 1976 right lower leg injury materially contributed to the development of his bilateral varicose veins. This is insufficient to sustain claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

ORDER

The Referee's order dated April 29, 1983, which we understand to be an affirmation of the SAIF Corporation's de facto denial of a claim for medical services, is affirmed.

DIANE B. THORNE, Claimant
Richardson, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 83-02928
May 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Mulder's order which set aside its denial of claimant's occupational disease claim for allergic rhinitis.

Claimant began working as a secretary for the employer in November 1977. The employer's principal business is the manufacture of pet foods. That activity takes place in two large buildings; one has an office in the front, and dry dog food manufacturing facilities in the back; the other building also has an office in the front, and a cat and dog food cannery in the back. Claimant worked mainly in the office portions of both buildings, but she was occasionally required to be in manufacturing portions of the buildings. Claimant testified that the papers she worked with were often covered with dust from pet food products.

Although she had previously suffered no such problems, claimant began to experience sinus difficulties in late 1979 or early 1980. Claimant has since received treatment for her sinus condition from numerous physicians, including Drs. Wagner, Intile, Joe, Lahti, O'Hallaren, Weingarten, Lipman, Davis, Knister and Bardana. Testing revealed that claimant had allergic reactions to garlic, corn, oats, rice, wheat, filberts, peanuts, milk, and yeast. Claimant was also found to have reactions to house dust, all animal epidermals, particularily cat and feathers, and pollens from many trees and some grasses and weeds. Claimant's symptoms were also effected by weather changes, emotional upsets, smoke, heat, dust and paint.

Cereals and garlic are used in the manufacture of some of the employer's pet food products.

Claimant left her position with this employer on October 21, 1982. Claimant thereafter received unemployment benefits for several months before obtaining another job. By March 1983 claimant's sinus symptoms had substantially disappeared.

In addition to the employment exposure to irritants noted above, the record reveals that claimant was also exposed to many irritants while off the job. Claimant smoked until May 1981; her husband continues to smoke. Claimant has owned a dog and one or more cats at various times, and has lived in apartment complexes in proximity to other domestic pets.

On December 7, 1982 Dr. Intile reported:

> "It is my professional opinion and I think that Dr. Joe's short comment [that claimant is a 'chronic allergic individual'] would

support the fact that this [claimant] . . . is probably chronically allergic, and that exposure to certain allergens does not cause the allergy itself. * * * Exposure to similar allergens in any environment by an allergic individual, who happens to have the specific allergies, would have created the same problem."

On December 8, 1982 Dr. Joe reported:

"[I] can definitely state that [claimant's] food allergies, which she had upon our testing, did not develop while in employment at the Hervin Company. I also strongly feel that [claimant] would have had problems with her inhalent allergies no matter where she was employed. It is well known that people can develop allergies as they get older. * * * In summary, I feel that [claimant's] inhalent allergies would have existed no matter where she would have been employed."

On December 9, 1982 Dr. Lahti reported:

"In my opinion, this would be difficult to establish a cause and effect relationship as a result of working at the Hervin Company. The allergens incriminated here are ones that we are exposed to daily in many areas of the average American environment. . . ."

On December 17, 1982 Dr. Lipman reported:

"My impression was one of chronic allergic rhinitis, probably related to multiple allergenic substances . . . . I do not feel that the nasal condition is the direct result of working . . . in an office environment, but rather chronic allergic rhinitis due to a variety of environmental allergenic substances."

On April 13, 1983 Dr. O'Hollaren reported:

"In reference to her work environment, in view of her severe reactions to these food allergens including garlic and some cereal allergens, it is indeed possible that inhalation of these substances in a food processing area would indeed cause severe symptoms and incapacitate her in reference to constant headaches and respiratory symptoms. * * * I would be interested in knowing more specifically what food products are being prepared."

On May 20, 1983 Dr. Weingarten reported that he felt claimant developed her allergies while working for Hervin Company and that

the work environment caused a persistence and worsening of her condition.

On July 11, 1983 Dr. O'Hollaren reported that:

> "It is my opinion that exposure to garlic and the cereal allergens probably triggered off her symptoms and will continue to bother her if she works in this environment."

Claimant has been treated with various types of nasal sprays, dietary changes and immunotherapy.

The Referee found claimant to have established that she suffered from a compensable occupational disease, based mainly on Dr. O'Hollaren's opinion and the temporal connection between claimant's symptoms and employment. We conclude that the preponderance of the evidence is to the contrary.

Dethlefs v. Hyster Co., 295 Or 298 (1983), was an occupational disease case which involved a similar claim for a respiratory disease. The court stated:

> "[W]e conclude that if a causative agent at the work place and a causative agent away from the work place are different in kind and concur to cause an indivisible disease which requires medical services or causes disability, a claim therefore is compensable if the causative agent at the work place is the major cause of the disease." 295 Or at 310.

In this case, claimant has been found to be allergic to a great variety of irritants. Two of these irritants, garlic and cereals, were present and claimant suffered some exposure in her place of employment. However, many other irritants are encountered outside of claimant's employment, such as weeds, grasses, pollen, dust, animal epidermals and smoke. It is clear that claimant was exposed to many of these irritants off the job. At least prior to her sinus difficulties, claimant apparently ate foods with cereal products in them, and was certainly exposed to grasses, weeds, pollens, smoke and dust. Claimant had a cat for a period of time before her marriage in May 1981, and two cats and one dog after her marriage. Claimant was thus exposed to animal epidermals, to which she is allergic, off the job. Claimant smoked prior to her marriage and her husband currently smokes.

The fact that claimant is allergic to so many ubiquitous substances makes it difficult to establish that work exposure was the major cause of or aggravating factor of her allergic rhinitis. This difficulty is reflected in the medical opinions of Drs. Lipman, Lahti, Intile and Joe, all quoted above. All of these physicians are basically of the opinion that either: (1) Claimant's employment did not cause her condition; or (2) that it would be impossible to implicate her employment as the major cause or aggravating factor of her condition because she is allergic to so many substances that are disseminated throughout the environment. Although the Referee relied in large part on the opinions

of Dr. O'Hollaren, we interpret Dr. O'Hollaren's reports to say only that claimant's work exposure was possibly the major cause her condition.

We are also not persuaded by the temporal connection between claimant's symptoms and her employment. As stated by the court in Edwards v. SAIF, 30 Or App 21, 24 (1977), inferences based on temporal connections are generally insufficient in situations involving complex medical questions. This is such a case. Additionally, we believe that the "temporal connection" analysis cuts both ways in this case. Although it is true that claimant had no symptoms prior to her employment here in issue, it is interesting to note that claimant worked in that setting for approximately two years before the onset of any symptoms. Also, it is uncertain why claimant eventually became asymptomatic in 1983. It may be due to the fact that claimant stopped working around pet food manufacturing. However, it may also have been due to the immunotherapy claimant was receiving from her physicians, or various other factors such as claimant's change of residence or the fact that she stopped smoking marijuana. Each appears to be at least equally possible.

We believe that the above noted factors distinguish the current case from cases such as Penifold v. SAIF, 60 Or App 540 (1982) and Reining v. Georgia Pacific Corp., 67 Or App 124 (1984). In finding the claims in Penifold and Reining compensable, the court emphasized the strong temporal connection between the respective claimant's employments and the waxing and waning of their symptomatology. Not only does the subtantially weaker temporal connection distinguish the current case from Penifold and Reining, but so also does the lack of medical evidence supporting compensability. In both Penifold and Reining there was considerably more and stronger medical evidence in favor of compensability than in the current case. What evidence there is in support of compensabilty in this case, however, is far from a preponderance.

In summary, we find the medical and nonmedical evidence in this case fails to establish that claimant's work exposure was the major cause or aggravating factor of her allergic rhinitis. The expert medical evidence establishes that claimant is allergic to numerous, pervasive substances. The nonmedical evidence establishes that claimant is exposed to many of these substances in nonemployment circumstances. The only medical opinion completely favorable to claimant is that of Dr. Weingarten. However, we note that there is nothing in Dr. Weingarten's opinion which indicates that he even considered claimant's nonemployment exposure to numerous irritants. In any event, we conclude that Dr. Weingarten's opinion is insufficient to overcome the preponderance of the contrary medical evidence.

ORDER

The Referee's order dated November 3, 1983 is reversed. The employer's denial dated March 3, 1983 is reinstated and affirmed.

WILLIAM Z. VINSON, Claimant
Roberts, et al., Defense Attorneys

WCB 83-05605 & 83-05604
May 31, 1984
Order of Dismissal

The insurer moves to dismiss claimant's request for Board review on the grounds that claimant failed to serve a copy of his request for review on the insurer within 30 days of the date of the Referee's order herein, and that the insurer failed to receive actual notice of the request for review within that period. See ORS 656.289(3) and 656.295(2).

The Referee's order was entered on March 29, 1984. Claimant's request for Board review was mailed on April 30, 1984. The Board mailed notices of acknowledgement of the request for review to claimant and the insurer on May 7, 1984. This acknowledgement was received by the insurer on May 8, 1984, well outside the statutory 30 day period. Counsel for the insurer states in his affidavit that the Board acknowledgement was the first notice the insurer had of claimant's request for review of the Referee's order.

In Argonaut Insurance v. King, 63 Or App 847 (1983), the court stated that, "[c]ompliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." 63 Or App at 852. Since the insurer's first notice of the request for Board reivew came after the statutory period for providing such notice elapsed, this appeal must be dismissed.

IT IS SO ORDERED.

BOBBIE BLAKELY, Claimant
David Force, Claimant's Attorney
John Snarskis, Defense Attorney

WCB 81-07215
June 6, 1984
Order on Remand

On review of the Board's Order dated May 16, 1983, the Court of Appeals reversed the Board's Order and reinstated the Order of the Referee dated June 29, 1982.

Now, therefore, the above-noted Board Order is vacated, and the above-noted Referee's Order is republished and affirmed.

IT IS SO ORDERED.

KEITH LINDSTROM, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-02758
June 6, 1984
Order of Dismissal

The claimant has requested review of Referee's order dated April 30, 1984. The request for review was filed with the Board on June 1, 1984 , more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The claimant's request for review is hereby dismissed as being untimely filed.

BILLY A. BURCH, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 83-0361M
June 6, 1984
Own Motion Order

Claimant, by and through his attorney, requests that the Board award additional compensation for reasonable and necessary medical services incurred as a result of claimant's August 9, 1965 industrial injury. This claim for medical services arises under ORS 656.278 in view of the fact that claimant's injury occurred before January 1, 1966, the effective date of ORS 656.245. See William A. Newell, 35 Van Natta 629 (1983).

Claimant sustained a compound comminuted fracture of the right tibia in August of 1965. As a result, it eventually became necessary to amputate the leg below the knee. Claimant was fitted with a prosthesis, and claimant's attending physician, Dr. Degge, believed that claimant had adapted well to wearing the prosthesis at the time of his closing examination in February 1968. At that time, Dr. Degge noted that claimant previously had experienced lowback difficulty while he was walking on crutches, but that his lower back problems had subsided while wearing the prosthesis.

Claimant subsequently found that he was unable to wear his leg prosthesis due to pain. A lumbar sympathectomy was performed in late 1968, which relieved some of claimant's symptoms. Claimant's continued recovery was not uneventful; however, by April 1970, Dr. Rockey reported that the leg no longer caused claimant pain except for an occasional mild neuritic twinge in the back of the end of claimant's stump. Dr. Rockey noted that a newer prosthesis did not fit well and was too tight, but that an older prosthesis had been working fairly well for short periods of time.

Claimant's recovery was complicated by his inability to return to gainful employment and an apparently significant increase in weight, which contributed to the difficulty in bearing weight on the prosthetic appliance.

In September of 1970, Dr. Rockey's examination revealed no soreness or pain in claimant's stump. Claimant had been walking in the prosthesis, which was, at that time, quite loose because the swelling had finally cleared from the leg. Dr. Rockey considered claimant's condition stationary, and the claim was reclosed. In September 1971, claimant submitted to cardiac surgery. He had lost considerable weight as a result, and Dr. Rockey referred claimant for a rebuild of the prosthesis socket.

In April 1977 Dr. Rockey prescribed a new prosthesis for claimant, which reportedly fit well and was comfortable.

Apparently in June of 1982 claimant's stump began hurting, associated with cramping, after relatively short periods of ambulation. An October 1, 1982 report of physical examination by Dr. King indicates that claimant had a new prosthesis fitted, but the new prosthesis offered no improvement. This report also indicates that claimant experienced aches in the stump even while at rest. Dr. King's examination describes claimant as "moderately obese." Dr. King recommended right femoral arteriography in order to rule out arterial insufficiency of the stump. At that time, claimant's physician was Dr. Cox.

On January 10, 1983, Dr. Cox reported to SAIF that claimant was suffering from pain radiating down both buttocks into his legs, the cause of which was uncertain, but which "may be" related to claimant's amputation. Dr. Cox referred claimant to Dr. Fraback for consultation.

Dr. Fraback completed a form 827 dated January 20, 1983, in which he indicated that the cause of claimant's bilateral leg and buttock pain was undetermined. Dr. Fraback ordered a CT scan of the lumbar spine. The report of this test, dated February 3, 1983, indicates a slight midline bulge of the L3-4 disc; a slightly greater bulge of the L4-5 disc; some overgrowth of the superior articular facets of the L5 vertebra, which was not producing significant encroachment upon either the lateral recesses or the spinal canal; and a vacuum effect at L5-S1, with evidence of a midline bulge of the disc.

Dr. Cox prescribed a wheel chair for claimant and, in a report to SAIF dated March 4, 1983, explained that claimant was having difficulty with pain, aching, and swelling of the joint. Dr. Cox indicated that the origin of claimant's pain was probably vascular and, perhaps, secondary to degenerative joint disease. In this report, Dr. Cox stated: "Please note that this pain is distinct from his bilateral buttock pain. The etiology of which has escaped accurate detection [sic]."

The Oregon Artificial Limb Company referred claimant to Dr. McKillop in March of 1983 for the purpose of obtaining a prescription for a new artificial limb. Dr. McKillops's report to SAIF indicates that claimant had been referred to an artifical limb shop in September of 1982 for construction of a new prosthesis, but that he had experienced continuing difficulties with this prosthesis and was unable to wear it. Dr. McKillop recommended that the design of claimant's old prosthesis, which had been successful, be utilized and requested that SAIF provide authorization for this. His report stated "although the new limb did not last very long, he seemed to have gone through a sufficient amount of difficulty and has many attempts at giving him a better fit [sic]. Since this has not worked out, I would suggest an entire new prosthesis. This man probably has a difficult stump for fitting and this kind of problem is not unusual in amputees, and the only recourse is to start over and make a new limb."

An office memorandum from Dr. Norton, SAIF's medical consultant, dated May 10, 1983, contains the following information:

> "The investigations (CT scan, arteriogram) for back, buttock and thigh pain are for investigation of medical problems, not the result of his old leg fracture or its consequences. The problem is probably in the area of vascular disease. The prescription for the wheel chair for periodic use is probably okay for an aging, markedly, obese amputee. The need stems from both work-related (amputation) and nonwork-related factors of which the amputation is the most significant. As Dr. McKillop states, I likewise see no recourse

but to make him a new prosthesis, if he continues to use it periodically."

Claimant sought treatment with Dr. Berry, a chiropractic physician, who, in a report to SAIF dated July 18, 1983, indicated that claimant complained of pain in his low back, constant headaches, neck pain and stiffness, with limited motion of his neck and low back. Dr. Berry diagnosed "radicular headaches; cervical strain/sprain; thoracic strain/sprain with myofascial residuals; left scoliosis effect of the lower thoracic spine, possibly due to the influence of the prosthesis on the pelvis; lumbar strain/sprain with myofascial residuals -- traumatically induced; lumbar spondylosis (Grade 1 retrolisthesis of L5); and prosthesis of the lower right leg." Dr. Berry explained that claimant's low back, headaches and spinal problems appeared to stem mainly from his having to wear a prosthetic right leg. "This has caused a tidal wave chain reaction. The prosthesis throws the level of the pelvis off balance in turn causing the spine to bend to the left side creating a scoliosis effect and throwing the upper cervical spine further off to the left of the gravitational line."

Dr. Berry reported that the prognosis was guarded, that claimant was obtaining progressive general relief of symptoms, and that claimant was subject to episodes of exacerbation caused in part by his prosthesis.

Claimant's medical file was reviewed by Dr. Brown, SAIF's neurological consultant, in order to determine the possible causal relationship between claimant's bilateral leg pain and his original industrial injury. Dr. Brown reported that the right femoral arteriogram performed at St. Vincent's Hospital in October of 1982 unquestionably demonstrated that arterial disease was present. Dr. Brown expressed the opinion that claimant's bilateral leg pain was vascular in origin, as opposed to radicular and emanating from claimant's low back area, particularly in view of the CT scan which failed to disclose "any significant changes in the lumbar spine." Dr. Brown stated "therefore, this area is not likely the source of his leg pains. Furthermore, such degenerative changes or any low back problem is not related to the fact that the claimant had an amputation or therefore to the original injury. * * * No amount of chiropractic manipulations of this man's back is going to change the underlying atherosclerosis changes demonstrated in the femoral cardiac arteries of this individual."

Dr. Fraback previously had expressed his opinion that claimant's leg pain probably was radicular from his lower back "perhaps related to the degenerative changes in his facet joints." In a later report to SAIF, in July of 1983, Dr. Fraback reiterated that the pain in claimant's left thigh probably was radicular from the lower back. He stated "this may be related to abnormal mechanical forces resulting form wearing the prosthesis."

By a letter dated August 3, 1983, SAIF informed claimant that claimant already had selected "six treating physicians," including Drs. Degge, Long, Rockey, Cox, Fraback and McKillop, and that, in order to change "treating physicians" in the future, it would be

necessary to obtain SAIF's approval. SAIF apparently was relying upon the provisions of ORS 656.245(3). SAIF also indicated in this letter that, "authorization may be given subject to the approval of the Workers' Compensation Board for further medical benefits under ORS 656.278 for treatment which would directly relate to your right amputation."

SAIF referred claimant to Dr. Inahara, a vascular surgeon, for examination in October of 1983. In a report to SAIF dated October 24, 1983, Dr. Inahara related a history indicating that the change in claimant's prosthesis ". . . apparently led to a problem with his low back because of the pelvic tilt. The prosthesis length was corrected and gradually the low back problem has improved." The main complaint at the time of Dr. Inahara's examination was noted as inability to walk any distance with limitation to one-half block or less, as a result of pain. Based upon his findings on examination, as well as claimant's history and the October 1982 right femoral arteriograms, Dr. Inahara concluded that, although the arterial circulation to claimant's right lower extremity was impaired, it was nevertheless quite adequate and probably was not the basis of claimant's complaint of pain in the stump with radiation along the lateral aspect of the thigh toward the hip. Dr. Inahara indicated that these complaints appeared to be more related to difficulty in fitting the stump with a socket. Dr. Inahara indicated that claimant's prior prosthesis of 12 years' use apparently had been extremely satisfactory. In view of claimant's desire to return to this type of a socket, the doctor recommended that this be considered, as this, in his opinion, probably was the basis of claimant's problem "and would avert further evaluations and consultative expenses."

By a letter to the Board dated December 5, 1983, SAIF indicated that treatment claimant was undergoing in January and February of 1983 consisting of several treatments by Drs. Cox and Fraback, as well as some physical therapy, apparently was related to claimant's original industrial injury. SAIF indicated that they currently were paying these bills for claimant's medical treatment. SAIF further indicated, however, that in view of the "five doctor limit under the medical rules of the Workers' Compensation Department," it was unwilling to authorize treatment with Dr. Berry, the chiropractor. Payment for treatment by Dr. Berry also was refused for the additional reason that there apparently was no relationship between claimant's original right lower leg injury and claimant's chiropractic treatment which, SAIF stated, "rather would be due to underlying disease processes and the aging process."

The only issue, therefore, is SAIF's responsibility for payment of claimant's chiropractic treatment with Dr. Berry. First we dispose of SAIF's opposition to payment of these treatments on the basis of the "five physician limit" contained in ORS 656.245(3).

Claimant's injury occurred on August 9, 1965. On the date of claimant's injury, ORS 656.245 did not exist in any form. That is why this claim for medical services is before the Board under the provisions of ORS 656.278. ORS 656.245 does not apply retroactively. William A. Newell, supra, 35 Van Natta at 633. The five physician limit presently contained in subsection (3) of the statute was not enacted until 1979, 14 years after claimant's industrial injury. Oregon Laws 1979, chapter 839 § 32.

The real issue, therefore, is whether, since SAIF has refused to voluntarily pay for claimant's chiropractic treatments, ORS 656.278(4), the Board should, in the exercise of its discretionary own motion authority, order payment of this compensation. Based upon our review of the evidentiary record, we believe it is appropriate to do so.

Various physicians examined claimant in order to determine the etiology of claimant's bilateral leg pain. SAIF apparently is satisfied that a preponderance of the available medical opinion indicates that this bilateral leg pain is related to claimant's original right leg injury and complications resulting therefrom. The medical opinions concerning the etiology of claimant's bilateral leg pain can be neatly divided into two different schools of thought: It is either vascular in origin or it results from radiating pain caused by a mechanical low back problem which, in turn, originates from difficulties associated with claimant's prosthetic appliance. Dr. Brown was of the apparent opinion that the condition of claimant's low back was not a source of claimant's leg pains and, furthermore, that the degenerative changes noted by the CT scan, or any low back problem for that matter, was not related to claimant's original injury and resulting amputation. We believe that Dr. Brown was most concerned with identifying the origin of claimant's leg pain, one possible cause being a radicular component to an apparent low back problem. Dr. Brown, who did not have the opportunity to examine claimant, did not indicate whether, in his opinion, claimant actually had a mechanical low back problem, causing symptomatology not necessarily associated solely with claimant's leg pain.

We find, as a matter of fact, that claimant did experience difficulties with his lower leg prosthesis which, in turn, resulted in mechanical low back problems described by Chiropractor Berry. Dr. Inahara, who most recently examined claimant in October of 1983, appeared to express the opinion that the basis of claimant's problem (pain in the stump with radiation along the lateral aspect of the thigh toward the hip) appeared to be primarily related to the difficulty claimant had recently experienced with regard to finding a suitable prosthesis. Dr. Fraback, most recently, was of the opinion that the pain in claimant's left thigh probably was radicular from the lower back, which might be related to "abnormal mechanical forces resulting from wearing the prosthesis."

We find it entirely plausible that a leg amputee who is unable to obtain an appropriate fit for a prosthesis and who attempts to ambulate with a poorly fitting artificial limb, will experience low back difficulties of the nature described by Dr. Berry, whose description of claimant's problems is implicitly (if not explicitly) supported by Drs. Fraback and Inahara. Regardless of the cause of claimant's leg pain, we conclude that, as a compensable consequence of his original industrial injury, claimant developed a mechanical low back problem, and that the chiropractic treatment in issue was incurred as a result thereof.

We hold that SAIF is responsible for payment of the chiropractic treatments administered to claimant by Dr. Berry as of the date of this order. We note that Dr. Inahara's history in

his report of examination on October 18, 1983, indicates that claimant's low back problem gradually has improved. We have no information currently before us concerning the present condition of claimant's low back and whether or not claimant continues to undergo chriropractic treatment. This order is not to be construed as a carte blanche for continuing chiropractic treatment. Under the terms of this order, SAIF's obligation is to pay those bills for chiropractic treatment by Dr. Berry which claimant has incurred as of the date of this order.

Claimant's attorney has been instrumental in obtaining this additional compensation in claimant's behalf pursuant to ORS 656.278. Accordingly, claimant's attorney is entitled to a reasonable attorney's fee in an amount equal to 25% of the bills for chiropractic treatment which SAIF is obligated to pay under the terms of this order, not to exceed a maximum fee of $500, which is to be paid out of claimant's compensation and not in addition thereto. OAR 438-47-070(2); OAR 438-47-010(4); 438-12-010(5); Bernie Hinzman, 35 Van Natta 739, 35 Van Natta 1374 (1983).

IT IS SO ORDERED.

RICHARD W. MAYS, Claimant
Emmons, et al., Claimant's Attorneys
Steven P. Allen, Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Asst. Attorney General

WCB 82-04471 & 82-05408
June 6, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seifert's order which upheld the SAIF Corporation's denial of claimant's low back condition.

Claimant had preexisting grade 1 spondylolysthesis as of October 1979 due to a fall at home. He had experienced low grade back pain due to that condition with occasional exacerbations precipitated by unusual activity. In November 1981 claimant visited Dr. Stanley, orthopedist, complaining of low back pain which occasionally radiated down his legs. Claimant complained of some leg weakness, but no numbness. This particular episode was brought on by the previous day's activity of hauling several cords of firewood. Dr. Stanley noted no neurological or motor deficits, but found tenderness in the lumbosacral area in the paraspinal muscles with acute low back muscle spasm. He prescribed physical therapy, muscle relaxants and pain relievers. X-rays were not taken and, therefore, no x-ray evidence was obtained at that time as to the state of claimant's spondylolysthesis. Claimant's pain subsided to the point that he was experiencing minimal symptoms.

In March 1982 claimant was hired to remodel a house. Part of his duties included operating an electric jackhammer on about March 6 to loosen some concrete. Claimant testified that his back began hurting again with that activity. On approximately March 10, claimant was using a sledge hammer to knock out cast iron plumbing. Claimant stated he had severe back pain following that activity. He reported his back pain to his employer that afternoon. On March 11 claimant checked into the Albany General Hospital

emergency room. The admitting report states: "Doing some remodeling work past week and strained back while doing sledge hammer work and running electric jackhammer . . . flattened lumbar curve . . . back muscles in spasm." The diagnosis was recurrent low back strain and claimant was referred to his own physician. On March 17, 1982 claimant was seen by Dr. Stanley's associate, Dr. Anderson. Dr. Anderson put no findings in the chart note. Claimant saw Dr. Stanley on March 24, 1982. Dr. Stanley noted that claimant was having back pain. There was no evidence of nerve root compression. No x-rays were taken, although old x-rays from May 1981 were reviewed and did reveal very minimal spondylolisthesis.

Claimant last saw Dr. Stanley on April 12, 1982, and Dr. Stanley still had not released him to work due to his pain. Dr. Stanley was deposed and he testified that the only objective finding he made in March 1982 was muscle spasm. It was his opinion that the remodeling activity had caused an exacerbation of symptoms rather than an aggravation of the underlying condition of spondylolysis/spondylolisthesis.

The Referee determined that the pain and muscle spasm resulting from the jackhammering and sledge hammering activity more closely fit the description of an occupational disease than of an accidental injury. He further found that, regardless of whether the condition fit either an occupational disease or an accidental injury, claimant has the burden to prove that he has suffered a worsening of his underlying condition, rather than only an exacerbation of symptoms, for the claim to be compensable under the test of Weller v. Union Carbide Corporation, 288 Or 27 (1979), and Cochell v. SAIF, 59 Or App 391 (1982).

We find claimant's jackhammering and sledge hammering incidents to be more accurately labeled as injuries rather than as an occupational disease.

The Oregon Supreme Court has described an occupational disease in the following manner:

> "An occupational disease is stealthy and steals upon its victim when he is unaware of its presence and approach. Accordingly, he cannot later tell the day, month or possibly even the year when the insidious disease made its intrusion into his body.
>
> Although his weakened condition may manifest ill health, its cause may be uncertain and puzzle even the most skillful of physicians." White v. SIAC, 227 Or 306, 322 (1961).

In this case, claimant's symptoms became immediately worse with his jackhammering and sledge hammering activities.

Claimant was able to identify the injury-producing activities, and his physician stated that claimant suffered "an exacerbation of symptoms" and that "the symptoms [claimant] was having probably related more to his recent activity" of remodeling work.

Since the Referee's order, we issued our order in Paul Scott,

35 Van Natta 1215 (1983). In Scott, we noted that the most recent cases of Boise Cascade v. Wattenbarger, 63 Or App 447 (1983), and Jameson v. SAIF, 63 Or App 553 (1983), hold that the requirement that a claimant prove a worsening of his underlying condition to have a compensable claim does not apply in industrial injury cases.

In this case, the evidence is unequivocal that claimant suffered a worsening of his low back symptoms which required medical care and time loss.

There is no closing report in the record from any of claimant's treating physicians and, therefore, it would be premature to determine at this time whether claimant's injuries caused any permanent disability.

ORDER

The Referee's order dated July 20, 1983 is reversed. This claim is remanded to the insurer for processing. Claimant's attorney is awarded $1,000 for services at hearing and $650 for services on Board review, to be paid by the SAIF Corporation.

LINDA REINING, Claimant
Larry Sokol, Claimant's Attorney
Deborah MacMillan, Defense Attorney

WCB 80-01849
June 6, 1984
Order on Remand

On review of the Board's Order dated April 29, 1983, the Court of Appeals reversed the Board's Order.

Now, therefore, the above-noted Board Order is vacated, and this claim is remanded to the insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

DOUGLAS J. WINDRESS, Claimant
Williamson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01168
June 6, 1984
Order of Abatement

The Board issued its Order on Review on May 11, 1984.

On June 1, 1984 the Board received a letter from claimant-respondent contending he and his attorney did not receive a copy of the SAIF Corporation's brief until April 1984 when the Board forwarded a copy to his attorney's office. Claimant argues that his attorney has had insufficient time to prepare his respondent's brief and that the Board's order was premature. To date, the Board has received no correspondence from claimant's attorney of record.

We shall treat claimant-respondent's letter as a motion to reconsider our Order on Review dated May 11, 1984.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated, and the SAIF Corporation is requested to file a response to the motion within 10 days. We also request that claimant's attorney of record advise the Board as to his present status concerning this claim, including his response to claimant's allegations.

IT IS SO ORDERED.

CAROLYN HOOD, Claimant
Bottini & Bottini, Claimant's Attorneys
Rankin, McMurry, et al., Defense Attorneys
Richard Barber, Defense Attorney

Own Motion 84-0240M
June 7, 1984
Own Motion Order Referring for Consolidated Hearing

Claimant, by and through her attorney, requested that the Board exercise its own motion authority and reopen claimant's claim related to her December 13, 1974 injury. Claimant's aggravation rights have expired.

Claimant has a request for hearing pending in WCB Case Nos. 83-07977, 84-03016, 84-03017, 84-03018 and 84-03019 which have been consolidated for hearing. Claimant has requested that the Board issue an order to direct a paying agent pending the outcome of the hearing. The Board is unwilling to take this action in own motion matters. Also requested are penalties and attorney fees for Argonaut's failure to process the claim and SAIF's failure to continue making time loss payments. We decline to act based on Bernie Hinzman, 35 Van Natta 1374 (1983). Claimant also asks that the Board refer this own moton claim to the Hearings Division for consolidation with the proceedings presently pending. We conclude that it would be in the best interest of the parties to consolidate these matters for hearing. In addition to taking evidence on the issues raised in WCB Case Nos. 83-07977, 84-03016, 84-03017, 84-03018 and 84-03019, the Referee shall take evidence on whether claimant's current condition is related to her December 13, 1974 injury, and whether the condition has materially worsened so as to justify reopening. At the conclusion of the hearing, the Referee shall forward to the Board a copy of the transcript of the proceedings together with a recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case Nos. 83-07977, 84-03016, 84-03017, 84-3018 and 84-03019.

IT IS SO ORDERED.

THOMAS W. McBROOM (Deceased), Beneficiaries of
Pozzi, et al., Attorneys
Roberts, et al., Attorneys

WCB 81-07286
June 7, 1984
Order on Review

Reviewed by the Board en banc.

The insurer requests review of Referee Galton's order which set aside its denial of this claim for death benefits. The issue is compensability -- more specifically, whether the decedent's death by drowning in a jacuzzi pool arose out of and in the course and scope of his employment.

Decedent was a 53 year old salesman for the Chamber of Commerce in Portland. As part of his duties, decedent was required to attend an annual meeting in May 1981 in Los Angeles. Decedent's expenses, including his transportation, overnight lodging and food were paid by his employer.

Decedent's flight departed from Portland at approximately 8:15 am on May 9, 1981 and arrived at Los Angeles at approximately 10:30 am. Several other Portland employes of the Chamber of Commerce were on the same flight as decedent. There is testimony in the record from some of these co-employes (although not without some discrepancy) that claimant had been drinking before he boarded the

flight to Los Angeles. There is also testimony (with greater unanimity) to the effect that claimant continued drinking while en route to Los Angeles.

Michael Burnett, also a Chamber of Commerce employe, testified that after disembarking at Los Angeles, decedent fell while getting on a bus to the hotel where the meeting was to be held, and that he was "unsteady" while walking. Decedent's whereabouts and activities from the time he registered at the hotel at about 11:00 am until the time of the business meeting, which began at 1:00 pm that afternoon, are unknown.

The business meeting, which decedent attended, lasted from about 1:00 pm on the afternoon of May 9 until 5:00 or 5:30 pm that afternoon. Accounts of the decedent's conduct during the meeting vary. Elwood McNight testified that he sat with decedent during part of the meeting and that decedent appeared perfectly normal to him and was not drinking during the meeting. Michael Burnett testified that decedent sat next to him during part of the meeting and that, during one portion of the meeting while the lights were dimmed, the decedent either passed out or fell asleep. Mr. Burnett also testified that claimant's speech was slurred and that he was boisterous. Thomas Ames testified that he observed the decedent taking notes and asking pertinent questions during the meeting. Bob Nyssen testified that he sat next to the decedent during part of the meeting and that, although decedent did fall asleep, Nyssen did not smell any alcoholic odor about the decedent.

A cocktail party was held after the business meeting. The party lasted approximately one hour, and decedent was observed with a drink in his hand.

Following the cocktail party, decedent attended a banquet. Accounts of decedent's conduct during the banquet vary. Michael Burnett testified that decedent was staggering, loud and pushy and thus, in Burnett's opinion, "obviously inebriated." Richard Duer testified that he had to wake decedent up after he fell asleep at the banquet table. However, Eldon McNight testified that he ate dinner with decedent at the banquet and that decedent appeared "reasonably normal," was not staggering or acting as if he were drunk.

Following the banquet, decedent went to his hotel room and telephoned his wife in Portland at approximately 10:00 pm. Decedent's wife testified that decedent sounded perfectly normal to her and gave no indication that he had been drinking. The decedent described the day's events to his wife and told her that he was going to try to get some sleep.

Decedent's subsequent activities for about the next four hours are unknown. At about 2:00 am on the morning of May 10, 1981, decedent appeared at the hotel security office and inquired about the location of the "jacuzzi pool." Hotel personnel told decedent that the pool was closed for the night. Thomas Ames testified, however, that the jacuzzi was located only about 20 yards from his hotel room, and that he observed three or four people at the jacuzzi at approximately 2:00 am.

On the morning of May 10, 1981, at approximately 7:00 am, Thomas Ames found decedent clad in a pair of swimming trunks and floating face down in the jacuzzi. He was pronounced dead at 7:15 am.

An autopsy indicated that the cause of death was drowning. Tests revealed decedent's blood alcohol level to be .40%. Expert testimony at the hearing indicated that this level of blood alcohol would be fatal or near fatal in and of itself. A pint bottle of vodka was found in decedent's hotel room that was about three-quarters empty.

Expert testimony was presented at the hearing from Dr. William Brady, Oregon State Medical Examiner, and Dr. Archie Hamilton, Coroner of Clark County, Washington. Both pathologists fixed the time of death at between 3:00 and 5:00 am on May 10, 1981.

Dr. Brady opined that it was unlikely that decedent would have sounded normal to his wife when he telephoned her at 10:00 pm on May 9 if he had been significantly intoxicated at that time. Dr. Brady felt that it would be highly unlikely for a person to be able to carry on an intelligent conversation if he had a blood alcohol content of .40%. Dr. Brady thus reasoned that decedent probably consumed one to two pints of an 80 proof alcoholic beverage after 10:00 pm in order to have a blood alcohol level of .40% at the time of death. Dr. Brady further testified that the autopsy report revealed no pathological evidence that decedent was an alcoholic. Dr. Brady explained that when an individual who has been drinking gets into heated water, such as in a jacuzzi:

> "There would be a significant shift in the blood within his body, so that the heat from the pool would cause a dilation or expansion of the blood vessels of the skin, causing blood to flow from the organs inside the chest, abdomen and head into the peripheral portions of the body. This would reasonably be expected to be accompanied by a fall in blood pressure, a sensation of weakness, quite likely dizziness, passing out."

Dr. Hamilton expressed some doubt about the autopsy finding of a .40% blood alcohol content. Dr. Hamilton said that the finding was based on only a single test, and that the circumstances surrounding decedent's death indicated that further testing should have been done. Dr. Hamilton also suggested that the autopsy finding was somewhat inconsistent with the apparent fact that decedent was able to take off his clothes and put on his swimming trunks and with the admitted fact that decedent did communicate with hotel personnel prior to using the jacuzzi.

The Referee concluded that: (1) Decedent was an alcoholic; (2) decedent was able to communicate effectively with his wife when he telephoned her at 10 pm on May 9 only because of his "alcohol tolerance"; (3) Dr. Brady's testimony had to be rejected since it was based on the assumption that decedent was not significantly intoxicated when he telephoned his wife; (4) decedent was a traveling employe who was engaging in activity that was contemplated and acquiesced in by the employer at the time of death; and, therefore, (5) that this claim for death benefits is compensable under the applicable case law. Although we think that the case law in this area is somewhat ephemeral, we conclude that the claim is not compensable.

The central question is whether decedent's death arose in the course and scope of his employment with the Chamber of Commerce. There are many appellate court decisions that could be analyzed for factual similarities to the current case. In fact, the Referee's order and the parties' briefs on review attempt to do just that. However, the court stated in Wallace v. Green Thumb, Inc., 296 Or 79, 81 (1983), that "the reading of other decisions is normally of little assistance when this [course and scope of employment] issue is presented and that each case must be decided on its own particular facts." We believe that this statement is particularly applicable to the current case.

Slaughter v. SAIF, 60 Or App 610 (1982), states the general rules applicable to traveling employes. Slaughter involved a traveling employe, a truck driver, who was severely beaten in a tavern during a layover in California and made a workers' compensation claim for the resulting injuries. Quoting from 1 Larson, Workmen's Compensation Law 5-172, § 25.00 (1972), the court stated that the general rule in such circumstances is:

> "Employes whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually held compensable." 60 Or App at 613-14.

The court in Slaughter also stated that the claimant's presence in a liquor establishment did not "ipso facto connote a 'distinct departure on a personal errand.'" 60 Or App at 614.

Although the court in Slaughter found claimant's injury compensable because the activity at the time of the injury was reasonably related to the claimant's travel status, the court cautioned that the coverage allowed for traveling employes was not necessarily portal-to-portal:

> "The broader coverage, however, is not unlimited. Although a traveling employe will remain covered while engaged in some personal activities such as eating or sleeping, he will not be covered while engaging in other personal activities that are a 'distinct departure on a personal errand.'" 60 Or App at 615.

The Slaughter court quoted a passage with apparent approval from a New York case, Robards v. New York Div. Electric Products, Inc., 307 NYS 2d 599 (1970), to the effect that where an employe is required as part of his duties to remain in a particular place, the employe may indulge in any reasonable activity at that place, and if he does so, the risk inherent in such activity is an incident of his employment. 60 Or App at 615-16.

Similar to the cautionary language the Court of Appeals used in Slaughter, in Wallace v. Green Thumb, Inc., supra, the Supreme Court stated:

"Compensation awards should not result, however, from the 'mere fact' that the employment placed the employe at the site of the injury; a disfavored outcome in Oregon. See Blair v. State Ind. Acc. Comm'n., * * * ('For a personal injury to arise out of and in the course of the employment, there must be some connection between the injury and the employment other than the mere fact that the employment brought the injured party to the place of the injury'); Stuhr v. State Ind. Acc. Comm'n., * * * ('The mere fact that the employment brought the injured person to the place of the accident is not sufficient to establish a work connection.')" 296 Or at 83.

Summarizing the above case law, we understand the relevant considerations to be: (1) Activity that causes injury or death must have some work connection; (2) for a traveling employe, the required work connection generally is satisfied only by the worker's traveling status; but (3) the required work connection can be broken when activity that causes injury or death is distinctly personal and/or unreasonable. Applying this understanding, we conclude in this case that decedent's activities did constitute a distinct departure on a personal errand, and that decedent was not engaged in activity that can be considered reasonable under the circumstances.

We have summarized the often conflicting testimony about decedent's activities from before his boarding a plane to Los Angeles and during the day of May 9, up through the evening banquet meal, primarily because the parties base some of their arguments on this testimony. In our opinion, however, the primary focus should be on decedent's activities after the end of the evening banquet meal. After decedent left the banquet and went to his hotel room on the evening of May 9, there is no evidence that he engaged in any business-related activities. All that is known for sure is that decedent telephoned his wife about 10 pm and spoke with hotel personnel about 2 am. Otherwise, there is no direct evidence about where decedent was or what he was doing. The limited circumstantial evidence that does exist suggests to us a distinct departure on a personal and/or unreasonable errand that was the ultimate cause of death.

The Referee's conclusion that decedent was an alcoholic is important because the Referee utilized this conclusion to reject Dr. Brady's testimony that decedent was probably not significantly intoxicated when he telephoned his wife after the banquet. The Referee was thus able to conclude that decedent's extremely high blood alcohol content was the result of drinking decedent engaged in prior to his leaving the banquet, during which time decedent was clearly engaged in business-related activities.

We completely disagree with the Referee's conclusion that claimant was an alcoholic. The only evidence in the record to that effect was the testimony of Thomas Ames, whose only basis for that belief was his observations of decedent at a few parties and receptions in the past. However, decedent's wife -- who is

certainly in a better position to know than Mr. Ames -- testified that decedent was definitely not an alcoholic. This testimony is strongly reinforced by the autopsy report which, according to Dr. Brady, gave no indications that decedent was an alcoholic.

We find that the preponderance of the evidence indicates that, although decedent had been drinking off-and-on throughout the day, he was not substantially intoxicated at the time he left the banquet the evening of May 9. Although the testimony of those who observed decedent at the banquet varies, we find it particularly significant that decedent was able to leave the banquet and go to his room with no assistance, and then to telephone his wife and carry on a conversation that was sufficiently coherent for his wife to conclude that he had not been drinking.

Our finding that decedent was not substantially intoxicated when he left the banquet revives Dr. Brady's opinion, which the Referee rejected. According to Dr. Brady, assuming decedent was not sufficiently intoxicated when he left the banquet, and accepting the autopsy finding of .40% blood alcohol, decedent would have had to consume between one and two pints of 80 proof alcoholic beverage between 10 pm on May 9 and the time he entered the jacuzzi sometime after 2 am on May 10. According to Dr. Brady, it was this excessively high blood alcohol content that precipitated claimant's death by drowning.

We have considered Dr. Hamilton's reasons for doubting the autopsy finding of .40% blood alcohol, but are unable to conclude on this record that those reasons are sufficient to disregard the results of such a routine and usually reliable scientific measurement.

Thus, although it is unclear exactly where, exactly when, or under what exact circumstances decedent consumed enough alcohol to raise his blood alcohol content to .40%, it is at least reasonably clear that the great majority of that consumption must have been done following the conclusion of decedent's business activities. Although the use of alcohol itself certainly does not defeat compensability, we think that a departure on a personal errand is indicated by the sheer amount of alcohol in decedent's blood and the approximate five hour gap between the time decedent went to his room and the estimated time of his death. There is no direct evidence that decedent left his hotel room after telephoning his wife and continued drinking elsewhere, but that would not be an unreasonable inference to make on this record.

Therefore, we do not believe that decedent's death can be said to have arisen out of the necessity of the decedent's stay away from home. Slaughter v. SAIF, supra, 60 Or App at 613-15. Nor do we think it can be said that consuming such a quantity of alcohol following conclusion of business and related social activities was a reasonable activity for the decedent to engage in, even considering the fact that he was traveling and away from home. Slaughter, supra, 60 Or App at 615-16.

ORDER

The Referee's order dated July 13, 1983 is reversed. The insurer's denial dated July 2, 1981 is reinstated and affirmed.

BOARD MEMBER LEWIS DISSENTING:

I respectfully dissent from the majority opinion. I would affirm the Referee's order which found the claim for death benefits compensable. I do not agree with the majority's conclusion that decedent was not within the course and scope of his employment when he died. I agree with the Referee's conclusions that decedent's activity at the time of his death -- attending the annual meeting, his drinking and the use of the jacuzzi -- were both known to and acquiesced in by his employer.

The majority states that, from this record, it would not be an unreasonable inference that decedent could have left the hotel and continued drinking elsewhere. It would also not be unreasonable to assume that decedent left to buy one pint of alcohol at a store nearby and had returned to his room, that the only drinks he had were from the three-quarters empty pint bottle found in his room, that he went to the jacuzzi, and the combination of alcohol with the heat of the jacuzzi caused a chemical reaction and he passed out and drowned.

We review de novo, and I would reject any one of the above inferences that would draw conclusions from facts not in the record before us. For the reasons stated above, I would affirm the Referee. I, therefore, respectfully dissent.

WILLIAM E. GLASS, Claimant
Ann Witte, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09351
June 8, 1984
Order Denying Motion to Dismiss

Claimant moves to dismiss the SAIF Corporation's request for Board review on the grounds that SAIF failed to serve a copy of the request for review on claimant within 30 days of the date of the Referee's order herein. See ORS 656.289(3) and 656.295(2).

The Referee's order was entered on April 20, 1984. SAIF timely requested Board review of that order on May 15, 1984. SAIF's request for review indicates that a copy was sent to claimant's attorney. The Board acknowledged receipt of SAIF's request for review on May 17, 1984, by mailing a letter of acknowledgment to SAIF and claimant's attorney.

In Argonaut Insurance v. King, 63 Or App 847, 852 (1983), the court stated that "[c]ompliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In this case, the Board acknowledged SAIF's request for review well within the 30 day period subsequent to the Referee's order. Assuming normal mail delivery, claimant's attorney should have received the acknowledgment on May 18 or May 19, 1984, which would have been within the statutory period. Claimant's attorney does not allege that she did not receive the acknowledgment within the 30 day period. Actual notice that is conveyed within the statutory period is usually sufficient notice, even if conveyed by some means other than the literal requirements of the statute. Stroh v. SAIF, 261 Or 117 (1972); Argonaut Insurance v. King, supra; Ralph W. Gurwell, 35 Van Natta 1310 (1983). Accordingly, claimant's motion to dismiss SAIF's request for Board review is denied.

IT IS SO ORDERED.

ALICE C. HOFFMAN, Claimant
Michael Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03220
June 13, 1984
Order on Reconsideration

Claimant requests reconsideration of our Order on Review dated May 18, 1984. On reconsideration we rescind our Order on Review and reverse the Referee's order.

The evidence establishes that claimant has a preexisting congenital foot deformity known as first metatarso-cuneiform articulation, bilateral. The evidence also establishes that claimant's work as a waitress was the major cause of symptoms in claimant's feet. Claimant was previously asymptomatic. When a preexisting condition is asymptomatic, there is no requirement that claimant prove a worsening of the underlying condition in order for the symptoms to be found compensable. Wheeler v. Boise Cascade, 66 Or App 620 (1984). Accordingly, the SAIF Corporation's denial of claimant's occupational disease claim is overturned.

ORDER

The Board's Order on Review dated May 18, 1984 is rescinded. The Referee's order dated November 25, 1983 is reversed. The claim is remanded to the SAIF Corporation for processing. Claimant's attorney is awarded $700 for services at hearing and $500 for services on Board review, to be paid by the SAIF Corporation.

CHARLES MADDOX, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 79-09937
June 14, 1984
Corrected Order on Remand

The Board issued an Order on Review in the above-entitled case on May 15, 1984. It has come to our attention that the Order on Review contains a typographical error. The "Order" portion of the Order on Review states:

> "The Referee's order dated June 30, 1980 is reversed. Claimant is awarded 40% (128°) unscheduled permanent partial disability, that being an increase of 25% over and above the Determination Orders of March 14, 1978 and April 20, 1979. This award is in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly."

Although the order states that claimant received a total of 25% permanent partial disability by prior Determination Orders, claimant in fact received no permanent disability whatsoever prior to the Referee's order which awarded claimant permanent total disability.

The "Order" portion of our Order on Review is, therefore, corrected to read as follows:

> "The Referee's order dated June 30, 1980 is reversed. Claimant is awarded 40% (128°) unscheduled permanent partial disability. This award is in lieu of all prior awards.

Claimant's attorney's fee should be adjusted accordingly."

As corrected above, we hereby reaffirm and republish our May 15, 1984 Order on Review.

IT IS SO ORDERED.

ARNOLD C. BLONDELL, Claimant
Flaxel, et al., Claimant's Attorneys
W.D. Bates, Jr., Defense Attorney

WCB 82-04202
June 15, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of those portions of Referee Brown's order which: (1) Did not allow the employer to offset temporary disability benefits for the period July 15, 1981 through March 23, 1982 as an overpayment; and (2) additionally assessed a penalty equal to 25% of the above benefits pursuant to ORS 656.262(10). Claimant cross-requests review of that portion of the Referee's order which did not impose a penalty for the employer's failure to timely submit requested medical records to claimant.

Claimant compensably injured his left shoulder on June 24, 1980. On April 27, 1982 a Determination Order was issued awarding claimant 16° for 5% unscheduled permanent partial disability, temporary total disability from July 30, 1980 through September 3, 1980, temporary partial disability from July 15, 1981 through August 6, 1981, and temporary total disability from August 7, 1981 through March 23, 1982. By the date of hearing, the employer had not paid the temporary disability due from July 15, 1981 through March 23, 1982 pursuant to that order.

The Referee concluded that claimant was actually medically stationary and released to return to regular work as of September 2, 1980; and that, therefore, claimant's entitlement to temporary disability terminated as of that date. The Referee correctly observed that the employer nevertheless should have paid the temporary disability awarded by the Determination Order, and he ordered that this compensation be paid. Because the employer had failed to pay the temporary disability, the Referee determined that the appropriate penalty was to prohibit the employer from claiming the amount ordered by the Determination Order as an offset against future compensation to which claimant might become entitled. The Referee relied upon our decision in Mark L. Side, 34 Van Natta 661 (1982), in imposing this type of penalty. The Referee found that an additional penalty was warranted for the employer's nonfeasance. As he stated:

> "[T]he employer, if it doubted the accuracy of the Determination Order, could have asked for reconsideration. ORS 656.268(4). It did not. [Claimant did not file a hearing request with the Board until May 13, 1982.] Nor did the employer file a request for hearing from the Determination Order. The first notice in the file that

> the employer was challenging claimant's entitlement to temporary total disability came long after repeated attempts by claimant's attorney to secure payment or an explanation for its failure. If the purpose of a penalty is to discourage future transgressions, then the maximum allowable penalty is appropriate in this case."

As previously indicated, the Referee imposed an additional penalty equal to 25% of the temporary disability benefits awarded by the Determination Order.

The employer objects to the Referee's imposition of a penalty equivalent to 125% of the compensation which the employer should have paid and failed to pay. In addressing this issue, we need go no further than to refer to our decision in Joel I. Harris, WCB Case No. 81-01123, 36 Van Natta 829 (decided this date), in which we have reconsidered our decision in Mark L. Side and concluded that, in Side, we exceeded our statutorily authorized penalty powers. In Harris, another case involving an employer/insurer's failure to pay benefits in accordance with the procedural requirements of the Workers' Compensation Law, we determined that the maximum penalty that the Board could assess was the penalty provided by ORS 656.262(10):

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation . . . the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

In light of our decision this day in Harris, we conclude that the Referee imposed an excessive penalty. The Referee correctly ordered the employer to pay the temporary disability benefits awarded by the Determination Order. This is not a penalty; this is the payment of compensation that was "then due," but which the employer failed to pay. The appropriate penalty for this failure to pay is the maximum penalty allowable, or 25% of the compensation that should have been paid under the terms of the Determination Order. Even if the Side penalty was appropriately imposed in this procedurally different situation, because of our decision in Harris, it follows that the employer is not prohibited from claiming this overpayment of temporary disability (compensation which the employer was required to pay because of the procedural dictates of the law, but compensation to which claimant has failed to establish a substantive entitlement) as an offset against compensation to which claimant may become entitled in the future. Any recovery of this overpayment must be accomplished in accordance with the court's decision in Forney v. Western States Plywood, 66 Or App 155 (1983).

There is a potential issue lurking in the background with respect to the employer's entitlement to recover this overpayment of temporary disability. ORS 656.313 provides, in pertinent part:

> "(1) Filing by an employer or the insurer

> of a request for review or court appeal shall not stay payment of compensation to a claimant.
>
> "(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal."

We have interpreted ORS 656.313(2) to mean that, when the Board reduces or disallows compensation awarded by a Referee's order, those amounts paid pending review are not recoverable by the employer/insurer as an offset against additional compensation to which the claimant is entitled or becomes entitled in the future. Sharon F. Webster, 35 Van Natta 1638 (1983); Wesley Stiennon, 35 Van Natta 365, 367 (1983); Harry C. Jordan, 35 Van Natta 282 (1983); Glenn O. Hall, 35 Van Natta 275 (1983). The Court of Appeals seemingly agrees with our interpretation of this statutory provision. Hutchinson v. Louisiana-Pacific Corp., 67 Or App 577 (1984).

In this case, subsection (2) does not operate to preclude the employer from possibly recovering this admittedly overpaid compensation because, unlike the cases cited above, we have not in this case reduced the compensation awarded by the Referee. Although the compensation awarded by the Determination Order, which award was enforced by the Referee's order, may not have been paid until the Referee ordered the employer to do so, the fact that payment was not made until after issuance of the Referee's order does not transform this compensation into compensation awarded by the Referee's order within the meaning of ORS 656.313(2), in view of the Referee's determination that claimant had failed to establish, as a matter of substantive entitlement, his right to receive the temporary disability compensation in question. For these reasons, we conclude that ORS 656.313(2) does not preclude the employer from claiming an offset for this overpayment of temporary disability.

Regarding the issue of late submission of medical records to claimant the Referee held:

> "The record indicates that medical records were requested by claimant's attorney on May 12, 1982. The date of submission by the employer is not a matter of record, although the employer's attorney conceded tardiness generally in his closing argument. I find no prejudice to the claimant by the delay. No penalty and separate attorney fee is appropriate. Newman v. Murphy Pacific Co., 20 Or App 17 (1975)."

Claimant raised the issue of entitlement to a penalty and attorney's fee for the insurer's failure to provide requested documents within fifteen days as required by OAR 436-53-460 in his

responding brief to the Board. The insurer does not address the merits of claimant's contention, but only states that we should not consider the issue since claimant did not raise the issue by a separate request for Board review or a formal cross-request for Board review. In Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983), we held:

> "There is no requirement that a party cross-request Board review in order to have particular issues considered on de novo review. Neely v. SAIF, 43 Or App 319, 323 (1979); Francoeur v. SAIF, 20 Or App 604, 606, 607 (1975). There are no specific pleading requirements in proceedings before the Board . . . Where a respondent files a brief making an argument or raising an issue which diverges from those raised or argued in the appellant's brief, we consider the additional argument or issue even in the absence of a cross-request for review."

The record shows that claimant requested medical records from the employer on May 12, 1982. Claimant argues that, "The requested reports were furnished under the Appellant's attorney's cover letter of September 27, 1982, mailing the exhibits to the Referee with a copy to Claimant's attorney. This amounted to a delay of 4 1/2 months." The Referee stated that the "employer's attorney conceded tardiness generally in his closing argument."

Further, contrary to the Referee's statement, a claimant need not prove prejudice before a penalty will be assessed for failure to provide timely discovery under OAR 436-83-460. In Morgan v. Stimson Lumber, 47 Or App 315 (1980), the court held that a claimant need not prove that there was prejudice in the preparation of the case by the delay of provision of documents because, "The purpose of the rule is to expedite the processing of cases, and the presumption of unreasonable delay is not rebutted unless the employer gives a reasonable basis for his failure to comply with the rule." 47 Or App at 320. Here, no reason was given for failure to comply with the discovery rule. As the maximum penalty of 25% has already been assessed on all amounts that were due, we are unable to assess an additional penalty amount for this violation. Gary Clark, 35 Van Natta 117 (1983). However, we do award claimant's attorney $250 as a further fee for prevailing on the issue of late provision of medical documents. Kenneth M. Rumsey, 29 Van Natta 440 (1980).

ORDER

The Referee's order dated December 8, 1982 is reversed in part. That portion of the order which imposed a penalty in the form of prohibiting the employer from claiming an offset for the temporary disability benefits ordered payable by the April 27, 1982 Determination Order, but which were not timely paid by the employer, is reversed. The employer may claim this overpayment as an offset against compensation to which claimant becomes entitled in the future, subject to the procedural requirements of the Workers' Compensation Law. That portion of the order which failed to penalize the employer for failure to comply with the disclosure

rule in a timely fashion is reversed, and the employer is ordered to pay claimant's attorney $250 as an attorney's fee in connection with this issue. The remainder of the Referee's order is affirmed.

RICHARD O. FISCHER, Claimant
Cash Perrine, Claimant's Attorney
Minturn, et al., Defense Attorney

WCB 82-06483
June 15, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of those portions of Referee Danner's orders which set aside the decision of the Director of the Workers' Compensation Department and ordered that claimant be reinstated in his authorized vocational rehabilitation program and be allowed to complete his training at Central Oregon Community College, with time loss benefits to be paid effective on the date of re-enrollment. SAIF contends that the Referee's finding was error.

In May 1980 claimant sustained a compensable back injury which was diagnosed as a herniated L4-5 disc. Surgery was performed in September 1980. Dr. Bernson, claimant's treating physician, recommended that claimant be considered for vocational rehabilitation because he did not believe claimant would be able to return to his pre-injury employment.

A February 10, 1981 Determination Order awarded claimant 15% unscheduled permanent partial diability. This award was increased to 30% by stipulation in April 1981.

On September 17, 1981 claimant received formal approval for a vocational rehabilitation program. Claimant was to receive training as an industrial mechanic at Central Oregon Community College (COCC). Claimant was to attend COCC for three terms beginning September 28, 1981 and ending June 11, 1982. The program was approved contingent on claimant's compliance with the following requirements:

> "1. Have regular attendance.
>
> "2. Cooperate totally with your counselor toward completion of the training.
>
> "3. Have your progress reports to your counselor no later than the fifth of each month.
>
> "4. [G]et at least a 2.00 grade point average. Complete a minimum of 12 credits each term and an average of 15 credits.
>
> "5. Meet other written, agreed upon requirements so training will be completed as planned.
>
> "6. Provide your counselor with a copy of your grade or progress reports within two weeks of the date of issue.
>
> "7. Tell your counselor right away if

anything may interfere with successful completion, including absences or coursework problems."

Claimant successfully completed his first two terms at COCC. However, during spring term 1982, claimant began missing school, and he dropped out of school entirely between April 14 and April 24, 1982.

After a 15-month absence from medical treatment, claimant returned to Dr. Bernson on April 22, 1982 complaining of back pain. Dr. Bernson prescribed a back brace but gave no indication that claimant could not continue with his coursework at COCC. Claimant also saw Dr. Bernson in May 1982. Again, there was no indication from Dr. Bernson that claimant could not continue his training program. On June 18, 1982 Dr. Bernson reported that claimant should be considered disabled as of April 22, 1982. Dr. Bernson eventually performed repeat lumbar surgery in September 1982. Claimant's claim was reclosed by Determination Order dated April 1, 1983.

On May 28, 1982 claimant was notified that his training program was terminated as of May 3, 1982 for failure to cooperate in meeting the requirements for continued participation in the program. Specifically, the termination notice stated that claimant had failed to maintain contact with his counselor on a regular basis, failed to follow through on requests for information or contacts with prospective employers and failed to provide monthly progress reports at the required time. Pursuant to OAR 436-61-998, claimant requested review of this decision by the Director of the Workers' Compensation Department. ORS 656.283(2). Claimant also submitted an affidavit to the Director alleging certain facts to be true. On February 28, 1983 the Director issued an order upholding the termination of vocational assistance. Claimant requested a hearing.

After noting certain discrepancies in the factual accounts of claimant and his vocational counselor, the Referee concluded:

> "[I]t is my finding that claimant's termination from his program in April of 1982 was occasioned by his deteriorating medical condition, and in that sense, was not a voluntary termination, nor caused by a lack of motivation or interest."

In essence, the Referee concluded that claimant's complying or failing to comply with the requirements of his vocational program was irrelevant, since he withdrew from the program due to a deteriorating medical condition. We disagree.

ORS 656.283(1) provides:

> "Subject to ORS 656.319 any party or the director may at any time request a hearing on any question concerning a claim. However, decisions of the director regarding participation in, but not eligibility for, an authorized vocational rehabilitation program may be modified only if the decision of the director:

"(a) Violates a statute or rule;

"(b) Exceeds the statutory authority of the agency;

"(c) Was made upon unlawful procedure; or

"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

In John Davidson, 34 Van Natta 240 (1982), we examined the problem of distinguishing matters concerning eligibility from those involving participation. We stated:

> "We deem eligibility issues to be limited to the question of whether an injured worker will be admitted to an authorized program at all. We deem participation issues to include the scope, extent or duration of an authorized program." 34 Van Natta at 240.

Since the current case involves an issue regarding the extent and/or duration of claimant's training program, our review is limited to the standards set forth in ORS 656.283(1)(a) through (d). There has been no contention that the Director's decision violated a rule, exceeded statutory authority or was made upon unlawful procedure. Therefore, we review only for abuse of discretion.

Considering the record as a whole, we cannot conclude that there has been an abuse or unwarranted exercise of discretion by the Director in this case. Although it is true, as noted by the Referee, that claimant's medical condition as of April 22, 1982 was such that claimant would probably have been unable to complete his program, claimant's program was terminated, not as a result of his medical condition, but as a result of his failure to comply with the requirements (as previously recited) claimant agreed to abide by when he began that program. Claimant had already deviated from these requirements before his medical condition deteriorated in late April 1982.

With regard to the question of whether claimant failed to cooperate with his vocational counselor, there is a conflict between claimant's testimony and the reports from claimant's counselor, Mr. Wheeler. Nothing would be gained by a detailed recitation of the various areas of conflict. Due to numerous discrepancies in the medical reports and the information contained in claimant's affidavit, we resolve this conflict in favor of Mr. Wheeler, as did the Director.

However, even without the conflict between claimant's and Mr. Wheeler's versions of the facts, there is an otherwise adequate basis to support the Director's action. For example, when claimant belatedly completed his monthly progress report for April 1982, he reported he missed only two days of school. This is contrary to almost all the other evidence on this subject in the record, including claimant's testimony at the hearing. Additionally, two of claimant's instructors (as well as claimant's attendance records) indicated that claimant had not been attending classes

since about the beginning of the spring term. Claimant's minimal participation is also indicated by the fact that, when his tools were repossessed, many of them had never been used and were still in their original plastic packages.

There are numerous other reasons in the record which support the decision of the Director and which are adequately set forth in the Director's decision. We cannot conclude that the Director's decision was an unwarranted exerise or abuse of discretion. We, therefore, affirm the Director's decision.

Our decision upholding the Director's decision requires us to address the question of the extent of claimant's disability in relation to the April 1, 1983 Determination Order which issued following claimant's recovery from his September 1982 surgery. Claimant requested the Referee to make a determination on this issue. However, since the Referee ordered claimant reinstated in his vocational program, he concluded that it would be premature to rate claimant's disability.

There is no need to remand this case to the Referee for a determination of the extent of claimant's disability. There is ample evidence in the record to enable us to make that determination. In fact, the Referee stated:

> "Based upon Dr. Bernson's closing examination report, however, were I to rate disability at this time, I would grant claimant an additional ten percent of the maximum allowable by statute for unscheduled disability. The physician indicates that the disability is greater, noting a greater restriction of physical activities, and accordingly, I would find an increased loss of earning capacity."

We agree with the Referee. Based on Dr. Bernson's closing report of March 7, 1983, we find that claimant is entitled to an award of an additional 10% unscheduled permanent partial disability. As noted by the Referee, this award is subject to offset for amounts of temporary total disability claimant received between March 1, 1983, the date he was found medically stationary by Dr. Bernson, and April 1, 1983, the date the Determination Order issued.

ORDER

The Referee's orders dated June 16, 1983 and October 25, 1983 are affirmed in part, modified in part and reversed in part. Those portions of the Referee's order which set aside the February 28, 1983 decision on Director's Review and ordered claimant reinstated in a program of vocational rehabilitation are reversed. The decision of the Director is reinstated and affirmed. Claimant is awarded 40% (128°) unscheduled permanent partial disability for injury to his low back, that being an increase of 10% (32°) over and above the Determination Order of April 1, 1983. This award is subject to offset by SAIF for temporary total disability benefits paid claimant from March 1, to April 1, 1983 in the sum of $969.97. Claimant's attorney is allowed 25% of the additional permanent partial disability compensation granted by this order as a reasonable attorney's fee. The remainder of the Referee's order is affirmed.

DEBRA M. MORRIS, Claimant
Cummins, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-03976
June 15, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Baker's order which: (1) Upheld the SAIF Corporation's denial of claimant's occupational disease claim; (2) ordered SAIF to pay claimant interim compensation from February 12, 1983 through March 7, 1983; and (3) ordered SAIF to pay claimant a penalty equal to 25% of the above interim compensation and to pay claimant's attorney a $100 fee because of SAIF's failure to comply with its discovery obligations under the Board's rules.

The issues for review are: (1) The compensability of claimant's foot condition variously diagnosed as hallux abductovalgus deformity and/or plantar fasciitis; (2) claimant's entitlement to interim compensation from February 12, 1983 through the date of the hearing for SAIF's alleged failure to deny claimant's plantar fasciitis condition; (3) penalties and attorney's fees for SAIF's alleged failure to pay interim compensation as in #2; (3) penalties and attorney's fees for unreasonable denial; and (4) additional penalties and attorney's fees for SAIF's failure to comply with the applicable discovery requirements.

Claimant's arguments in regard to the interim compensation issue -- and the related penalty and attorney fee contentions -- are based on her theory that her hallux abductovalgus deformity and her plantar fasciitis are actually two distinct conditions. Claimant argues that, because SAIF's denial only specified that it was denying her "bunion" condition (the hallux abductovalgus deformity), she is entitled to interim compensation until the plantar fasciitis was orally denied by SAIF at the hearing.

We disagree. First, generally claims are only made for compensation for disability, the cause of which is often not even known at the time a claim is made; thus, claims need not be made and are often not made for specific medical conditions. Second, even if greater specificity were required in claims, we are not convinced on this record that claimant's plantar fasciitis is a condition that is so distinct from her hallux abductovalgus deformity that it should have been more specifically denied by SAIF. We interpret the medical testimony as stating that claimant's congenital or developmental hallux abductovalgus deformity itself is a cause or the major cause of her plantar fasciitis condition. Thus, a denial of the hallux abductovalgus deformity would necessarily constitute a denial of the plantar fasciitis. However, even assuming that the two conditions are distinct and unrelated, the record clearly reveals that at least until the time the hearing convened, both parties were proceeding on the understanding that claimant's entire foot condition was in denied status, not just the hallux abductovalgus deformity. It is clear that SAIF so intended and that claimant so interpreted the denial. For all of these reasons, we reject all of claimant's arguments (interim compensation, penalties and attorney fees) predicated on the assumption that every separate medical diagnosis in some way requires a separate denial.

With regard to the questions of the compensability of claimant's foot condition(s) and penalties and attorney's fees for unreasonable denial and/or failure to provide proper discovery, we agree with the Referee and affirm his order.

ORDER

The Referee's order dated November 17, 1983 is affirmed.

BETTY G. OLSON, Claimant
Evohl Malagon, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-08490
June 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests and claimant cross-requests review of Referee Daron's order which awarded claimant 65% (208°) unscheduled permanent partial disability for her neck and upper back injury which was an increase of 55% (176°) over a November 17, 1982 Determination Order which granted temporary total disability but did not award any permanent partial disability in excess of the 10% (32°) awarded in a September 22, 1980 Determination Order. The insurer contends the Determination Order's award was sufficient. Claimant contends she is permanently and totally disabled or that the partial disability award should be increased.

Claimant was 46 years old at hearing. In December 1977, while performing her duties as a meatwrapper, she sustained a neck and upper back injury. She has received a variety of conservative treatment for her compensable injury.

Her treating osteopath, Dr. Brink, has diagnosed her condition as chronic cervical and upper back pain secondary to a strain. In February 1982 Dr. Brink opined that claimant should avoid repetitive or prolonged lifting, bending, twisting, flexion or use of her arms and hands above her head. Dr. Brink recommended claimant receive rehabilitation training in occupations which required minimal physical effort. In view of these restrictions, Dr. Brink expressed grave doubts concerning claimant's capability to perform the duties of a clerical specialist, an occupation for which claimant had been receiving rehabilitation training.

In May 1982 claimant's treating chiropractor, Dr. Pullen, opined that claimant was fully disabled and unable to perform any job for which she was qualified. Dr. Pullen felt claimant was suffering from emotional trauma due to her physical inability to achieve success in her rehabilitation program as a secretary and clerical specialist. Dr. Pullen suggested psychological evaluation and counseling.

In October 1982 Dr. Lechnyr, claimant's clinical social worker, felt that claimant was depressed, frustrated and anxious. Dr. Lechnyr opined that claimant was "about 45% disabled relative to any chance to return to it [former occupation]." Dr. Lechnyr advised that claimant could not work as a secretary because she was unable to sit and use her arms for any length of time. Although he felt claimant would probably never be pain free, Dr. Lechnyr stated

that a training program as a barber would be appropriate, a program which claimant was anxious to pursue.

On two occasions claimant has been examined by Dr. Stanley, orthopedist. In November 1982 Dr. Stanley diagnosed mild degenerative arthritis of the cervical spine with neck and upper back pains. The doctor noted a full range of motion with a tenderness to palpations along the cervical spine. Dr. Stanley rated claimant's permanent disability in the mild to moderate range. Dr. Stanley also advised against overhead work as well as any prolonged activities such as sitting.

In February 1983 Dr. Skelley of the Callahan Center stated that claimant should avoid employment which required the flexion of her neck, such as work at bench level or work which required prolonged sitting. Dr. Skelley recommended that claimant be restricted to job duties in the light range. Claimant's case manager noted that claimant demonstrated pain behavior when performing a task described as clerical, but performed much better when tasks requiring similar skills, but not labeled as clerical, were introduced. The case manager felt that claimant demonstrated an ability to work a six-hour day where she could stand and be able to shift about.

Claimant has undergone approximately nine months of rehabilitation training as a secretary and clerical specialist. Although claimant had been progressing satisfactorily in the program, she was forced to terminate it and her on-the-job training as a forestry clerk, due to increasing neck and upper back discomfort.

Claimant testified that the duties of a clerk were difficult for her. Sitting for any length of time was bothersome, particularly when it was necessary to use her hands out in front of her. However, she believed she could handle a job as a part-time barber in her own home because she could control the amount of customers. Therefore, it would not be a "steady 8 hour day-type thing."

The Referee increased claimant's disability award from 10% to 65%. Concluding claimant suffered from a chronic pain syndrome, of which the industrial injury was a material contributing cause, the Referee reasoned claimant was substantially impaired.

We believe claimant is impaired to a degree in excess of the Determination Order's award. However, we find the Referee's award was excessive.

Claimant has a high school education, nine months of training as a secretary and clerical specialist, and nine months of training at a beauty school. In addition to her 10 years of experience in the meat wrapping industry, claimant has experience as a variety store, drug store and grocery store clerk. Her treating physicians are pessimistic concerning her return to her former occupations as well as her physical and emotional capabilities to perform secretarial or clerical duties. Her work restrictions limit her job duties to the light to sedentary classifications.

Pursuant to OAR 436-65-600 et seq., we consider claimant's age, education, work experience, adaptability, mental capacity,

emotional state, labor market findings, and physical impairment, including disabling pain, in rating the extent of claimant's disability. Considering the above guidelines and comparing this case to similar cases, we conclude that a total award of 30% would more appropriately compensate claimant.

ORDER

The Referee's order dated August 25, 1983 is modified. In lieu of the Referee's award, and in addition to the 10% (32°) unscheduled disability awarded by the September 22, 1980 Determination Order, claimant is awarded 20% (64°) unscheduled disability for a total award to date of 30% (96°) unscheduled disability for her neck and upper back injury. Claimant's attorney's fee shall be adjusted accordingly.

JOEL I. HARRIS, Claimant
Robert L. McKee, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 81-01123
June 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Braverman's order which: (1) Approved the Workers' Compensation Department, Compliance Division, Suspension Order dated November 5, 1980; (2) failed to award a penalty and attorney fee for unilateral termination of benefits by the insurer before receipt of the November 5, 1980 Suspension Order; (3) awarded a penalty for the delayed payment of temporary total disability benefits which were to commence on November 25, 1980, but which based that penalty on an incorrect period of time; (4) awarded claimant an attorney fee of $150 in association with the above penalty; (5) affirmed the January 23, 1981 Determination Order without independently examining whether that order was correct; (6) held that the employer was justified in not referring claimant for vocational rehabilitation until after 18 months had passed; and (7) authorized the insurer to offset temporary total disability benefits that were paid pursuant to an Interim Order by the Referee dated October 26, 1981.

Claimant compensably injured his low back at work on March 11, 1980. The diagnosis of his condition was acute low back strain. His treating physician, Dr. William Platt, neurologist, treated him conservatively with home bed rest, physical therapy and pain medication. Dr. Platt authorized time loss from work beginning March 12, 1980. On June 6, 1980 Dr. Platt reported that claimant had:

> ". . . tenderness over the lumbosacral junction area, forward bending to within 20 cm. of the floor, lateral and rotatory movements, 75% bilaterally, and backward bending 50%. Neurological testing revealed no definite disturbances of cranial nerve motor sensory coordination or reflex function.
>
> "Overall it appeared that he was little changed, though his back motions have improved a bit, especially backward extension."

Claimant's complaints at that time were of periodic muscle spasms which occurred every few days. Dr. Platt thought that claimant was "approaching a stationary status" and that his case should be referred to the Orthopaedic Consultants "without undue delay" for evaluation and possible closure. By report dated June 14, 1980, Dr. Platt reiterated that claimant was "certainly approaching a medically stationary status with regard to his low back problem and should be ready for closure soon. However, I again would emphasize that an Orthopaedic Consultants' examination could be helpful." Dr. Platt felt that claimant could soon return to light-duty work, but that vocational assistance may be needed by claimant. Dr. Platt concluded, "Based on lack of minimal x-ray changes, and lack of objective neurologic signs, I think a rating of minimal for the low back would be appropriate."

On July 8, 1980 claimant was in a motorcycle accident injuring his right knee. On July 14, 1980 claimant's right knee anterior cruciate ligament and medial collateral ligament were found to be torn and were surgically repaired. He was discharged from the hospital on July 16, 1980 with crutches and medication for pain.

Meanwhile, on July 10, 1980 claimant was seen by Orthopaedic Consultants for evaluation of his low back injury. Orthopaedic Consultants obtained a history from claimant, but were unable to complete the physical part of the examination due to claimant's right knee injury: "He walked into the examining room on crutches, dragging his right leg which was in a brace from his hip down to this [sic] foot. Under these circumstances the examiners felt that evaluation of his low back condition would not be meaningful at the present time."

On August 8, 1980 claimant was examined for the last time by Dr. Platt. By report dated August 11, 1980, Dr. Platt stated that claimant's low back may be improved from a symptomatic standpoint:

> "[T]hough objective assessment is difficult still because of the knee problem, I certainly think he is approaching a stationary status. I would recommend that once his right leg cast is off and he is
>
> well accustomed to his knee brace and walking easily, that perhaps a closing examination should be scheduled at Orthopaedic Consultants."

The insurer rescheduled claimant to complete his examination with Orthopaedic Consultants on October 21, 1980.

NOVEMBER 5, 1980 SUSPENSION ORDER

Although claimant attended the October 21, 1980 appointment with Orthopaedic Consultants, the physical examination was not completed. Claimant contends that the reason it was not completed was because a "white-haired guy" at the doctor's office on October 21 told him, "We can't examine you." A letter from Orthopaedic Consultants dated October 21, 1980 stated:

> "Mr. Joel Harris came into Orthopaedic

> Consultants, P.C. today to complete his examination but states that he had his right knee operated on six weeks ago and refused to be examined as far as his back and legs are concerned, at this time.
>
> "He felt that it was going to cause him too much discomfort and wished to wait until Dr. Wisdom [his knee surgeon] released him to have the examination. The patient, therefore, was not examined and it would be our recommendation that when Dr. Wisdom feels that he can complete a back examination, that another appointment should then be made to complete his evaluation."

An EBI claims examiner's notes dated October 30, 1980 show that Dr. Wisdom was telephoned and that he stated that he didn't "see why [claimant] can't be examined for back, even w/knee still injured!"

Meanwhile, on October 22, 1980 the EBI claims examiner, Ms. DelVal, called the Compliance Division and spoke with Ms. Wanda Meithof. Ms. Meithof is an assistant to Mr. Dan Zahn of the Compliance Division. It was Ms. DelVal's understanding after talking by telephone with Ms. Meithof that it would be proper to suspend claimant's compensation for his failure to allow Orthopaedic Consultants to conduct a physical examination on October 21, 1980, and EBI immediately suspended payment of temporary total disability payments. The last date for which claimant received benefits was October 20, 1980. It was not until October 24, 1980 that Ms. DelVal wrote a letter to Mr. Zahn of the Compliance Division requesting an order suspending compensation for claimant's failure to keep a medical examination. On November 5, 1980 the Compliance Division issued a Suspension Order authorizing suspension of compensation as of October 21, 1980 until such time as claimant notified EBI of his agreement to be examined and, in fact, submitted to an examination by the physicians designated by EBI. By the time claimant received the Suspension Order, he had already realized that his compensation had been suspended. He made a call to Ms. DelVal who informed him that he must have another appointment with Orthopaedic Consultants before his compensation could be resumed. Claimant then made an appointment for the next available time which was November 25, 1980. On that date claimant underwent a complete physical examination by Orthopaedic Consultants, thereby becoming eligible to receive temporary total disability benefits pursuant to the terms of the Suspension Order.

The Referee sustained the November 5, 1980 Suspension Order based on his conclusion ". . . that the claimant interfered with the Orthopaedic Consultants' examination on October 21, 1980 by his unwarranted and unreasonable refusal to be examined pursuant to ORS 656.325."

Claimant contends that it was not unreasonable to refuse to permit Orthopaedic Consultants to complete the physical examination portion of his appointment on October 21, 1980

because, as of that date, he had not been told by his knee surgeon, Dr. Wisdom, that it would be permissible for him to undergo a physical examination. However, there is no evidence in the record that Dr. Wisdom told claimant he should not participate in Orthopaedic Consultant's physical examination. In fact, when contacted by Ms. DelVal on October 30th, Dr. Wisdom stated he felt there was no reason why claimant could not have gone through with the physical examination. Claimant points to Dr. Platt's August 11, 1980 letter which stated that the closing examination with Orthopaedic Consultants should not be performed until claimant was well accustomed to his knee brace and walking easily. However, there is no evidence in the record that by October 21, 1980 the claimant was not out of his right leg cast, well accustomed to his knee brace and walking easily.

Orthopaedic Consultants had the foresight in their July 10, 1980 examination of claimant not to continue with the physical examination until claimant's right knee condition was better. It is reasonable to assume that, had they thought claimant should not continue with the physical examination as of October 21, 1980, they would have delayed the physical examination again.

Regarding the validity of the Suspension Order, claimant also points to several inaccuracies that were contained in the October 24, 1980 letter from Ms. DelVal to the Compliance Division requesting the Suspension Order. It does appear there were some inaccurate statements in Ms. DelVal's letter along with a failure to strictly follow the procedural rules for requesting suspension of compensation under OAR 436-54-283. However, those errors are harmless in light of our conclusion that, on the merits of the suspension, claimant did unreasonably refuse to submit to the physical examination on October 21, 1980.

UNILATERAL TERMINATION OF TEMPORARY TOTAL DISABILITY BENEFITS

As stated above, the evidence in the record shows that the insurer terminated payment of temporary total disability benefits, prior to receiving the November 5, 1980 Suspension Order, based on a telephone call to Ms. Meithof in the Compliance Division on October 21, 1980. The insurer ceased paying benefits to claimant on October 21, 1980, whereas, it did not receive the November 5, 1980 Suspension Order authorizing it to suspend compensation until November 7, 1980. Had the insurer properly waited to receive the Suspension Order, claimant would have received checks for two full weeks of temporary disability benefits both on October 22, 1980 and November 5, 1980. Instead, claimant received a short check mailed October 21, 1980, and no check at all on November 5, 1980. Further, the insurer did not resume payment of benefits as required by the Suspension Order upon the claimant's completion of his examination with Orthopaedic Consultants on November 25, 1980. Apparently, on November 25, 1980 the insurer called Orthopaedic Consultants and learned that they thought claimant's condition was medically stationary. The insurer then called Ms. Meithof and asked her if they still had to resume payments pursuant to the Suspension Order given that information.

The insurer contends that, since claimant's condition was found medically stationary on November 25, 1980, they had no duty to resume payment of benefits at that time on the advice of Ms. Meithof. Again, this advice to the insurer not to resume

temporary total disability benefits was obtained by telephone from Ms. Meithoff from the Compliance Division.

The Referee addressed the insurer's failure to resume temporary total disability benefits as of the date of Orthopaedic Consultants' final examination. We agree with the Referee's conclusion that the Suspension Order required the insurer to resume payment of temporary total disability benefits when claimant was examined on November 25, 1980. The Referee stated:

> "An employer may not rely on a telephone call from the Workers' Compensation Department as a basis to unilaterally and permanently avoid the payment of temporary total disability benefits, especially where an Order exists to the contrary. [John C. May, 34 Van Natta 114 (1982)]. The [A]ct provides that any payment of temporary total disability benefits which are paid beyond the point that the claimant is medically stationary can be recouped by the employer as an offset against future benefits. [OAR 436-54-320.] The law does not sanction the unilateral stoppage of payment of temporary total disability benefits or the nonpayment of these benefits based upon telephonic communication."

The insurer was obligated to pay temporary total disability benefits from November 25, 1980 until the January 23, 1981 Determination Order was issued authorizing the cessation of such benefits. We note that the Referee stated that the obligation to resume payments began December 2, 1980. We believe this date was an inadvertent error on his part because he stated that the payments should have resumed on the date of Orthopaedic Consultants' examination, and that examination took place on November 25, 1980.

We find that the Referee's conclusions as to the unreasonableness of the insurer's reliance upon a telephone call to the Compliance Division to cease payment of temporary total disability benefits applies equally to the telephone exchange on October 21, 1980. "The workmen's compensation law protects the workman against arbitrary suspension of payments by an employer. Once the employer accepts a claim, he must pay 'periodically, promptly and directly.' ORS 656.262(2)." Jackson v. SAIF, 7 Or App 109, 115 (1971). ORS 656.262(4) requires that compensation be paid at least once every two weeks. Compensation ordinarily continues until, "the workman returns to regular work, is released by his doctor to return to regular work, or there has been a determination that the workman's condition is medically stationary under ORS 656.268." Jackson v. SAIF, supra, 7 Or App at 115.

In this case, the Determination Order was not issued until January 23, 1981. Claimant had not returned to work, nor had he been released to regular work. Therefore, the insurer was obligated to continue payment of benefits until receiving authorization through an order allowing cessation of payment.

On January 14, 1981 the insurer did eventually make payment for the period November 25, 1980 through January 13, 1981. When the Determination Order was issued on January 23, 1981, it awarded temporary total disability benefits from March 12, 1980 through November 25, 1980 less the period of suspended compensation from October 21, 1980 through November 24, 1980. Under the terms of this Order on Review, this award of temporary disability benefits is affirmed. This means that the January 14, 1981 payment was an overpayment, except for benefits due for the one date of November 25, 1980.

PENALTIES FOR UNILATERAL TERMINATION OF BENEFITS

We now turn to the question of the proper penalty for: (1) The insurer's failure to pay benefits from October 21 to November 5, 1980; (2) the delayed payment made on January 14, 1981 for benefits due from November 25, 1980 through January 13, 1981; and (3) the failure to pay any benefits for the period January 14, 1981 up to January 23, 1981.

In Mark L. Side, 34 Van Natta 661 (1982), we discussed the proper penalty to be awarded in cases where an insurer unilaterally terminates payment of benefits. In Side, the insurer had terminated benefits three months before a Determination Order issued. As it turned out, the Determination Order awarded temporary total disability compensation only up to the date that the insurer had unilaterally stopped paying benefits, but claimant was entitled to a penalty since the insurer had ceased payment without authorization. We ordered the insurer to pay temporary total disability benefits to the claimant between the date they ceased paying claimant's medically stationary date and the date of the Determination Order, and prohibited the insurer from taking the automatic offset provided for in OAR 436-54-320. (OAR 436-54-320 has since been invalidated. Forney v. Western States Plywood, 66 OR App 155 (1983). We determined that form of a penalty to be more appropriate than awarding only 25% of that amount, as allowed under ORS 656.262(10).

In this case, the Referee ordered the opposite of the penalty provided in Side, by allowing the insurer to offset the overpaid amount, yet ordering the insurer to pay 25% of that amount to claimant as a penalty.

In another recent case, Arnold C. Blondell, (WCB Case No. 82-04202, 36 Van Natta 818 (decided this date), a Referee awarded the claimant both a penalty of a disallowance of the offset, and a 25% penalty of that amount.

These varying results have caused us to reexamine our decision in Side. We conclude that the appropriate penalty in these cases is a penalty equal to 25% of the amount that should have been paid while the insurer was awaiting receipt of an order from the Workers' Compensation Department. We have two reasons for departing from our order in Side. First, it is a generally held legal principle that there must be statutory authority before an administrative agency can assess a penalty. The Workers' Compensation Board derives its authority to assess a penalty from ORS 656.262(10). That statute states: "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, . . . the insurer or self-insured employer shall be liable for an additional amount up to 25% of the amount

then due plus any attorney fees which may be assessed under ORS 656.382." (Emphasis added.) The Board may only award up to 25% of benefits that are not properly paid. Our rule in Mark L. Side amounts to a 100% penalty of the amount of compensation which should have been paid. That penalty is excessive under the statute.

Although claimant may not retain 100% of the benefits unilaterally offset by the insurer as a penalty, he may retain them until the Workers' Compensation Department or Board approves such offset by order. Forney v. Western States Plywood, 66 Or App 155 (1983). The insurer has provided evidence establishing its entitlement to an offset for an overpayment of benefits from November 25, 1980 through January 13, 1981.

For the foregoing reasons, we conclude that the proper penalties in this case are: (1) An amount equal to 25% of the temporary total disability benefits that would have been paid from October 21, 1980 to November 7, 1980 had the insurer waited to receive the November 5, 1980 Suspension Order; and (2) 25% of the amount of temporary total disability benefits that should have been timely paid from November 25, 1980 through January 23, 1981 while awaiting receipt of the January 23, 1981 Determination Order. The overpayment made by the insurer on January 14, 1981 was properly allowed to be offset by the insurer pursuant to the Referee's order as required by Forney v. Western States Plywood, supra.

The Referee awarded claimant's attorney $150 in relation to this penalty issue. Claimant's attorney contends that the amount of $150 was unrealistically low. In his argument for a greater fee, claimant's attorney includes several factors that have nothing to do with litigation of the specific penalty issue. However, considering that the major portion of the hearings on August 5, 1982 and August 11, 1982 was taken up with examination of Ms. DelVal and her handling of the claim with regard to starting and stopping of temporary total disability payments, we find that claimant's attorney is entitled to a larger fee.

JANUARY 23, 1981 DETERMINATION ORDER

Claimant contests the January 23, 1981 Determination Order which awarded him: (1) Temporary total disability benefits from March 12, 1980 through November 25, 1980, less the October 21, 1980 through November 24, 1980 period covered by the November 5, 1980 Suspension Order; and (2) 64° for 20% unscheduled permanent partial disability benefits for his low back injury.

Temporary Disability Benefits

The Referee concluded that claimant was medically stationary on October 21, 1980, without stating any specific factors that led him to that conclusion. Our review of the evidence shows that, although Dr. William Platt thought claimant was reaching a medically stationary state in the fall of 1980, it was not until claimant was examined by Orthopaedic Consultants on November 25, 1980 that any doctor found claimant's low back injury medically stationary. On December 23, 1980 Dr. William Platt concurred with the Orthopaedic Consultants' report.

Meanwhile, claimant had stopped receiving treatment from Dr. William Platt in August 1980 and began receiving treatment from Dr. David Platt, chiropractor, on October 17, 1980. Through an 827 form dated October 29, 1980, Dr. David Platt reported claimant's condition as not medically stationary. On December 31, 1980 Dr. David Platt stated that he thought the Orthopaedic Consultants' evaluation of claimant was incomplete and not in keeping with the facts of the case. However, Dr. David Platt didn't explain why he thought the evaluation was incorrect. Dr. David Platt also stated in his December 31, 1980 letter to the insurer that claimant was not stationary at that time, but he estimated he could be released for light modified work by approximately February 1, 1981. On February 5, 1981 Dr. David Platt wrote the insurer stating he still thought claimant was improving with treatment. It was not until October 21, 1981 that Dr. David Platt found claimant's condition to be stationary. At the time of claim closure in January 1981, claimant's treating physician was Dr. David Platt. Generally, more weight is given to a treating physician's opinion when determining a medically stationary date. However, in this case, we find that claimant was medically stationary as of November 25, 1980, as stated by Orthopaedic Consultants and Dr. William Platt. Claimant's first treating physician, Dr. William Platt, did have the advantage of treating claimant at the onset of his injury and for several months thereafter. He reviewed the Orthopaedic Consultants' November 25, 1980 report and agreed with their findings. Dr. David Platt's disagreement with Orthopaedic Consultants would have been given more weight had he offered some explanation for his disagreement in the way of his own detailed physical examination or a comparison of prior medical reports. However, this was not done. Therefore, the persuasive evidence indicates that claimant's low back condition became stationary on November 25, 1980. We affirm the Determination Order's award of temporary total disability benefits.

Permanent Disability Benefits

At hearing, the Referee declined to independently evaluate the extent of claimant's permanent disability because claimant was enrolled in an authorized vocational rehabilitation program at the time of hearing. The Referee observed that claimant would be receiving a later Determination Order at the completion of his vocational program and concluded:

> "Therefore, it would be meaningless for me to make my own evaluation of permanent disability at this time as the claimant is in a vocationally transitory period. I do not evaluate claimant's permanent partial disability and specifically defer such an evaluation to Closing and Evaluation at the appropriate time in the future for the purposes of these proceedings. Therefore, I adopt and affirm the Determination Order of January 23, 1981 awarding claimant a 20 percent permanent partial disability for injury to his back. This is not an independent rating of my own. It is one of administrative convenience based upon the

> expectation that the claimant will receive a meaningful disability evaluation when he has completed his vocational rehabilitation training."

The Referee then ordered that the January 23, 1981 Determination Order be affirmed.

Claimant contends that under the cases of Minor v. Delta Truck Lines, 43 Or App 29 (1979), and Leedy v. Knox, 34 Or App 911 (1978), the Referee erred in refusing to evaluate claimant's permanent disability. In Minor and Leedy the court held that the Board may not deny hearings on the issue of extent of disability for the reason that a claimant is enrolled in a vocational rehabilitation program.

In its respondent's brief, the insurer moves to dismiss claimant's request for review for lack of jurisdiction, with respect to the portion concerned with the Referee's refusal to consider the extent of claimant's permanent disability. The insurer relies upon our decision in Larry J. Barnett, 33 Van Natta 655 (1981).

In Barnett, the claimant requested review of a Referee's order which granted the insurer's motion to defer a scheduled hearing on the issue of extent of permanent disability, for the reason that the claimant at the time was enrolled in a vocational rehabilitation program. As a threshold matter the Board found it necessary to consider whether it had jurisdiction to review the Referee's order deferring claimant's hearing request. We stated that the Referee's order was the functional equivalent of an order of postponement pursuant to OAR 436-83-800; and, therefore, was an interim order not reviewable by the Board under current law. Although we found ourselves constrained to dismiss claimant's request for review based on this conclusion, we also stated our belief that claimant was entitled to a hearing for purposes of evaluating the extent of his permanent disability as it presently existed, based upon Minor and Leedy; and by copy of our order, we so advised the Presiding Referee. 33 Van Natta at 656. See also, William J. Dale, 34 Van Natta 747 (1982); Bill Painter, 33 Van Natta 704 (1981).

There is a distinction between the Referee's order in this case and the Referees' orders in Barnett, Dale and Painter. The Referees in those cases merely deferred, or postponed, claimant's hearing requests. Referee Braverman, in this case, affirmed the Determination Order based upon his conclusion that it was administratively convenient to do so. His order affirming the award of permanent disability is a final order entered pursuant to ORS 656.289, notwithstanding the fact that the Determination Order was affirmed for reasons of administrative convenience. Accordingly, this Board has jurisdiction to review the propriety of that portion of the order, pursuant to ORS 656.295.

As indicated, we previously have stated that, under the court's decisions in Minor and Leedy, and in the absence of an administrative rule providing for postponement of a hearing on extent of disability while a claimant is enrolled in a vocational rehabilitation program, the claimant is entitled to a hearing and is entitled to a Referee's evaluation of permanent disability as

it exists at the time of hearing. Barnett, supra, Dale, supra, Painter, supra. Accordingly, although we agree with the Referee's convenience/conservation of administrative resources rationale, it was error for him to refuse to evaluate claimant's permanent disability. See OAR 438-06-105 (effective 5-1-84).

There is sufficient evidence in the record for the Board to evaluate claimant's permanent disability. Accordingly, it is unnecessary to remand to the Referee for this purpose. On our de novo review, we affirm the Determination Order's award of 64° for 20% unscheduled permanent disability for claimant's low back injury. We base this finding on the following facts. Claimant's original injury was an acute low back strain based on muscle spasms which restricted his motion. Dr. William Platt reported on June 14, 1980 that he expected claimant's impairment to be minimal. The Orthopaedic Consultants rated claimant's impairment as mild based on pain and stiffness resulting in a decreased range of motion. X-rays revealed some relatively mild narrowing of the lumbosacral disc space. Claimant was 29 at the time of hearing and has a high school education. He has an I.Q. "in the high 70's." Claimant's prior work experience has included work as a painter and sandblaster, gas station attendant, sawmill worker, slaughterhouse worker, farm worker and construction worker. At the time he was injured he was working on a cutoff saw at a wire works company. Whereas he was able to perform heavy labor prior to his injury, he is now limited to light or medium work.

Based on the above factors, we find that claimant is adequately compensated by an award for 20% unscheduled permanent partial disability benefits.

FAILURE TO REFER FOR VOCATIONAL REHABILITATION

Claimant contends that the insurer unjustifiably delayed referral of claimant's case for vocational rehabilitation benefits. Claimant was injured March 11, 1980 and lived on continuous time loss benefits through November 25, 1980 (except for the period of time covered by the Suspension Order). ORS 656.330(1) states:

> "In order to assist the director in determining whether an injured worker should receive disability prevention services, the insurer or self-insured employer of a worker who incurs a disabling compensable injury shall report the circumstances of the injury to the director in each of the following situations:
>
> * * *
>
> "(c) When the worker incurs a disabling compensable injury for which a determination pursuant to ORS 656.268 has not been made and the worker has not returned to work within 180 days of the date of injury, the report shall be made not later than 190 days after the date of the injury."

OAR 436-61-111(2) stated during the pertinent time period:

> ""[T]he insurer shall elect to serve the worker, or refer the worker to Field Services Division, according to the election system filing in effect and the insurer's individual election for the worker, within 14 days of the first to occur of the following: (a) Having knowledge of the worker's potential eligibility. (b) The 90th day of the workers' unbroken time-loss. (c) The 180th day of the worker's broken time-loss."

The insurer, however, did not refer claimant for vocational assistance until July 30, 1981. Meanwhile, claimant had applied for unemployment compensation to ease his financial situation in February 1981 and again in May 1981. On this issue the Referee held:

> "The seeking of vocational rehabilitation benefits is a joint obligation shared by the employer and the claimant. In this particular case, the claimant decided to apply for unemployment compensation benefits rather than rehabilitation benefits. The record and testimony indicate that the employer was justified in believing that the claimant was employable consistent with his permanent impairment and nonmedical factors. The evidence further establishes that once it became clear that the claimant needed vocational rehabilitation all reasonable attempts to secure this benefit on claimant's behalf were undertaken by the employer."

Claimant was eventually enrolled in an authorized training program to learn the trade of auto painting beginning April 19, 1982. Claimant was still enrolled in this program at the time of his hearings in this case on August 5, 1982 and August 11, 1982.

Claimant points out that under the statute it is the insurer, and not the claimant, who has the duty to refer the claimant's claim for vocational assistance. It is not a joint obligation. Claimant cites a report by Marilyn Brown, Service Coordinator at Field Services Division, dated October 21, 1981, as evidence of the insurer's unreasonable delay:

> "Delay in Referral
>
> "In the field of vocational assistance and job placement, it is commonly accepted that the longer a person is off work, the lower his chances to ever return to work. Mr. Harris' date of injury was 3-11-80. On May 6, 1980, Dr. [William] Platt stated Mr. Harris would need vocational assistance. On June 11, 1980, Mr. Harris had had 90 days of continuous time loss and should have been referred to Field Services. [OAR 436-61-111(2)(b)] His case

was received by the Compliance Division of the Workers' Compensation Department on July 30, 1981; one year and one month late. In Mr. Harris' case, the lack of referral to Field Services or a private rehabilitation counselor has unnecessarily compounded the six factors outlined above [work history, hobbies, mental capacity, emotional factors, seizures, socioeconomic status]; which may have severely limited his endeavor to return to work. It is quite likely that if this case were referred in a timely fashion, Mr. Harris would presently be well on the way to gainful employment.

"At this point, it appears that Mr. Harris will first need a vocational evaluation in order to define an area of potential employment which would be suitable for his abilities, and lastly, of course, he will need assistance in finding a job. As of yet, he has not been vocationally evaluated and it would be impossible to predict what type of work he could possibly do. He is being referred to the Callahan Center for Vocational/Psychological testing on an emergency basis."

Claimant further points out that Ms. DelVal's supervisor stated in a report to Ms. DelVal on January 12, 1981: "Better get 1292 filed ASAP! This is negligent long ago!" A 1292 form is used to request vocational assistance for a claimant.

The insurer had a duty to report the claim to Field Services at the end of 90 days and to Disability Prevention Services at the end of 190 days. This wasn't done and was noticed by a claim supervisor at EBI. Marilyn Brown, Service Coordinator for Field Services, reported on the delay as quoted above and stated in a second supplemental report dated October 12, 1981: "No referral made to FSD. Linda DeVal [sic] -- EBI stated the file was not referred to FSD on time probably as the result of an oversight on her part." Under these facts, it does appear that the insurer negligently and unreasonably delayed referral of claimant's case for vocational assistance. However, under ORS 656.745 and OAR 436-61-981, it is the Director of the Workers' Compensation Department and not the Workers' Compensation Board that is authorized to assess penalties in these situations. Therefore, we decline to assess a penalty due to lack of jurisdiction.

OCTOBER 26, 1981 INTERIM ORDER

The parties appeared three times for hearing in this case. They first appeared on October 23, 1981 and again on August 5, 1982 and August 11, 1982. Prior to convening the hearing on October 23, 1981, claimant offered some additional documents which apparently included the October 21, 1981 report of Marilyn Brown, Service Coordinator for Field Services Division. Upon receiving this report at hearing, the insurer stated that it was not prepared to address all the issues that were raised in it. The Referee suggested that a postponement could be granted on behalf

of the insurer if the insurer would pay claimant benefits for such period of time as it would take to get the case rescheduled. At that time, claimant was contending that his case was prematurely closed and that he was entitled to continuous compensation up through and continuing beyond October 23, 1981. Claimant states it was his understanding from the agreement reached at hearing that he would be entitled to the interim benefits until the hearing was reconvened, and would not have to pay them back through an offset, if it was found that the delay in referral for vocational assistance was due to the procrastination of the insurer.

Our examination of the transcript from the hearing of October 23, 1981 reveals the Referee's following statement:

> "I have not heard any evidence in this case and do not know how the issues will revolve [sic] themselves, but in the event I determine at the future scheduled hearing that the Claimant's claim was properly closed prior to today, October 23, 1981, and/or that the Claimant's claim is medically stationary and/or that he is not permanently and totally disabled as he today alleges, then I will, if the circumstances dictate, grant EBI's request for credit against any TPD [sic] benefit paid beyond today until the case is again at hearing.
>
> "I want to make it clear to the Claimant that I by my choice of words am not trying to anticipate all of the possible future decisions or judgments which may affect such a credit of TPD [sic] benefits, but that I will, based upon the evidence at the conclusion of these proceedings, independently decide if such a credit is justified by all of the facts in the case."

In the Referee's written Interim Order dated October 26, 1981 he ordered:

> "(1) The carrier-employer shall pay claimant interim temporary total disability benefit from October 23, 1981 until the case is heard.
>
> "(2) Temporary total disability paid pursuant to this Order may be credited, upon further approval, against claimant's permanent partial disability, if any, or future temporary total disability on a 25 percent credit basis, if claimant is found not to be entitled to interim benefits while currently paid."

In the Referee's October 24, 1982 final order, he concluded that claimant had been medically stationary prior to October 23, 1981. The Referee also stated:

> "[A]n Interim Order for payment of temporary total disability benefits was issued by this Referee on October 26, 1981. As I have concluded that the claimant was not otherwise entitled to temporary total disability benefits paid pursuant to this Interim Order, I authorize the carrier to offset any benefits paid in the manner consistent with the Order and the law."

Claimant's argument is that, had the claim been speedily referred for vocational assistance, there would not have been a gap in payment of compensation benefits because, even though claimant was found stationary by his medical doctors in November 1980, his prompt participation in a vocational assistance program would have kept his claim open making him eligible for temporary total disability compensation during that program. It does not appear from either the transcript or the Interim Order that the parties understood that claimant would be allowed to keep the interim benefits, even if he was medically stationary in that interim, should the Referee find that the insurer unreasonably delayed referral to vocational assistance. There is no authority cited that allows a claimant to receive interim benefits when he is medically stationary and not yet enrolled in vocational rehabilitation program -- even when the reason he is not yet enrolled in such a program is due to the insurer's unreasonable delay.

We conclude that claimant's remedy for the delayed referral for vocational assistance is to bring the matter to the attention of the Director of the Workers' Compensation Department pursuant to ORS 656.745 and OAR 436-61-191.

ORDER

The Referee's order dated October 4, 1982 is modified in part. EBI companies shall pay to claimant a penalty equal to the sum of 25% of temporary total disability benefits which should have been paid from October 21, 1980 to November 5, 1980. Further, EBI Companies shall pay to claimant an additional penalty equal to 25% of temporary total disability benefits which should have been paid from November 25, 1980 to January 23, 1981. EBI Companies shall pay to claimant's attorney the sum of $400 as an attorney's fee for services before the Hearings Division and Board on the issue of failure to pay temporary total disability benefits. The extent of claimant's disability due to his March 11, 1980 injury has been independently reviewed and the Determination Order dated January 23, 1981 which awarded 64° for 20% unscheduled disability for injury to claimant's low back, is affirmed. The remainder of the Referee's order is affirmed.

NORMAN S. HARWELL, Claimant
Emmons, et al., Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB 79-08902 & 80-03265
June 15, 1984
Order on Remand

This case comes to the Board on remand from the Supreme Court. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984). The issue on Board review was the extent of claimant's unscheduled permanent disability. Prior Determination Orders had awarded claimant no permanent disability benefits, while the Referee had awarded 60% unscheduled permanent partial disability benefits. In our Order on Review, we decreased that award to 15%. The Court of Appeals affirmed our order without opinion. Harwell v. Argonaut Insurance Co., 62 Or App 662 (1983).

Claimant contended at the Supreme Court that the Board had improperly disregarded the testimony of claimant and his wife with regard to their subjective statements of the effect of claimant's disabling pain. The court held that "[w]hen pain has disabling effects, they must be considered in establishing awards for unscheduled permanent partial disability." The court also took note of OAR 436-65-600(2)(a), which provides in part: "Injury related impairment of the whole person must be documented in the medical record." The court pointed out that a claimant is a competent witness to testify as to the pain he suffered and his impaired ability to perform physical labor, Uris v. Compensation Department, 247 Or 420, 427 (1967), and that the term "medical record" should be construed to include the testimony of claimant and his witnesses.

The Supreme Court then remanded the case to the Board with the following instructions: "(1) [T]o determine if its previous decision considered the claimant's subjective complaints of pain, (2) if the complaints were not considered, to proceed to make that consideration, and (3) to consider if OAR 436-65-600, et seq., are correct in view of this opinion."

A review of the record and our notes and computations made at the time of Board review indicate that we did, in fact, consider both subjective and objective evidence of disabling pain.

We consider objective evidence to be that evidence of symptoms, conditions and limitations beyond the control of the claimant which is directly observable with the naked eye or which is indirectly observable as by reading of x-rays or electrical studies. We consider subjective evidence to be statements and actions by a claimant which express his sensations and feelings that he or she experiences when being examined by a physician or when going about his or her daily working and living activities.

The claimant's condition in this case has been diagnosed as chronic low back strain. This type of condition is very difficult to test objectively, e.g., as by x-rays or electrical studies, but, on occasion, directly observable muscle spasm may be seen. As in most cases of chronic muscle strain, there was little or no objective evidence in this case.

Claimant injured his back lifting bales of hay which weighed from 90 to 150 pounds while working on a ranch on September 2, 1978.

On September 5, 1978, a record from Cascade Medical Clinic noted objective symptoms of lumbar muscle spasm and subjective reports of pain and limited straight leg raising on the left.

On November 28, 1978, Dr. John Carroll reported that claimant had no discomfort in his back as of that time. Although he reported that claimant intermittently had low back and left buttock pain, x-rays indicated possible early mild narrowing of the lumbosacral joint with no other definite pathology in the bones or soft tissue structure of the lower spine. All other testing for the low back strain was normal except for slight tightness and discomfort displayed upon the extreme of left straight leg raising. He recommended that claimant return to a lighter form of work.

A January 23, 1980 x-ray report showed mild lumbar scoliosis or possible muscular spasm on the left.

The January 24, 1980 report of Dr. Mohammed Hoda, orthopedist, noted normal x-ray and neurological examinations including sensation, motor and reflexes in both lower extremities. The patient reported some tenderness in the left sciatic notch and pain at the upper limit of straight leg raising on the left side at that time.

On November 3, 1980 Dr. Chen Tsai, neurosurgeon, reported that a lumbosacral spine x-ray revealed lumbar scoliosis. All other testing during the neurological examination was normal, except that claimant reported tenderness over the L4-L5 spinous processes without radiation, midline low back pain and occasional right buttock pain with no leg pain.

By report dated January 14, 1981, the Orthopaedic Consultants found claimant's lower back to be minimally impaired. The objective test of direct observance showed no visible or palpable muscle spasm in the lumbar paravertebral muscles. The objective indirect observation, i.e., x-ray, showed a completely normal lumbar spine. The claimant reported intermittent pain in the low back which radiated into the right hip. Claimant said he awakened in the morning with stiffness and pain in his lower back, but that it was relieved by taking a hot shower or bath, and did not return for the remainder of the day unless he attempted to perform heavy lifting. As claimant was put through the various range of motion tests, he apparently only reported pain on the extreme of left straight leg raising and upon left leg dorsiflexion.

A hospital emergency room report dated May 13, 1981 noted no objective evidence of impairment (no paraspinal muscle spasm) but also noted claimant's complaints of tenderness over the lower thoracic spine, lower lumbar area and a decrease in sharp sensations over the lateral aspect of the lower leg.

A vocational report from VERK Consultants, dated May 18, 1981, reported that Dr. Tsai gave a lifting limit of 10 pounds for claimant with no twisting or bending. Similarly, a June 2, 1981 vocational report states that Dr. Tsai had limited claimant to lifting five to 10 pounds with no twisting or bending and noted that these restrictions indicate that claimant's present level of physical functioning is in the sedentary range as defined by the Dictionary of Occupational Titles.

The Supreme Court stated in its opinion that the Board may use physicians as "preliminary" fact finders and their reports as filtering agents for a claimant's subjective complaints of pain. We, of course, examine very carefully the weight that the physicians give to a claimant's subjective complaints of pain because they are the medical experts and can best judge the correlation that the subjective complaints have to the testing that the physician uses in his or her examination. Therefore, it is against the backdrop of the medical reports that we view the testimony of a claimant and others with regard to the limitations a claimant now possesses as a result of a work injury or occupational disease.

As seen above, the physicians in this case reported little or no objective evidence, but consistently reported claimant's subjective complaints of pain and limitations. No doctor indicated that these subjective reports were unbelievable or exaggerated.

At hearing on August 19, 1981, claimant reported pain in his lower back at the belt line across his right hip, right buttocks and down the right leg. He also reported one spot of pain eight inches above his belt line in his back. The pain was brought on by driving for approximately one hour. Claimant reported good days and bad days with his back, and on bad days he had to lay down. Prolonged standing was painful as well as backwards bending. Claimant testified he avoids lifting anything from the floor but thought he could sometimes lift 30 to 40 pounds from table level. He stated six or eight blocks of walking would bring on back spasm even on a good day. He has morning back spasm approximately every third day for which he takes medication. Twisting is bothersome. He has difficulty sleeping due to pain and takes sleeping pills. He averages four hours of consecutive, uninterrupted sleep per night. He testified he has pain in his right leg most of the time with numbness from time to time, and he has pain in both legs periodically. The right leg has the more severe pain. Climbing or descending stairs and hills can be bothersome to his back. He is unable to pursue his hobbies of hunting and fishing and is unable to lift his 35-pound, four-year-old daughter. He is unable to perform yard work, but can do some housework, e.g., dishwashing and vacuuming. He will sometimes wash or repair his car, but he avoids that activity due to pain.

It appears that the complaints of disabling pain at hearing went considerably beyond the complaints of pain contained in the prior physicians' reports. Although the physicians diagnosed chronic lumbar strain and suggested that claimant should perform lighter work, no physician has characterized claimant's chronic lumbar back strain in quite the disabling nature as has claimant. With that in mind and noting the lack of or scant, objective evidence of impairment, we found the subjective evidence of impairment, including disabling pain, to be approximately 5% of the whole person. Had we relied solely on the objective evidence of impairment, this figure would have been lower than 5%.

In answer to the court's first two questions, we state that we did consider the claimant's subjective complaints of pain when this case was on Board review and that we estimated the extent of impairment due to that disabling pain to be 5%.

Finally, we turn to the court's concern as to whether the guidelines at OAR 436-65-600, et seq., correctly allow for

consideration of subjective complaints of pain. Although the guidelines do not specifically state that subjective complaints of pain must be considered when rating impairment, they do allow for that consideration. For example, for the range of motion tests such as flexion, extension, rotation, etc., typically a doctor will measure the range of motion up to the point a claimant reports pain. While a range of motion may be limited for a purely anatomical reason such as for a back fusion, most often the limitation comes due to a report of pain at a certain degree of motion by a claimant. When we compare a record before us with an evaluator's worksheet and the accompanying Determination Order, it becomes apparent that evaluators do take subjective complaints into consideration for range of motion tests. Consideration must also be given to those situations where a claimant may be able to attain a particular range of motion on a one-time basis in a doctor's office, but may not be able to sustain that range of motion while repetitively performing activities outside the doctor's office. While it is difficult to tell from an evaluator's worksheet whether that factor is taken into consideration when rating an impairment, it should be, and we assume that it is.

However, as the court pointed out, OAR 436-65-600(2)(a) may well give the mistaken impression that only statements by those rendering medical care to a claimant are considered. So, in answer to the court's third question, we find that OAR 436-65-600, et seq., are being correctly applied in that they do allow for consideration of subjective complaints of limitation, but we recommend that those rules could be clarified by specifically stating that subjective evidence is to be considered when determining extent of disability.

ORDER

We reaffirm our Order on Review dated August 18, 1982.

WILLIE B. HAYES, Claimant
Jack Ofelt, Claimant's Attorney
Alice Bartelt, Defense Attorney

WCB 82-08671
June 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Gemmell's order which held that claimant had proven an aggravation claim entitling him to additional temporary disability compensation and which granted claimant an award of 64° for 20% unscheduled disability. Compensability of the aggravation claim and extent of disability are the issues on review.

The Board affirms those portions of the Referee's order concerning extent of disability. We reverse on the aggravation issue.

Claimant compensably injured his low back on February 12, 1981 while lifting an I-beam. Prior to that incident he had an extensive history of back and leg problems. The most severe preexisting problem was phlebitis which had kept claimant off work for some time prior to 1980. When claimant returned to work in 1980 he was assigned jobs which were within specific limitations imposed by the plant physician.

Following claimant's industrial injury, he was diagnosed as having a bulging disc at L4-5 which was caused by the industrial injury. The treating physician found claimant medically stationary as of January 6, 1982. Claimant continued working during this period.

In August 1982 the employer began discussing with claimant the possibility of having him work on a machine known as a pot shell straightener. The expressed concern was that there was a danger of claimant bruising his legs working on the machine. The employer suggested that claimant wear leg warmers for protection. The employer also stated that it would put in different footing. Claimant apparently initially balked at doing that job but on about August 23, 1982 he agreed to try it. He testified that the trial was unsuccessful because his back pain increased and his leg swelled up.

On September 9, 1982 claimant was laid off as part of a plant-wide reduction in the work force. The plant physician, Dr. Semler, filled out an insurance form for claimant's group health carrier. He noted that he had examined claimant on August 17 and August 30, 1982. He diagnosed lumbo-sacral strain, resolved, and problems with both knees. He indicated that claimant's conditions were partly related to his employment. Dr. Semler testified that when he saw claimant in August 1982 there was no indication of any recent problems with claimant's back.

Claimant's treating physician, Dr. Franks, wrote on August 24, 1982 that claimant had low back pain. However, he recommended conservative management and specifically said there was no indication for aggressive management. On November 3, 1982 Dr. Franks stated:

> "Apparently [claimant] was laid off because he could not do all his work endeavors. He says he can do most of the work, just not one specific job....[Claimant] does want to work and it seems that because of one specific situation at work, he has now been laid off."

On November 4, 1982 Dr. Franks wrote claimant's attorney:

> "There is no question that this [working on the pot shell straightener] is a symptomatic stress to a documented abnormal back. I think Willie could work today if he had a job. It is just that he cannot do excessive stresses."

The Referee found claimant a credible witness. She opined that claimant's time off work from September 8, 1982 until May 8, 1983 was due to a worsening of claimant's condition. She, therefore, awarded claimant time loss for that period. We disagree. In order to establish an aggravation, claimant must prove that his condition worsened and that his compensable injury was a material cause of that worsening. He has failed to sustain his burden of proof. There is insufficient evidence to establish that his condition worsened. Claimant apparently continued to work

at his regular job after his attempt at working on the pot shell straightener. He lost time from work not because of a worsening of his condition, but because his condition precluded him from doing the heavier job. It was only when his regular job was no longer available that claimant missed work.

ORDER

The Referee's order dated September 28, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order concerning extent of disability are affirmed. The balance of the Referee's order is reversed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the insurer.

RANDY L. TEETER, Claimant
Frank Ierulli, Claimant's Attorney
Schwabe, et al., Defense Attorney

WCB 83-00927
June 15, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Presiding Referee Daughtry's order which dismissed claimant's hearing request because claimant failed to respond to an Order to Show Cause.

Claimant's request for hearing was filed on January 28, 1983. On May 11, 1983 an Order to Show Cause was entered because claimant had not yet made application for a hearing date.

Claimant's attorney alleges that, in a telephone conversation in June 1983, he received an extension of time in which to respond to the Order to Show Cause. There is no documentation which memorializes this conversation or sets a new deadline for claimant's response to the Order to Show Cause. Claimant's attorney thus contends that, after obtaining the oral extension, he did not know that he had any particular deadline for responding to the Order to Show Cause.

In a different context, we have recently noted that this agency can create problems when agency personnel conduct agency business by telephone without the "stabilizing effect of the written word." Elaine L. Williams, 36 Van Natta 290, 291 (1984). That observation is also applicable in this context, with the notable difference that here, unlike in Williams, it was claimant's attorney who chose to conduct business in a manner that created greater danger of miscommunication.

Nevertheless, the facts remain that: (1) A May 11, 1983 Order to Show Cause directed claimant to respond within 30 days; and (2) claimant had not responded more than four months later when the Presiding Referee entered an Order of Dismissal on September 29, 1983. Regardless of any possible confusion or misunderstanding that may have been created by the June 1983 telephone conversation, and for which this agency may be partially responsible, we agree with the Presiding Referee that failure to respond for this length of time makes dismissal appropriate.

ORDER

The Presiding Referee's order dated September 29, 1983 is affirmed.

RALPH J. BENCOACH, Claimant
Flaxel, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 81-11360
June 18, 1984
Order on Reconsideration

The Board entered its Order on Review herein on May 3, 1984. The self-insured employer has requested reconsideration of that portion of our order which held that claimant's 1973 injury, from its inception, was a disabling injury. We abated our Order on Review to allow a sufficient opportunity for consideration of the employer's argument on reconsideration.

The employer asserts that, "The analysis employed in the Order on Review . . . will wreak havoc with claims which were once thought to be 'nondisabling,' but which, because (many years later) eventuated in disability, are thus to be recharacterized as something other than what they were when they occurred."

The employer's own claims processing information strongly suggests that, when the employer received notice of this injury claim in December of 1973, it was accepted and processed as a claim for a disabling injury. This is evidenced by the hand written inscription of "disabling" on that portion of the injury report form completed by the employer's claims processor. For purposes of the disposition of this case, therefore, we have not "recharacterized" this claim as something other than what it was thought to be when it occurred.

If the employer/insurer classifies a claim as nondisabling and conveys the requisite notice of this classification to the claimant, the claimant's right and duty to contest this classification arises at that time. No such notice was conveyed in this case, which we believe to have been the result of the employer's apparent belief that the claim was for a disabling injury, a belief most likely shared by claimant at that time.

The facts surrounding claimant's condition at the time of his injury in 1973, as well as the surrounding facts and circumstances concerning the processing of the claim at that time and thereafter, lead to the conclusion that it was appropriate to classify this claim as one for a disabling injury from its inception. Accordingly, we decline to modify our prior order as requested by the employer.

ORDER

On reconsideration of the Order on Review dated May 3, 1984, the Board adheres to its prior order which hereby is readopted and republished.

CLYDE W. EICHER, Claimant
Burt, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-07749 & 83-03393
June 18, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Seymour's order which modified the Determination Order by increasing claimant's award for claimant's nose injury from 32° for 10% to 160° for 50% unscheduled disability benefits. SAIF contends that claimant is entitled to an award of only 20%.

Claimant, who was 62 years of age at the time of the hearing, was working as a production welder when he received a traumatic injury to his face, particularly his nasal bones and nasal lasolacrimal ducts. As a result claimant lost his sense of taste and smell, and sustained a complete obstruction of his nasal lacrimal ducts due to scarring which impairs the drainage of tears from his eyes and nose resulting in excessive tearing and an inability to properly clear irritants from his eyes.

Claimant's job as production welder, which he had held for eleven years, involved irritating welding fumes. Therefore, claimant is unable to return to that job. His prior job as a linotype pressman, which he had held for 20 years, involved contact with fumes, dust, inks and oils which prevent him from returning to that profession. Claimant's work experience also includes two or three years of sales experience in the 1940s. He possesses three and a half years of college education as a pre-medical major. To his credit, claimant has been diligently looking for work, but has been unable to find a new job.

We find that, although claimant may not be able to return to two of his previous jobs or other work requiring exposure to noxious irritants such as fumes, dust and smoke, his disability is less than that awarded by the Referee because a large portion of the labor market is still available to him. Utilizing the guidelines at OAR 436-65-600 et seq., specifically OAR 436-65-645, and considering the social and vocational factors of this case, we find that claimant is entitled to an award of 96° for 30% unscheduled disability benefits for his injuries.

ORDER

The Referee's order dated October 12, 1983 is modified. Claimant is awarded 96° for 30% unscheduled disability benefits in lieu of prior awards. Claimant's attorney's fee shall be adjusted accordingly.

RONALD W. MOGLIOTTI, Claimant
Dennis H. Henninger, Claimant's Attorney
Keith D. Skelton, Defense Attorney

WCB 81-10963
June 18, 1984
Order on Remand

On review of the Board's Order on Review dated March 31, 1983, the Court of Appeals reversed the Board's order, remanded the matter to the Board, ordered the employer/insurer's December 16, 1981 denial set aside and awarded claimant's attorney a fee of $2,445. Claimant now moves the Board for an order awarding attorney's fees in addition to those awarded by the Court of Appeals.

The first hearing convened on October 5, 1981, and the employer made a motion to have the case dismissed on the basis of res judicata. A second hearing was held on February 25, 1982, and the parties agreed that the Referee should decide the dismissal issue prior to a decision on the merits.

On April 12, 1982 the Referee issued an order denying the employer's motion to dismiss. The employer requested Board review of that order. On June 4, 1982 the Board entered an order dismissing the employer's request for Board review as premature.

On July 21, 1982 the Referee issued an order upholding the employer's December 16, 1981 denial, and on March 31, 1983 the Board entered an order affirming the Referee's order. The matter then proceeded to the Court of Appeals.

Claimant argues that he is entitled to an additional award of attorney's fees on the grounds that this case was argued twice at the hearing and Board levels. We deny the claimant's motion.

In Hubble v. SAIF, 57 Or App 513 (1982), the court stated that in cases where a claim has been denied by the Board but the claimant prevails on review in the Court of Appeals, that:

> "We construe the statute to allow the award of attorney fees by this court for legal services rendered at both the Referee and Board levels, as well as for those rendered in this court." 57 Or App at 518. (Emphasis added.)

Thus, the attorney fee awarded by the court includes reasonable fees for legal services performed in representation of the claimant before the Referee and in the review by the Board. 57 Or App at 520.

In this case claimant was awarded attorney's fees in the amount of $2,445 by the Court of Appeals. In the absence of any indication to the contrary, it must be assumed, pursuant to Hubble, that claimant was awarded attorney's fees by the court for all services rendered by his attorney before the Referee and in the review by the Board.

Based on the above, claimant's motion for an award of additional attorney's fees is denied. The Board's order dated March 31, 1983 is vacated, and this claim is remanded to the employer/insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

WILLIAM C. MYERS, Claimant
Blair, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-09689 & 82-09690
June 18, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies requests review of Referee Quillinan's order which set aside its denial of claimant's aggravation claim. The issue on review is EBI's liability for payment of claimant's compensation pursuant to the provisions of ORS 656.273. A procedural issue is raised in EBI's appellant's brief by way of a motion to strike an exhibit which EBI contends the Referee erroneously admitted into evidence. EBI's motion is denied. We have considered the contested exhibit in our review; however, for the reasons stated in EBI's brief, we consider the exhibit as being of limited probative value. On the merits of the aggravation claim, we reverse.

Claimant initially sustained a compensable lumbar strain while

working for the employer as a route salesman. On December 5, 1980 claimant injured his low back while lifting a keg of beer. The claim was accepted and processed to closure by a May 18, 1981 Determination Order, which awarded approximately two weeks of temporary total disability. Prior to this industrial injury, claimant had experienced no difficulties with his low back.

Claimant continued working with this employer, and he lost no time from work in connection with his back injury for the ensuing year and a half. When claimant first returned to work, he apparently was performing a modified job loading trucks. He eventually returned to his regular work as a route salesman, which entails moving and lifting kegs and cases of beer. Claimant testified that a full 15-1/2 gallon keg of beer weighs approximately 160 pounds. Claimant, during the course of an ordinary day, would deliver between 24 and 60 of these kegs, some of which he lifted by hand. Claimant also handled approximately 100 cases of beer a day, which weigh 40 to 50 pounds each. Claimant apparently is an avid soccer player and plays on a weekly basis during the fall and winter.

During the year and a half preceding July of 1982, claimant sought no medical attention for low back problems. He did occasionally experience back pain related to lifting or certain movements at work and at home. Claimant testified that during these episodes he would have a difficult time standing erect, and that the pain associated with these episodes was similar to the pain he experienced at the time of his initial 1980 injury.

On Friday, July 9, 1982, claimant experienced back pain from his work activities that day, as he had on prior occasions after a day's work. On the following Saturday claimant limited his activities at home. During the day on Sunday claimant turned around and felt a pain in his back, which he described as "just another pain that let me know that my back was still hurting." During the remainder of that day, claimant's low back pain progressively worsened and spread into his hip and buttocks. His wife applied an ointment, claimant took some aspirin and lay down. Because his condition did not improve and he was unable to sleep, he went to the emergency room at Salem Hospital.

The record contains two medical reports (apparently) bearing on the condition of claimant's low back in July of 1982. One report, which is the subject of EBI's motion to strike, is an undated 827 form identifying EBI as the employer's insurer. The history given is low back pain with no history of injury and that claimant "twisted wrong." The physician's portion of the form indicates: "Pt. twisted while lifting at work today and has considerable amount of spasm and pain in the lower back. Has had similar kinds of injuries in the past, but it has been quite a while since he lost any work from this." The diagnosis stated is recurrent low back strain, related to work. This form contains the signature stamp of Dr. Floyd Strand.

Also in the record are office notes from Dr. Tiley, an orthopedic surgeon to whom claimant was referred by Salem Hospital. The first entry, dated July 19, 1982, recites claimant's prior history of low back episodes and the fact that claimant was referred from the emergency room with another such episode. The

office note continues: "He can think of two perhaps inciting physical episodes prior to onset of discomfort. One is some lifting of some beer barrels at work and the other is some soccer activity. * * * One wonders if we are not dealing with a little early disc degeneration at L4-5, perhaps even a little early disc protrusion."

The remaining office notes from Dr. Tiley indicate that claimant was examined on three subsequent occasions, the last being September 20, 1982, at which time claimant had returned to work full time. It was indicated that claimant was continuing to use a back brace and had to exercise caution in lifting. Dr. Tiley apparently planned a followup for a "final check" in two months. No other medical information is contained in the record.

The employer changed workers' compensation insurers in January 1982. On the date of claimant's July 1982 incident or exposure, the SAIF Corporation provided coverage for the employer.

On August 25, 1982 EBI denied claimant's aggravation claim, stating in effect that the available medical documentation tended to establish that claimant's current condition was due to a new incident or incidents and, therefore, not related to claimant's December 19, 1980 injury. EBI's denial also indicated that it no longer provided the employer's workers' compensation insurance. By denial letter dated December 24, 1982, the SAIF Corporation denied the claim, stating, "Based on the information obtained from you, your doctor, and your employer, it appears that the alleged injury to your back is not a direct result of your work activities, but attributable to a previous injury of December 5, 1980 and more recently, a twisting incident on [Sunday] July 11, 1982."

Claimant timely requested a hearing contesting both insurers' denials. Claimant's hearing request states in part:

> "I would respectfully suggest that these two hearings be set in tandem, and that in the meantime that [sic] a .307 hearing be conducted immediately to designate a paying agent to administer this claim and pay interim benefits. At this point, both carriers are denying responsibility for medical expenses and related compensation."

Subsequent correspondence from claimant's attorney to the Board states in part:

> "I would bring to your attention the fact that we requested that a .307 hearing be immediately commenced in connection with this file to designate an interim paying carrier since both carriers have denied the claim, each claiming the other is responsible. So far as I know, no action has been taken by the Hearings Division on that request. I would respectfully request you take a look at that matter immediately."

No order designating a paying agent was entered with respect to this claim. ORS 656.307 provides for entry of an order by the Director of the Workers' Compensation Department for the purpose

of designating an agent for payment of claimant's compensation if the claim is otherwise compensable. See generally OAR 436-54-330, et seq.

EBI and SAIF were both parties to this proceeding until the day that the hearing convened on April 29, 1983. On that morning, claimant and SAIF entered into a disputed claim settlement agreement pursuant to ORS 656.289(4), disposing of the "new injury claim" filed with SAIF. The hearing proceeded with only EBI as a party defendant, the issue being EBI's liability for payment of claimant's compensation pursuant to the aggravation statute, ORS 656.273. The settlement agreement entered into between SAIF and claimant was not reduced to writing and submitted to the Board until several months after the Referee's order had issued and EBI had requested review. The stipulation, therefore, was directed to the Board, and we have this day granted our approval of this disputed claim settlement agreement.

The fact that SAIF and claimant entered into a disputed claim settlement agreement is not directly relevant to the issue of EBI's liability pursuant to ORS 656.273; however, the Referee's evaluation of the evidence and claimant's arguments in support of his aggravation claim with EBI suggest that it may be beneficial to discuss certain considerations related to our approval of the disputed claim settlement, which do have a bearing upon our disposition of the issue before us on review, albeit indirectly.

The Referee determined that regardless of which legal standard one applies to the evidence of record, the evidence preponderates in favor of the conclusion that claimant's aggravation claim is compensable. The two legal standards of choice are the standard enunciated in Grable v. Weyerhaeuser Co., 291 Or 387 (1981) (whether industrial injury remains material contributing cause of worsened condition which is also caused in part by subsequent nonindustrial injury); and the standard for determining employer/insurer responsibility in cases involving successive industrial injuries, or the rule of Smith v. Ed's Pancake House, 27 Or App 361 (1976) (last injurious exposure rule). See SAIF v. Luhrs, 63 Or App 78 (1983); Wesley E. Graham, 35 Van Natta 1303 (1983); see also Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). In his argument on review, claimant appears to rely primarily upon appellate decisions involving issues of employer/insurer responsibility in which it was determined that the claim was the responsibility of the "aggravation insurer" rather than the "new injury insurer." See, e.g., Calder v. Hughes & Ladd, 23 Or App 66 (1975); Buchanan v. Owen Chevrolet, 44 Or App 31 (1981); Fireman's Fund Ins. Co. v. Ore. Ptld. Cement Co., 63 Or App 63 (1983).

This case presents compensability issues as well as responsibility issues; therefore, claimant's reliance upon principles and standards associated with responsibility law is misplaced. Before these principles come into play, it first must be established, essentially as a threshold matter, that this claim is compensable, regardless of which employer/insurer pays claimant's compensation. It is claimant's burden to prove the compensability of this claim. Claimant has already decided that it is in his best interest to resolve the denial of his "new injury" claim with SAIF by a disputed claim settlement agreement; therefore, the only remaining issue is the compensability of the aggravation claim with EBI Companies.

EBI contends that, in order to establish that his worsened back condition in July of 1982 is compensably related to his December 1980 industrial injury, claimant is required to produce persuasive medical evidence establishing this causal connection. EBI relies, in part, upon Oakley v. SAIF, 63 Or App 433 (1983). The Supreme Court very recently considered Oakley, a case involving the compensability of an aggravation claim, in Garbutt v. SAIF, 297 Or 148 (1984), in which the issue was the extent of claimant's unscheduled permanent partial disability. The Garbutt court stated that the Court of Appeals in Oakley was incorrect in stating that "an aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient." The Garbutt court further stated:

> "We allowed review in this case to make clear that a physician's report is not indispensable in a workers' compensation claim. In the case of an 'extent of disability' claim, such as this claim, as in the case of an aggravation claim, no physician's report is required to be statutorily sufficient. The worker's or other lay testimony may or may not carry the worker's burden of proving the extent of disability, but the law does not mandate a medical report. The same is true for an aggravation claim." 297 Or at ___.

We do not understand EBI in this case to argue that, as a matter of law, claimant has failed to establish the compensability of his aggravation claim for lack of proper medical verification. Rather, EBI contends that, as a matter of fact, persuasive medical evidence of a materially causal relationship between an industrial injury and a subsequently worsened condition is necessary in order to satisfy the claimant's burden of establishing medical causation in this case. EBI further contends that, based upon the facts and circumstances presented herein, this burden cannot be satisfied by lay testimony alone. We agree.

As a general proposition, we believe that the causal relationship between an industrial injury and a subsequently worsened condition is a question of science which must necessarily be determined by skilled, professional persons. See Uris v. Compensation Department, 247 Or 420, 424 (1967). We understand the court in Garbutt v. SAIF, supra, to have held that medical evidence is not always, as a matter of law, required in order for the claimant to satisfy the burden of proving compensability (or, as in Garbutt, extent of disability). We do not understand the Supreme Court's recent decision to change the longstanding principle that it is the claimant's burden to prove entitlement to the relief requested and that, in many cases, depending upon the nature of an injury or condition, competent medical evidence is necessary to satisfy this burden.

We find and hold that claimant has failed to establish, by a preponderance of the persuasive evidence, the requisite causal connection between his 1980 industrial injury and his worsened low back condition in July of 1982. We agree with EBI that, under the facts and circumstances of this case, some persuasive medical

evidence of a causal connection is required. This record is devoid of any such evidence. There is a possible inference that the 827 form carrying Dr. Strand's signature was completed at or about the time of claimant's visit to the emergency room in July of 1982; however, the only statement of causation contained in that form is the "yes" box which is marked in response to the question, "Is condition work related?" This check-the-boxes response is inadequate, in and of itself, to establish medical causation. See Joyce F. Adair, 34 Van Natta 203, 204 (1982); cf. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). This form, assuming it is otherwise reliable, adds little or nothing to claimant's testimony.

The only other medical evidence is the information contained in Dr. Tiley's office records. The office note entry recorded at the time of claimant's initial visit, as indicated above, indicates lifting beer barrels at work and soccer activity as possible inciting episodes. These references, of course, are not "medical opinion evidence" in the sense of a physician's statement of an opinion on causation; rather, they are more in the nature of the physician's recitation of the claimant's history. Even if these comments were to be considered an expression of the physician's opinion, no reference is made to claimant's 1980 industrial injury as a possible cause of the current medical problem. Indeed, the only opinion expressed by Dr. Tiley, although it may be speculative, is the suggestion that claimant may be suffering from early disc degeneration at the L4-5 level, or even a slight disc protrusion.

The circumstantial evidence of claimant's back difficulties after his December 1980 industrial injury is insufficient to establish the causal connection between that injury and claimant's back difficulties in July of 1982. This is particularly true in light of the facts that claimant's 1980 injury was a relatively minor low back strain resulting in approximately two weeks of time loss and no apparent permanent disability; and that claimant's return to his pre-injury employment was relatively prompt. In addition, the intervening one and one-half year period of heavy, vigorous work activity is a factor which must be considered.

The evidence of record establishes merely the possibility that claimant's July 1982 back difficulties are causally related to his December 1980 industrial injury. This is insufficient to sustain claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055, 1060 (1981). We hold that claimant has failed to establish that his December 5, 1980 industrial injury is a material contributing cause of the acute back difficulties he experienced during July of 1982. Accordingly, we reverse the Referee's orders holding to the contrary.

ORDER

The Referee's orders dated May 16, 1983 and June 14, 1983 are reversed, and EBI's denial dated August 25, 1982 is reinstated and affirmed.

MARGUERITE M. NEILSON, Claimant
Michael Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 79-10995 & 82-11189
June 18, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Seymour's order which awarded claimant permanent total disability. Prior to the hearing, claimant had received awards of 15% (48°) unscheduled permanent disability for injury to her right shoulder, 45% (144°) unscheduled permanent disability for injury to her low back, and 5% (7.5°) scheduled permanent disability for loss of her right leg. SAIF contends that claimant is not permanently totally disabled. We agree and reverse the Referee's order.

We make the following findings of fact. Claimant injured her right shoulder in 1977 while working as a school bus driver. She underwent surgery for adhesive capsulitis in February 1979. Claimant's treating doctor, Dr. Boyd, recommended that claimant return to modified work, but he raised questions about her motivation to do so. Claimant returned to work for four days in October 1979 at a job provided by her employer, the school district, but was unable to function with her shoulder pain.

Claimant was evaluated at the Northwest Pain Clinic in December 1979, where more questions about her motivation to participate in a vocational program and return to work were raised. When Orthopaedic Consultants later evaluated claimant's shoulder, they noted antalgic weakness of abduction in the right arm and mild to moderate functional overlay shown by inconsistencies and refusals.

The school district offered claimant another job which claimant accepted. On July 18, 1980 claimant slipped and fell at work, injuring her low back. Dr. Boyd found claimant to have a moderate degree of functional overlay, noted that she tended to feel pain more than others and that she had used prescriptive drugs such as Percodan inappropriately in the past. Claimant then began treatment with Dr. Poulson, who diagnosed a degenerated lumbosacral disc. Claimant declined the surgery Dr. Poulson offered. The February 1981 Callahan Center reports noted marked functional overlay and difficulties assessing claimant's physical capacities because of her questionable performance during examination, and opined that claimant could perform light work if she was motivated to do so. Dr. Stevens examined claimant in June 1981, noted that claimant did not attempt to influence him in favor of extreme disability and diagnosed L5 radiculopathy.

The school district employer offered claimant a third modified job which claimant accepted in August 1981. On August 11, 1981, claimant's right hip gave out and claimant fell. Claimant has not worked since that time. Claimant continued receiving care from Dr. Freeman, chiropractor, from whom she had received treatments since her original injury. Dr. Tsai saw claimant and diagnosed a herniated nucleus pulposus at L4-5. The BBV Medical Services examined claimant and noted that a CT scan showed evidence of a ruptured disc, but that claimant's clinical symptoms were masked by hysterical neurosis and moderate to severe functional overlay.

Dr. Snodgrass examined claimant at the request of the insurer and noted difficulties in assessing claimant's neurological weakness due to either claimant's conversion reaction or poor effort. Dr. Tsai disagreed with Dr. Snodgrass that claimant had overwhelming functional overlay, but referred her to Dr. Straumfjord for psychiatric evaluation. Dr. Straumfjord made no psychiatric diagnosis, and noted that claimant's complaints of pain seemed valid and that she seemed to accept her present circumstances.

Dr. Tsai eventually performed a laminectomy and discectomy at L5-S1 in March 1982. For the first two months following the surgery, claimant's condition improved. Then claimant began having increased right leg pain. In July 1982 Dr. Tsai diagnosed sensory conversion reaction and recommended evaluation by the Orthopaedic Consultants as soon as possible. The Consultants noted in September 1982 that claimant walked with a slight right leg limp, that she was physically capable of sedentary work, with limitations on bending, stooping, squatting and twisting, and that her loss of function due to her low back injury was moderate. Dr. Freeman diagnosed "severe pinch of right sacral nerve roots due to subluxation of L4, L5 and S1," and reiterated that claimant continued to have severe right leg pain and was able to work at a sedentary type of job for three or four hours per day with restrictions.

Claimant testified that she usually walks with a cane or holds onto something when standing due to right leg pain and weakness which causes her to fall frequently. At the time of hearing she lived with her daughter, who performed most household duties and who helped claimant put on her shoes and wash her hair, which claimant was unable to do. Claimant's daughter corroborated claimant's testimony. Claimant also testified to having difficulties standing more that fifteen minutes or sitting more that 30 minutes. Claimant's daughter testified that claimant spends three-quarters of her time lying down.

We have some difficulty accepting claimant's and her daughter's descriptions of claimant's physical limitations in light of the contrary medical evidence. The Orthopaedic Consultants' September 1982 report revealed that claimant walked with a slight limp, had a moderate impairment and was capable of sedentary work. No doctor has stated that claimant is incapable of working. In addition, most of the doctors who have treated or examined claimant have reported marked functional overlay, questionable motivation or conversion reaction. Claimant's motivation is further questioned by the fact that claimant did not seek work at any time since her March 1982 surgery and has not contacted the school district, who has shown considerable willingness to place claimant in a job within her restrictions.

We find that claimant's impairment is moderate and that she is capable of sedentary work. Furthermore, we do not believe that claimant's physical limitations would have made an attempt to find work futile. Inasmuch as claimant has not met the seek-work requirement of ORS 656.206(3), we are unable to find claimant permanently and totally disabled.

In evaluating claimant's permanent partial disability, we find that claimant has been adequately compensated for loss of use of her right leg by the award of 5% scheduled permanent disability. We further find, however, that the cumulative unscheduled permanent

partial disability awards of 60% (192°) do not adequately compensate claimant for her loss of earning capacity due to her right shoulder and low back injuries.

We evaluate claimant's loss of earning capacity considering the factors listed in ORS 656.214(5) and the guidelines found in OAR 436-65-600 et seq. Considering claimant's impairment, including her disabling pain, her age, education, work experience, adaptability and other social and vocational factors results in a disability rating of 75%. Comparing this case with other similar cases, we find that an award of 75% unscheduled permanent disability adequately compensates claimant for loss of earning capacity due to her right shoulder and low back injuries.

ORDER

The Referee's order dated July 25, 1983 is reversed. Claimant is awarded 75% (240°) unscheduled permanent disability for injury to her right shoulder and low back and 5% (7.5°) scheduled permanent disability for loss of her right leg, in lieu of all previous awards. This award represents an increase of 15% (48°) unscheduled disability over that previously awarded by Determination Orders. Claimant's attorney fee shall be adjusted accordingly.

SIMON ZINGANI, Claimant
Pozzi, et al., Claimant's Attorneys
Richard C. Pearce, Defense Attorney

WCB 81-06993
June 18, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of those portions of Referee Knapp's order which declined to award claimant benefits for permanent total disability and which upheld the insurer's denial of claimant's aggravation claim. Claimant contends that the Referee erred on both counts.

As a preliminary matter, claimant requests that the Board remand this case to the Referee for the receipt of a medical report by Dr. Caldwell dated January 21, 1984. Claimant's request for remand is denied. This record contains a total of 178 exhibits, which we think hardly indicates an incompletely developed record. A review of the proffered medical report -- which we have considered only to the extent necessary to make a determination on the remand question -- does not establish that it would be material or that it could conceivably have any effect on the outcome of this case. Moreover, although this January 1984 report was obviously not in existence when the Referee closed the record in this case in September 1983, there is nothing in claimant's motion which explains why the substance of this report was not previously obtainable with due diligence.

With regard to the issues concerning permanent total disability and aggravation, we agree completely with the Referee and affirm his order with one minor typographical correction. The Referee's order states in part: "The carrier's June 1, 1982 is affirmed." The correct date of the denial is June 2, 1983.

ORDER

As corrected above, the Referee's order dated September 19, 1983 is affirmed.

SHIRLEY C. GUNNELS, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01245
June 19, 1984
Order Denying Motion to Remand

Claimant moves the Board for an order remanding this matter for a new hearing and the taking of additional evidence. ORS 656.295(5). This case is currently pending before the Board as a result of claimant's March 12, 1984 request for Board review.

Claimant's attorney has submitted an affidavit which lists the names and addresses of five individuals who, according to claimant's attorney, "are willing to testify in claimant's behalf regarding the circumstances of the claimant's inguinal hernia condition, which, it is alleged, was sustained in the industrial accident at Good Samaritan Hospital." Claimant's attorney additionally states:

> "I have also been informed that two of the witnesses at the hearing were in collusion for the purpose of depriving the claimant of the Workers' Compensation benefits to which he is entitled under the Workers' Compensation Act. I have knowledge of at least one witness who can testify to such collusion, and am currently in the process of seeking other witnesses who have knowledge of this collusion."

The SAIF Corporation opposes claimant's request for remand. SAIF argues that the evidence claimant desires to offer is not newly discovered evidence, but was obtainable with due diligence prior to the hearing.

We deny claimant's request for remand. Claimant requested a hearing on this matter on February 4, 1983. Due to inaction on the part of claimant, Presiding Referee Daughtry issued an Order to Show Cause on June 1, 1983 why the case should not be dismissed as abandoned. Claimant's attorney responded on June 2, 1983 that additional time had been needed to obtain further medical evidence. The Order to Show Cause was vacated on June 17, 1983.

The case finally proceeded to hearing before Referee Menashe on November 16, 1983. Even then, however, the record was left open for the submission of additional evidence from claimant. That evidence was submitted on November 21, 1983. On December 30, 1983 claimant's attorney informed the Referee that claimant desired to introduce additional evidence and requested the record remain open. SAIF objected on the basis that the case had already been unnecessarily prolonged, that the evidence would have been obtainable with due diligence before the hearing and that any additional witness testimony could have been presented at the hearing. The Referee apparently agreed with SAIF as he denied claimant's request and closed the record on January 18, 1984.

We find that claimant has had more than an adequate opportunity to gather the evidence necessary to present her claim. There is no indication from claimant why the witnesses listed in the affidavit were not available prior to the hearing or why they were not contacted in the substantial amount of time

which passed between claimant's request for hearing and the actual date of hearing.

Even if, as claimant alleges, there was collusion between witnesses at the hearing, this still does not explain the discrepancies in claimant's testimony which the Referee found unreliable. Moreover, the affidavit signed by claimant's attorney does nothing more than state that he has been informed of possible collusion and that he has "knowledge" of at least one witness who could so testify. Had claimant submitted an affidavit from one or more of the witnesses alleged to have knowledge of collusion, we would have been inclined to grant claimant's request. Should claimant obtain such an affidavit, however, prior to the time the Board issues a final Order on Review in this matter, the motion may be renewed. Under the circumstances at the present time, however, we cannot say that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5); Bailey v. SAIF, 296 Or 41 (1983). Claimant's request for remand is, therefore, denied.

IT IS SO ORDERED.

JAMES R. KUNST, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-10956
June 19, 1984
Order on Reconsideration

On March 9, 1984 the Board issued its Order on Review (Remanding) herein. On March 26, 1984 claimant requested reconsideration of the Board's March 9, 1984 order. The Board abated its order on March 30, 1984 to allow sufficient time to receive the insurer's response and to consider claimant's motion.

On reconsideration, the Board adheres to its March 9, 1984 order with the following comments.

Claimant filed a back injury claim which was accepted as nondisabling. The insurer paid time loss benefits for about two months but then unilaterally terminated those benefits. Claimant requested a hearing on the unilateral termination of time loss benefits. After that hearing, the insurer denied compensability of the claim based on doubts raised by claimant's testimony at the hearing on time loss benefits. Claimant requested a hearing on that denial.

The Referee held that the insurer was barred by res judicata from denying compensability because the insurer could have raised the compensability issue at the first hearing on time loss benefits, and by failing to do so, it waived its right to deny, citing Mavis v. SAIF, 45 Or App 1059 (1980) and Million v. SAIF, 45 Or App 1097 (1980). On review, the Board found that Mavis and Million were not dispositive, found that Bauman v. SAIF, 295 Or 788 (1983), does not place a time limit on back-up denials issued by insurers on the basis of fraud, and reversed and remanded the case for a hearing on the merits of the insurer's denial.

Claimant contends that long before the hearing on termination of time loss benefits, the insurer was aware of the grounds on which it denied the claim. In support of this contention, claimant refers to the injury report on which the employer noted the reason why it doubted the validity of the claim, "Employee did

not complain of injury until approximately one week after it supposedly occurred." Claimant argues that the insurer "could have denied claimant's claim at any time up to the hearing and thus raised and litigated the issue of compensability." Consequently, claimant argues, the order regarding termination of time loss benefits bars further litigation of the issue of compensability by application of the doctrine of res judicata.

In Million v. SAIF, 45 Or App 1097 (1980), the court stated:

> "Res judicata . . . applies not only to every claim included in the pleadings but also to every claim which could have been alleged under the same 'aggregate of operative facts which compose a single occasion for judicial relief.' Taylor v. Baker, 279 Or 139, 144, 566 P2d 884 (1977); Dean v. Exotic Veneers Inc., 271 Or 188, 194, 531 P2d 266 (1975)." 45 Or App at 1102.

The Board has addressed the application of res judicata in the following situations where, at the time of the first hearing, the insurer had not issued the denial of the claim sought to be litigated at a subsequent hearing.

In Samuel Weimorts, 32 Van Natta 198 (1981), the Referee held that the claimant was barred from litigating the issue of compensability of his low back treatment because he could have litigated that issue at the time of a December 14, 1979 stipulation involving extent of disability of claimant's foot. The claimant made his claim for low back treatment on October 26, 1979. At the time of the December 1979 stipulation, no denial of that treatment had issued and no denial was issued until April 24, 1980. The Board held that the claimant was not barred from litigating the issue of his low back treatment because at the time of the stipulation, no denial had issued and the time within which to accept or deny had not expired.

In Hettie M. Eagle, 33 Van Natta 671 (1981), SAIF argued that the claimant was barred from litigating the compensability of medical bills because she could have litigated that issue at the first hearing on premature closure and extent of disability, in that the medical bills were unpaid at the time of the first hearing. The Board held that the claimant was not barred from litigating the issue because at the time of the first hearing, the medical bills had not been denied and the time within which the insurer had to accept or deny had not expired.

In Kevin McAllister, 34 Van Natta 158 (1982), the Referee found that the claimant was barred from litigating the issue of aggravation/new injury because he failed to do so at a prior hearing on extent of disability related to a 1979 injury. The incident giving rise to the aggravation/new injury issue happened on July 1, 1980. The hearing on extent was held on about July 15, 1980. Thereafter, SAIF denied the new injury and aggravation claims and the claimant requested a hearing on both denials. The Board held that the claimant was not barred from litigating the aggravation/new injury issue because at the time of the first hearing, those claims had not been denied and the time within which SAIF had to accept or deny had not expired.

In John Losinger, 36 Van Natta 239 (1984), the Referee found the claimant was barred from litigating issues of hand surgery and a shoulder claim because he failed to litigate those issues at the first hearing on extent of disability. The Board found that the claimant was not barred from litigating those issues because at the time of the first hearing, the insurer had not denied the hand surgery or compensability of the shoulder.

In all of the cases discussed above, the insurers contended that the claimants were barred from litigating issues which the insurers argued, could have been raised at the first hearing. The Board rejected the insurers' contentions, holding that the issues the claimants sought to litigate at the second hearing were not ones that could have been litigated at the first hearing because no denial had not been issued at the time of the first hearing. In these cases, the Board generally relied upon Million v. SAIF, supra, and Syphers v. K-W Logging Inc., 51 Or App 769 (1981).

By contrast, in the case at hand claimant contends that the insurer is barred from denying a claim which claimant argues could have been denied at the previous hearing. The posture of this case would be similar to that of the Board cases discussed above if the insurer here was contending that claimant was barred from litigating compensability because claimant could have litigated compensability at the prior hearing on termination of time loss benefits. If that were the posture of this case, we would have no problem finding that claimant is not barred from litigating compensability, in accordance with the Weimorts, Eagle, McAllister, Lossinger, line of cases discussed above, because no denial had been issued at the time of the first hearing.

Although application of res judicata is urged by a different party here than in the other Board cases discussed above, the pivotal question remains the same: Could compensability have been litigated in the prior proceeding? In Farmers Ins. v. Hopson, 53 Or App 109 (1981), a case involving the res judicata effect of a Board's Order on Reconsideration on the insurer's right to a hearing on a Determination Order, the court stated:

> "Generally stated, the doctrine of res judicata applies where a subsequent action is brought involving the same parties (or their privies) and the same claim or cause of action. Its effect is to preclude relitigation of any issues which were determined or which could have been determined in the initial case. Waxwing Cedar Products v. Koennecke, 278 Or 603, 610, 564 P2d 1061 (1977). This terminology is not directly analogous to the administrative proceedings involved here; it is perhaps more useful to inquire whether the issues to be determined on reconsideration are identical or necessarily include the issues which would be determined at the hearing on extent of disability. Shannon v. Moffett, 43 Or App 723, 604 P2d 407 (1979), rev den (1980)...." 53 Or App at 114.

We interpret the res judicata effect of "precluding relitigation" discussed in Hopson, supra, to be an absolute preclusion. That is, if one party would be barred from relitigating the issue, the other party is also barred. Therefore, inasmuch as claimant would not be barred from litigating compensability of the claim in a second hearing, in accordance with the Weimorts line of cases, the insurer likewise cannot be barred from denying the claim on the grounds of res judicata. Furthermore, the compensability issue the insurer now seeks to raise through its denial is not one which is identical to or necessarily included in the time loss issue litigated at the first hearing. Hopson, supra.

Nevertheless, we have misgivings about an insurer terminating time loss, appearing at a hearing on that issue without raising the issue of compensability of the claim, then later denying the claim. First, the Board has long objected to a proliferation of hearings. We expect that a request for hearing will resolve all matters at one time that can be resolved at that time, and that the conclusion of an order extends not only to matters actually determined but to other matters that could have been determined. Elfreda Puckett, 8 Van Natta 158 (1972).

Second, we believe that an insurer's vacillating activity injects a level of instability into the system that should be discouraged. Our concern in that regard, however, has been addressed by Bauman v. SAIF, 295 Or 788 (1983), which held that an insurer, after officially accepting a claim and after 60 days have elapsed, may not deny compensability of the claim unless fraud, misrepresentation or other illegal activity is shown. Therefore, our concerns in this case are resolved not by application of res judicata, but by application of the holding in Bauman. Bauman, however, does not place a time limit on backup denials based on fraud, etc., such as that involved in this case. Accordingly, we find that the insurer is not barred from denying compensability of the claim, on the basis of fraud, after the hearing on time loss benefits or at any other time. Had the insurer's denial not been based on fraud, misrepresentation or other illegal activity, we would find that the insurer was barred from denying compensability, not on the basis of res judicata, but on the basis of Bauman.

Moreover, another underlying concern addressed in the Weimorts line of cases is that the scheduling of a hearing on one issue does not work to cut short the statutory time limits applicable to the actions of either the claimant or the insurer. That is, in Weimorts, Eagle, and McAllister, to require the claimant to litigate the issue at the first hearing would have cut short the insurers' right to deny at any time within 60 days. ORS 656.262(6). We have serious doubts about applying a doctrine that will reduce an insurer's or claimant's right to act within a time period specified by statute. Similarly, to require the insurer in this case to deny compensability at the first hearing would have affected the insurer's right to deny on the basis of fraud, etc., a right which is not limited by any time period.

Therefore, we hold that the insurer is not barred from denying compensability of the claim. We adhere to our prior order which is republished as of the date of this order.

ORDER

On reconsideration, the Board adheres to and on this date republishes its Order on Review (Remanding) dated March 9, 1984, as supplemented herein.

CLARENCE J. RODGERS, Claimant
Bottini & Bottini, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10142
June 19, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee St. Martin's order which affirmed the October 20, 1982 Determination Order which awarded him 30% (96°) unscheduled permanent partial disability as a result of his back injury. Claimant contends the award was insufficient and that he should have been awarded an insurer-paid attorney's fee for prevailing on the SAIF Corporation's cross-request from the Determination Order.

Claimant's contention that he should have been awarded an insurer-paid attorney's fee has recently been resolved adversely to his position in Gleason W. Rippey, 36 Van Natta 778 (May 30, 1984). In Rippey we found that the claimant was not entitled to an insurer-paid attorney's fee where the insurer did not initiate the hearing nor raise any new issues at the hearing.

On the question of the extent of claimant's disability, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated May 27, 1983 is affirmed.

THOMAS A. THOMPSON, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02840
June 19, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of that portion of Referee Braverman's order which awarded claimant's attorney an insurer-paid fee of $3,000 for services at hearing in prevailing on a denied claim. SAIF contends that the attorney fee is excessive.

Claimant filed an occupational disease claim for asbestosis which SAIF denied. Claimant requested a hearing. Ten exhibits were submitted at hearing which included only three medical reports. Claimant and Dr. Lawyer, an expert on pulmonary diseases, testified at hearing. The Referee set aside SAIF's denial. Claimant's attorney submitted an affidavit indicating that he has significant expertise in asbestosis claims, and that he spent about 13 3/4 hours on this case. He requested an attorney's fee of $3,000 which the Referee awarded.

"Attorney fee awards are based on efforts expended and results obtained." Derry Blouin, 35 Van Natta 570 (1983). Considering the efforts expended, the acknowledged expertise of

claimant's attorney and the results obtained, we conclude that $2,000 would reasonably compensate claimant's attorney for his services at hearing.

ORDER

The Referee's order dated October 3, 1983 is modified. The attorney's fee awarded to claimant's attorney for services at hearing is reduced from $3,000 to $2,000.

JUANITA R. TREVINO, Claimant
January Roeschlaub, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-01912 & 80-07954
June 19, 1984
Order on Remand

The Board entered its Order on Review herein on May 14, 1982, affirming the Referee's order which found that claimant had failed to establish a worsening of her right knee condition since the last arrangement of compensation. The Board also affirmed the Referee's order insofar as he determined that claimant had failed to timely request a hearing contesting the SAIF Corporation's denial of claimant's 1980 left knee condition, which SAIF contended was not causally related to claimant's 1977 right knee injury. 34 Van Natta 632 (1982).

On review of the Board's order, the Court of Appeals determined that, although claimant had failed to timely request a hearing with respect to SAIF's May 1980 denial of claimant's left knee condition (which was processed as a new claim independent of claimant's original 1977 injury claim), claimant had established that her original 1977 claim was for injury to both legs, that in June of 1980 claimant had perfected an aggravation claim relating to a worsening of her left knee condition, and that SAIF had failed to accept or deny this 1980 aggravation claim with respect to claimant's left knee condition. The court reversed and remanded with instructions that claimant's 1980 left knee aggravation claim be accepted and for a determination of appropriate penalties and attorney fees for SAIF's failure to timely accept or deny this aggravation claim. Trevino v. SAIF, 66 Or App 410 (1984).

SAIF contends that the scope of the issues before the Board on remand includes a determination of whether SAIF's claims processing warrants imposition of a penalty and associated attorney's fee; i.e. whether SAIF's conduct was unreasonable. ORS 656.262(10); 656.382(1). Claimant contends that the court has already made the determination that SAIF's claims processing does warrant imposition of penalties/attorney fees (i.e. was unreasonable), that this is now the law of the case, and that the only determination for the Board on remand is the amount of the penalty/attorney fee to be imposed. We agree with claimant.

The court's opinion states in part:

> "We conclude that claimant made an aggravation claim for her left knee injury and that she has met her burden of proving a worsening in her condition since the last award of compensation. Because SAIF failed to accept or deny the aggravation claim, in

> spite of its investigation and claimant's attorney's request for the disposition of that claim, it is subject to penalties and attorney fees." 66 Or App at 414.

Read in context with the preceding portions of the court's opinion, this language clearly states the court's conclusion that imposition of a penalty and associated attorney's fee is warranted, based upon the apparent finding that there was evidence of unreasonable claims processing in connection with claimant's 1980 aggravation claim. We are not at liberty on remand to substitute our own judgment in this regard.

As to the question of the amount of the penalty that should be imposed in accordance with the court's mandate, the following passage from our Order on Review is relevant:

> "Claimant's brief refers to 'a claims history tangled enough to result in . . . a monumental misapprehension on the part of the Hearing Referee.' We agree that both the claims history and this record are confusing. We do not agree that there was a misapprehension on the part of the Referee; or, alternatively, we share that misapprehension." 34 Van Natta at 632.

The court's opinion also reflects the procedural confusion underlying this claim. "Although the case has developed into a procedural morass, we conclude that there was an aggravation claim made and that that claim should be allowed." 66 Or App at 412.

Each factfinder presented with the background of this case found it procedurally confused and/or confusing. It is reasonable to assume, therefore, that the individuals responsible for processing this aggravation claim found it equally confused and confusing. With this in mind, we find it is appropriate to require SAIF to pay claimant a penalty equal to 5% of the compensation "then due" at the time of the July 15, 1981 hearing, in connection with claimant's June 1980 left knee aggravation claim.

As to the penalty-associated attorney's fee, we consider the nature of the conduct warranting imposition of the penalty, Zelda M. Bahler, 33 Van Natta 478, 481 (1981), rev'd on other grounds, 60 Or App 90 (1982); and the efforts expended by counsel in prevailing on the penalty issue. We note that the Court of Appeals has awarded a reasonable attorney's fee for services rendered at the hearing, Board and court levels in connection with the issue of the compensability of this aggravation claim, see Zelda M. Bahler, supra; and we have taken into account the fact that claimant's attorney has rendered additional services before the Board on remand in connection with the penalty issue. See ORS 656.388(1). Considering all of these factors, we find that a reasonable attorney's fee pursuant to ORS 656.382(1) is $650.

ORDER

In accordance with the order of the court, the Order on Review dated May 14, 1982 is vacated, and claimant's 1980 left knee aggravation claim is remanded to the SAIF Corporation for acceptance and payment of benefits according to law. SAIF shall

pay claimant 5% of the compensation due claimant as of the date of hearing herein, as and for a penalty for SAIF's failure to accept or deny this aggravation claim. In addition, SAIF shall pay claimant's attorney $650 as an associated attorney's fee.

DEWEY R. BEGLEY, Claimant
Malagon, et al., Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 83-00588
June 21, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of those portions of Referee Seymour's order which: (1) Set aside its partial denial of psychiatric treatment; (2) awarded claimant "a penalty of 15% of any unpaid medical bills," apparently on the basis that the partial denial was unreasonable; and (3) increased claimant's award of permanent disability from 112° for 35% to 160° for 50% unscheduled permanent disability due to claimant's low back injury. Claimant cross-requests review of those portions of the Referee's order which declined to remand the psychiatric condition for processing until reclosure and which awarded only a 15% penalty and a $600 fee to claimant's attorney. Claimant contends he is entitled to a 25% penalty and an attorney fee in the amount of $1000 for his success in overturning the denial and obtaining a penalty.

Claimant sustained a compensable low back injury in January 1981, which ultimately led to surgery. According to claimant, the surgery produced unusually poor results. In early 1982 claimant was referred to a psychiatrist, Dr. Brown, who initiated treatment. The last report in the record from Dr. Brown is dated April 31, 1982. A fair summary of that report would be that the doctor opined: (1) Claimant had a psychiatric condition which existed before his January 1981 industrial back injury; (2) the back injury and its consequences caused at least a temporary symptomatic aggravation of claimant's preexisting psychiatric condition -- an aggravation that might only be a temporary flare up because it remained possible that claimant would return "to some approximation of his premorbid personality"; (3) whether claimant's psychiatric deterioration was a temporary or a permanent problem could not be determined as of April 1982; (4) further curative psychiatric treatment was required for an "undetermined" length of time; and, therefore (5) claimant was not then medically stationary.

Subsequently, claimant was examined by another psychiatrist, Dr. Quan, at the insurer's request. Dr. Quan reported on May 24, 1982 that, although claimant's psychiatric condition was not then stationary, he felt that "another three or four months of active therapy might be sufficient."

At the insurer's request, claimant was examined by Dr. Holland, psychiatrist, on September 15 and October 4, 1982. In an October 12, 1982 report, Dr. Holland expressed opinions that generally supported the notion that claimant's late 1982 psychiatric symptoms and treatment were compensable consequences of claimant's early 1981 back injury, but even in that report Dr. Holland cautioned, "a sunset clause [should] be placed upon [claimant's] psychiatric treatment so that he does not become habituated to it." After receiving Dr. Holland's October report,

the insurer advised the doctor that its understanding of claimant's history and situation was different than the data stated in the October report. Dr. Holland then issued another report, dated December 22, 1982, in which he modified some of the opinions he had stated in his earlier October report. Dr. Holland ultimately stated: "It is my opinion [claimant's] behavior is a result of his [preexisting] Axis II diagnosis and not an indication of the persistence of a psychiatric syndrome attributable to his industrial injury."

Presumably in response to Dr. Holland's revised opinion, on January 4, 1983 the insurer issued a partial denial of "past and ongoing psychiatric treatment." As previously indicated, the Referee set aside this partial denial.

The parties' arguments and, to some extent, the Referee's order suggest that it is appropriate in this case to break the partial denial into two component parts for separate analysis: (1) A denial of past treatment; and (2) a denial of treatment beyond January 4, 1983. As for the treatment before that date, we understand the insurer's present position to be that its denial was overbroad and incorrect in denying past treatment. And if the insurer is not conceding that point, we think it should be because we agree completely with the Referee's finding that "the initial psychiatric treatment was necessitated by the industrial injury." (Emphasis added.)

As the parties' positions have become refined on review, the real dispute now centers on whether claimant established entitlement to continuing psychiatric treatment beyond January 1983. We conclude that he did not. All three doctors who have expressed opinions on the relationship between claimant's industrial back injury and subsequent psychiatric problems have noted either a possibility or a probability that claimant's injury and surgery, etc., produced only a temporary exacerbation of claimant's preexisting personality problems. We read Dr. Brown's April 1982 report as recognizing that as a possibility. We read Dr. Quan's May 1982 report as opining that is a probability. And we read Dr. Holland's ultimate December 1982 report as agreeing with Dr. Quan's position about a temporary symptomatic exacerbation. In short, the trend in the medical reports generated throughout 1982 is toward increasingly strong expressions of opinion that claimant's continuing psychiatric treatment was for a preexisting problem rather than for the secondary consequences of his back injury. Moreover, by the time the insurer partially denied further psychiatric treatment, claimant was about two years post-injury and had received psychiatric treatment for about a year.

Under all of these circumstances, we think that in order to sustain his burden of proof on the partial denial, it was incumbent upon claimant to produce some evidence that his need for psychiatric treatment beyond January 1983 was causally related in a material sense to his January 1981 back injury. Claimant produced no such evidence. Dr. Brown's April 1982 report states that claimant's psychiatric treatment remained injury-related at that time, but no later information from Dr. Brown about the nature of or need for psychiatric treatment beyond January 1983 was produced at hearing. From the point of view of whether claimant sustained his burden of proving a need for injury-related

psychiatric care beyond January 1983, the most that can be said about the opinions of Drs. Quan and Holland is that they are somewhere between noncommittal and adverse to claimant's position. We conclude that claimant has failed to prove that he is entitled to compensable psychiatric treatment beyond the date of the insurer's partial denial, and modify the Referee's order accordingly.

We agree with the Referee's conclusions on the remaining issues. To the extent that the insurer's partial denial intentionally or unintentionally denied prior psychiatric treatment, we think it was unreasonable. We also think the penalty and associated attorney fee awarded by the Referee was appropriate in these circumstances. Finally, we agree with the Referee's assessment of the extent of claimant's disability as a result of his back injury.

ORDER

The Referee's order dated August 8, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the insurer's partial denial dated January 4, 1983 in toto is reversed and, in lieu thereof, the insurer's partial denial is reinstated and affirmed but only insofar as it denies psychiatric treatment beyond the date of the denial. The remainder of the Referee's order is affirmed.

VIRGINIA M. CASTOR, Claimant
Callahan, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorney

WCB 82-08450 & 83-00721
June 21, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Thye's order which ordered SAIF to accept claimant's claim for her neck injury. On review SAIF contends the claim should be barred because claimant received a third party settlement without informing SAIF and because claimant did not file her claim until two and one-half years after the injury.

The Board affirms the order of the Referee with the following comment.

On January 31, 1980 claimant injured her neck while riding as a passenger in a motor vehicle operated by her son. Claimant testified her son was driving her to the post office to pick up her employer's mail. Claimant was vice-president and office worker for her family's closely held corporation. The sole shareholder and president of the corporation was claimant's husband. She advised him of her injury the day of the accident.

Claimant and her husband testified that no claim was filed with SAIF because they were aware that the corporation's premiums would rise. They also felt the other driver was liable. Later in 1980, through an attorney other than her present counsel, claimant settled her third party claim. She testified her attorney told her the settlement was for the policy limits and that his investigation had indicated the third party was judgment proof.

SAIF was not advised of the injury, the third party action or

the settlement until claimant filed a claim on June 30, 1982. On September 2, 1982 SAIF denied the claim. SAIF cited several grounds for its denial including: (1) Insufficient evidence that the accident arose out of and in the course and scope of employment; (2) insufficient evidence that claimant's neck injury resulted from the accident of January 31, 1980; (3) late filing of the claim had prejudiced SAIF's investigation of the facts; and (4) SAIF was prejudiced by claimant's third party settlement without its permission.

The Referee noted that a number of statutes pertaining to third party settlements had been violated. However, he noted further that since the employer had knowledge of the injury, the claim was not barred and was compensable. As support for his finding, the Referee cited ORS 656.265(4)(a) and Baldwin v. Thatcher Construction Co., 49 Or App 421 (1980). Although SAIF set forth equitable theories supporting its arguments, it did not cite any statutory authority for barring the claim and we find none. Therefore, while we deplore the actions of claimant, we affirm the Referee's order.

ORDER

The Referee's order dated May 9, 1983 is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the SAIF Corporation.

MUNZO MASHADDA, Claimant
Coons & McKeown, Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 82-01374
June 21, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Brown's order which set aside its denial of claimant's injury claim. It is agreed that claimant was involved in an accident at work on September 2, 1981. The issue is whether, as a result, claimant sustained any compensable injuries.

Claimant was operating a roller in the course of his employment when the roller tipped over. As it was tipping over, claimant jumped to the ground. The evidence is in dispute regarding how claimant landed on the ground and regarding which parts of claimant's body were allegedly injured at that time. The Referee specifically found that claimant was not a credible witness. To the extent that this conclusion is premised upon the internal inconsistencies in claimant's testimony and the differences between claimant's testimony and the history related to various physicians, we agree completely with the Referee's credibility finding. In addition, we understand the Referee's characterization of claimant as "notably unresponsive" to be an evaluation of claimant's demeanor, which is the type of credibility finding to which we give great deference.

The day after this incident with the roller occurred, claimant sought medical attention from Dr. Goertz. The 827 form completed by Dr. Goertz at that time states in part: "Tender upper lumbar area without spasm. Pain increases with flexion and extension. Negative straight leg raising. DTRs [deep tendon

reflexes], strength normal, equal. Left wrist tender palmar surface with normal ROM [range of motion], no swelling." At that time, Dr. Goertz diagnosed back and left wrist sprains. He prescribed rest, local heat and Motrin. This form also indicates that claimant was not released for work.

A few months later, Dr. Goertz referred claimant to Dr. Wilson, a neurologist, because he was unable to identify a cause of claimant's continuing symptomatology. Dr. Goertz's December 10, 1981 letter of referral to Dr. Wilson explains:

> "[Claimant] is a 31-year-old man who was on the job one day last September when he reported that his roller turned over, throwing him to the ground. He had some immediate low back pain and was seen the next day at our clinic where other than some upper lumbar tenderness his exam was basically normal. The x-ray was also normal at that time. I assumed it was a simple strain and treated him conservatively with Motrin and rest. His back symptoms initially got better but then worsened again and have continued basically unchanged, still without any significant objective evidence of strain. He has been tried on various antiinflammatories and muscle relaxants as well as physical therapy, lumbar belt and traction. None of these have significantly helped.
>
> "In addition to his back symptoms, about a month after he was first seen he started having some episodes of severe frontal headache associated with an aura and some numbness in the right foot. His blood pressure was normal and I was unable to elicit any abnormalities on his other general and neurological exams. Though he had had frequent headaches in the past these were much more severe and somewhat different in quality. Also, though initially he hadn't mentioned any head trauma, he did say that he had hit the right side of his head in his initial accident. * * * What has finally precipitated this [consultation] is his recent visit during which he reported that he had three episodes of sensations of facial flushing associated with scatomata [sic] and tinnitus. In fact, on one of these episodes he did report a loss of consciousness. Apparently this episode was not witnessed and he has had no focal neurological symptoms. Again, today (December 9) I don't find any evidence of neurological deficit and his blood pressure continues to be normal with normal funduscopic exam. As I don't find any hard

findings and find this symptom complex a little bit confusing I am hoping you will be able to help me with this difficult patient. Also, if you do have any suggestions for treatment of his back pain I would appreciate these."

Dr. Wilson examined claimant on January 8, 1982. Claimant related a history of falling out of the roller, landing on his back and hitting his head. Dr. Wilson diagnosed chronic lumbar strain, post-traumatic headaches by history and functional overlay. His conclusions at that time were:

> "I find no objective evidence of neurological dysfunction in this man. I am surprised at his lack of improvement with appropriate medical care. The condition seems to be stationary. I do not feel that further investigations are in order.
>
> "I find no neurological impairment as the result of his injury. The headaches are purely subjective and unquantifiable. As you know, the severity and duration of post-traumatic headaches can be related to only two things, the patient's underlying personality, and the circumstances of the injury."

Dr. Wilson subsequently met with a claims management consultant who provided him with a copy of a written statement given by James Kimberlin, who was a witness to the incident in which claimant sustained his alleged injury. Dr. Wilson was also shown films of some of claimant's activities during the prior month. These films were viewed at the hearing and admitted as an exhibit. The written statement of James Kimberlin also was admitted, but only for the limited purpose of establishing the information that Dr. Wilson relied upon in formulating the following opinion:

> "Based on [the written statement of James Kimberlin] and assuming its veracity, I do not see how [claimant] could have injured his back or head in the alleged accident of September 2, 1981. Moreover, I reviewed with you a surveillance film taken of [claimant] sometime after his alleged injury. I was able positively to identify him in the film, and could see that most of the film, he was walking without a cane, normally. In one part of the film, he got out of his car without a cane, walked normally to [a hospital], back to his car, got his cane, and limped back to the building. There was incongruity between his gait on these two occasions which occurred concurrently."

Based on the statement of the witness and the film, Dr. Wilson modified his diagnoses to lumbar strain by history, post-traumatic headaches by history and functional overlay with

evidence of "dissembling." He concluded his report by stating: "I still feel that there is no residual neurologic impairment as a result of his injury, and doubt that there is an organic basis for his symptomatology."

Claimant was examined by Dr. Thompson on January 14, 1982, and in a January 20 letter to the insurer, Dr. Thompson stated his conclusions as follows:

> "At this point in time it would be my feeling that [claimant's] subjective complaints are far out of proportion to his objective findings. The inconsistency of some of the findings is such that I have serious question as to how much discomfort he is really having. Judging from the witness's description of the incident I do not feel that the incident was such that he could have sustained any injury to his back or head."

Dr. Thompson's reference to "the witness's description" is a reference to the written statement of James Kimberlin, which was also provided to him.

Dr. Goertz, the physician who originally examined and treated claimant, reviewed the reports of Drs. Wilson and Thompson. In a letter dated January 28, 1982, he stated agreement with their findings.

As indicated, Mr. Kimberlin's written statement appears in the record solely for the purpose of identifying what information Drs. Wilson and Thompson relied upon in formulating their opinions. Mr. Kimberlin's statement, dated November 2, 1981, states in part:

> "As the roller traveled up the bank, I knew it was going to go over and I saw [claimant] stand up just as the roller went over to the right. He jumped down, landing about 10 ft. away from where the roller came to rest and I estimate that he would have jumped a distance of not more than three and a half ft. in height from the seat of the roller to the ground. He landed on his feet, but sort of went down on his hands and knees. He did not fall down all the way, nor did he hit his head."

One of the witnesses who testified in behalf of the insurer was Jack Towe, an operating engineer who was working with claimant on the day in question. Mr. Towe witnessed the incident in which claimant's roller turned over. He testified as follows:

> "Q. And what did you see [claimant] do when the roller tipped over?
>
> "A. Well, he come [sic] out of it, landed on his feet, went to his hands and knees.
>
> "Q. He jumped off the roller in other words?

"A. Uh-huh.

"Q. And let's see. When he landed, you say he landed on his feet?

"A. Well, (indicating), and then went -- you know, then went to his knees and hands.

"Q. In other words, he landed on his feet and rolled forward to his hands and knees?

"A. Well, his momentum carried him that way (indicating)."

The Referee found that "an incident definitely occurred" on September 2, 1981 -- a point that we do not understand any party to now dispute. As for the details of that incident, the Referee found the testimony of Mr. Towe to be credible and the testimony of claimant not to be credible, as previously indicated. The Referee seems to have rejected the analysis offered by Drs. Wilson and Thompson, although the basis for any such rejection is not completely clear. The Referee concluded that because Dr. Goertz diagnosed a back sprain and left wrist sprain immediately after the at-work incident and took claimant off work at that time, and because Drs. Wilson and Thompson did not examine claimant until "way after the fact," claimant had established a claim for a compensable injury:

"Although I distrust his testimony, I don't think he expected that roller to roll over in the manner it did. And although given the problems with the credibility that I have noted, those problems all occurred long after the claimant first sought treatment with Dr. Goertz.

* * *

"I think the evidence fairly clearly indicates that absent some undocumented psychogenic problem, claimant's need for services, vis-a-vis this injury, terminated sometime after September 3rd, but that's not [what] the employer has denied. * * * The employer has denied that an injury took place. The law defines an accidental injury in terms of need for medical services and/or disability, ORS 656.005(8)(a). Both elements are present here. The employer's denial must therefore be overturned."

We disagree with the Referee's assessment of the evidence and conclusion. We have considered Mr. Kimberlin's written statement solely for the limited purpose of providing the basis for understanding the statements and conclusions rendered by Drs. Wilson and Thompson. Considering this evidence for this limited purpose only, however, we fail to see that it differs from the account rendered by Mr. Towe, whose testimony the Referee found

credible. The Referee apparently understood Mr. Kimberlin's account to be that claimant "landed on his feet and did not go into the ground." We read the written statement as indicating that Mr. Kimberlin observed claimant land on his feet and then go down on his hands and knees. The account of claimant's fall or jump out of the tipping roller, as related by Mr. Towe and set forth above, is exactly the same in this regard.

As the Referee observed, Dr. Goertz was the only physician in a position to state whether the physical complaints which claimant exhibited on the day of his initial examination, the day after the incident in question, were actually present as a result of this incident. There were absolutely no objective signs of injury reported by Dr. Goertz. The tenderness of the upper lumbar area noted in the 827 form is a subjective complaint. There was no muscle spasm. The pain noted, obviously, also is a subjective complaint. Claimant's wrist was noted to be tender, a finding based entirely upon the complaints expressed by claimant, but there was no evidence of swelling about the wrist. Nor were any bruises noted. Dr. Goertz's subsequent correspondence on referral to Dr. Wilson states that, based upon claimant's complaints on examination, he "assumed" that claimant had sustained a simple strain, further indicating that, in stating his initial impressions, he relied entirely upon the history related by claimant.

Drs. Wilson and Thompson subsequently opined that, as of the date of their examinations at least, claimant was not experiencing symptoms as a result of the September incident. Dr. Goertz expressed his concurrence with those findings. Dr. Goertz's vague statement of agreement is rather unenlightening with regard to the question of whether, when Dr. Goertz first examined claimant the day after the incident occurred, claimant actually was experiencing symptoms of the nature described in the 827 form as a result of that incident at work, or whether, even at that time, claimant simply was "dissembling" as Dr. Wilson later put it. However, Dr. Goertz's stated agreement with Drs. Wilson and Thompson is some reason to think that the latter is more likely than the former.

We harbor no belief that claimant intentionally caused the roller to overturn. The question remains of whether, as a result of this accident, claimant sustained a compensable injury. A compensable injury is defined as "an accidental injury, or accidental injury to prosthetic appliance, arising out of and in the course of employment requiring medical services or resulting in disability or death." ORS 656.005(8)(a).

There were absolutely no objective findings, i.e., indications of disability or a need for medical services within the meaning of the statute, on Dr. Goertz's examination the day after claimant tumbled out of the roller and landed on the ground. His initial conclusions were based entirely upon claimant's subjective complaints. Dr. Goertz later characterized his own diagnosis of a strain as an "assumption" on his part. He later concurred in Dr. Wilson's findings, one of which was "functional overlay, with evidence of dissembling." Although we agree with the Referee's finding that an incident occurred on the day in question, we simply are unable to conclude, based upon a preponderance of the persuasive evidence, that any injurious, i.e.

compensable, consequences resulted from this incident. Under the facts and circumstances presented herein, the question of whether claimant was hurt necessarily depends upon claimant's own statements, and his statements have been adjudged unworthy of belief.

ORDER

The Referee's order dated January 18, 1983 is reversed. The insurer's denial dated February 3, 1982 is reinstated and affirmed.

FRANK RAMSEY, Claimant
Yturri, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-10768
June 21, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Gemmell's order which set aside a Redetermination Order dated November 3, 1980 which had terminated claimant's award for permanent total disability, and reinstated a Determination Order dated March 4, 1974 which had first granted claimant an award for total disability as a result of his May 1968 compensable back injury.

The ultimate issue is whether the 1974 award should be modified, which breaks down into subsidiary issues of: (1) factually, the nature of claimant's condition in 1974; (2) factually, the nature of claimant's condition at the time of the current hearing; and (3) legally, the quantum of proof necessary to terminate a prior award for total disability.

I

Claimant's 1968 industrial injury led to low back surgery in 1972 and again in 1973. After recovering from the second operation, medical opinions about claimant's status were quite pessimistic. The most pessimistic assessment was offered by Dr. Pollock who opined in May 1974 that claimant was "totally disabled and unable to work" because he "walks with a cane in a short shuffling gait, stooped over, barely able to move about." Dr. Gnuechtel, claimant's primary treating physician, also then generally opined that claimant was severely disabled, although Dr. Gnuechtel's reports present a somewhat more mixed picture. For example, the doctor commented in February 1974:

> "There is no doubt that there is a strong functional overlay present and there is certainly very poor motivation for returning to any type of useful employment. * * * I would doubt that he will hold any type of occupational job over any length of time, even when placed in a job which requires only light work."

And, in the same vein, Dr. Gnuechtel reported in August 1974:

> "There has been no essential change in the patient's symptomatology. He is still complaining of rather constant pain in the

> lower lumbar region with radiating pain towards the dorsal spine. * * * The patient walks with a cane and presents marked stiffness in all movements of the spine.
>
> * * *
>
> "Clinically, the patient presents marked fibrosis in the paravertebral muscles of the lumbar region and lower dorsal region, with marked limitation of motion in the lumbosacral junction. The patient has difficulty in taking his shoes off and to undress and dress. The possibility of some overexaggeration of his symptoms, however, cannot be excluded.
>
> "The patient's psychological status has not changed. There is still very poor motivation for achieving some status of reemployability."

Dr. Gnuechtel's last statement is typical of the considerable comment on claimant's psychological condition before the March 1974 Determination Order, awarding total disability, was issued. Most comments were by medical doctors as distinguished from mental health professionals. For example, in December 1973 Drs. Fagan and Beals, orthopedic surgeons, diagnosed "conversion hysteria." Apparently the only mental health professional involved at that time was Dr. Hickman, a psychologist, who opined:

> "[T]here is evidence here of a chronic psychoneurotic condition. However, it still seems quite clear that [claimant's] preexisting emotional condition has been at least moderately aggravated by his accident and by his subsequent predicament. He has had two laminectomies since 1970, his symptoms persist, and he is probably being realistic in recognizing that it will be extremely difficult for him to find gainful employment. It seems unlikely that [claimant's] emotional condition will significantly improve. On the contrary, it may well worsen with the passage of time."

Presumably the above medical opinions and comments were before the Evaluation Division when it found that claimant was totally disabled in 1974. In the very nature of the process, however, it is not now possible to know what relative weight the Evaluation Division attached to claimant's physical and mental problems. It would probably be reasonable to assume that the 1974 decision was based primarily, if not solely, on claimant's physical impairment -- then described as "barely able to move," requiring a cane to walk, difficulty dressing and undressing, etc.

II

In September 1980 claimant was examined at the Callahan

Center by Dr. Storino, a neurologist, and Dr. Henry, a psychologist. Dr. Storino reported difficulty examining claimant and diagnosed a predominantly psychological problem:

> "I was not able to adequately examine range of motion of the back, as [claimant] would start to fall when either his wife or I let go of his arm. * * * I noted that even light palpation of the back elicited considerable groaning and moaning.
>
> * * *
>
> "[Impression:] Psychoneurotic exaggeration of physical symptoms, with functional sensory loss, both lower extremities.
>
> * * *
>
> "From the standpoint of his back injury I think [claimant] probably does have a moderate degree of impairment, but I think his major impairment is psychological, with much overreaction and inappropriate pain behavior, compounded by some element of drug dependency."

Dr. Henry concluded:

> "The current psychological evaluations suggest the presence of a well-established neurotic pattern, with difficulties in a number of areas. [Claimant] is very highly focused on his physical difficulties, seeing himself as completely disabled, and apparently as unable to manifest any improvement. Although it is likely that he himself believes these complaints, there is also an element of manipulativeness or overdramatization in presentation of complaints.
>
> * * *
>
> "Diagnosis impression: Multiple neurotic manifestations, perhaps most aptly described as 'compensation neurosis.'
>
> "[Claimant] does manifest significant psychological difficulties, and it is felt that he is in need of psychotherapeutic intervention. However, as part of his difficulties, he is not receptive to this, and thus psychotherapy would likely prove a fruitless endeavor. [Claimant] is not particularly insightful into his current situation and does not manifest motivation to change. The overall prognosis is judged to be quite poor."

Presumably these medical opinions and comments were before the Evaluation Division when it issued its Redetermination Order in November 1980: "The Department now finds that you are no longer permanently and totally disabled . . ."

Dr. Gnuechtel, who had continued to be claimant's treating physician since before claimant was found totally disabled in 1974, expressed disagreement with Drs. Storino and Henry. Dr. Gnuechtel reported in February 1981:

> "It can be stated that since [the 1974 total disability award, claimant's] orthopaedic status has not changed for the better. The complex of the clinical findings in regards to his low back condition has been stationary over the past 5 years, during which time period his psychological status has worsened in regards to a more obvious tendency to depression and anxiety due to his inability to participate in useful employment and compensatory recreational activities. The psychological component is certainly [a] contributing factor in his overall health status but <u>is not</u> the primary component in his unemployability."

Dr. Gneuchtel elaborated in July 1981:

> "[Claimant] is using 2 Canadian type crutches as walking aids at all times. Walking without crutches is possible only over very short distances and is increasing the pain from the lower back into the right lower extremity.
>
> "Although [claimant] is able to undress and dress himself without help, he is not able to climb stairs or ladders without assistance. Stooping, crouching, squatting and climbing are activities which [claimant] cannot handle and should not perform."

Evaluation of these more recent (1980-81) medical assessments is complicated by surveillance films that were introduced into evidence in the current hearing. These films, taken in October 1979 and August 1980, show claimant operating a tractor with a backhoe and a large caterpillar-type piece of earth moving equipment. Contrary to claimant's testimony and Dr. Gnuechtel's understanding that claimant is basically unable to walk without the assistance of a cane or crutches, the film shows claimant walking over rough and uneven ground without a cane or crutches. Contrary to claimant's testimony and Dr. Gnuechtel's understanding that claimant is unable to bend, twist, climb or kneel, the film shows claimant performing all of these maneuvers without apparent distress. The film shows claimant climbing onto heavy equipment, twisting from side to side and bending over while operating it and

then climbing off the equipment, all with apparent ease. In short, in this film claimant appears to be an able bodied man performing various and somewhat stressful physical activities. Evidence was also presented that claimant owns several pieces of heavy equipment that he usually leases to others, but claimant also occasionally operates the equipment himself as depicted in the films and has received some payment for his services when doing so.

III

The Referee concluded that the surveillance films raised "doubt" about claimant's credibility and thus doubt about medical opinions based on his subjective history, but that doubt about claimant's credibility was insufficient to sustain SAIF's burden of proving that claimant was no longer totally disabled. There is some appeal to that line of analysis, but we think that further consideration of the burden of proof in this kind of case is required before it can be embraced.

It is clear that the burden of proof in this kind of case is on the employer/insurer, Harris v. SAIF, 292 Or 683 (1982); Bentley v. SAIF, 38 Or App 473 (1979), but we detect some differences in Harris and Bentley about what is necessary to sustain that burden. The emphasis in Bentley appears to be on opinion evidence from medical experts that there has been improvement in the claimant's condition. See 38 Or App at 478-79. However, Harris involved facts that suggested something more in the nature of the claimant's successful adaptation to his disability -- in that he was able to engage in income producing activity, rather than improvement from a medical standpoint. In its decision in Harris, the Supreme Court's approach to the burden of proof appears to be broader and more general:

> "[A] claimant's permanent total disability award can only be revoked or diminished upon a specific and express finding that he or she is presently able to regularly perform a gainful and suitable occupation . . . [A] claimant's ability to generate income is only relevant insofar as it tends to establish his or her employability at some such occupation. A claimant's demonstrated ability to earn money is, in and of itself, insufficient." 292 Or at 696-97.

Reading Harris and Bentley together, we conclude that the quantum of proof that an employer/insurer is required to produce in this context comes down to something like: What job is the claimant presently capable of performing, with such capacity being indicated either by evidence of improvement in the claimant's medical condition or by circumstantial evidence of the claimant's employability.

Although some of the evidence in this case raises as many questions as it answers, we conclude that SAIF has sustained that burden in this case, albeit just barely. First, there is some evidence of medical improvement. Dr. Gnuechtel reported in 1974 that claimant was not able to dress and undress; the same doctor reported in 1981 that claimant was able to dress and undress. Dr.

Pollock reported in 1974 that claimant was "barely able to move about"; the surveillance films from 1979-80 prove to our satisfaction that claimant has at least regained some ability to "move about." Most of the older medical reports state that claimant requires a cane or crutches to walk; if that was previously the case, the more recent surveillance films indicate dramatic improvement.

Second, there is evidence that claimant has actually been able to work. From the mid to late 1970s, claimant owned and operated well drilling equipment. During the latter part of the decade, claimant shifted from well drilling to heavy equipment operation and he has personally performed some heavy equipment operation for mining companies, including a mining company he owns or owned. Claimant has also demonstrated the ability to operate smaller equipment; a neighbor of claimant's testified that claimant rototilled the neighbor's yard using what sounds like a small garden tractor.

On the other hand, Dr. Gnuechtel, who has been involved in claimant's treatment longer that any other physician, continues to strongly opine that there has been no change in claimant's status and that claimant remains totally disabled due to low back and radiating leg pain. We do not understand Dr. Gnuechtel to so opine based on objective findings; rather, the doctor's opinion is based on claimant's reports of his subjective symptoms to the doctor. Like the Referee, we are unable to fully accept the accuracy of claimant's reported symptoms considering the record as a whole. The Referee correctly cited Lewis Clair, 31 Van Natta 28, 32 (1981), for the proposition that claimant's lack of credibility does not necessarily advance satisfaction of the burden of proof by the employer/insurer. But we think that claimant's lack of credibility is sufficient reason to basically disregard Dr. Gnuechtel's opinions in deciding whether the preponderance of the persuasive evidence supports SAIF's position in this case.

Finally, the most troublesome aspect of this case involves claimant's psychological condition. It is fairly clear that: (1) Claimant had preexisting psychological problems before his 1968 industrial back injury; (2) that back injury and its consequences, including surgery, were a material cause of at least a temporary exacerbation of those preexisting problems that were still apparent to Dr. Hickman as late as 1973. What is not at all clear to us is the causal link, if any, between the 1968 injury and claimant's psychological status at the time of the hearing in this case. Dr. Henry is the only mental health specialist to comment since Dr. Hickman, and we understand Dr. Henry's 1980 report to be a description of current symptoms with little or no insight offered regarding causation. It is rather difficult to consider whether circumstances have changed, Bentley v. SAIF, supra, when it is not even clear what circumstances previously existed.

In any event, a rather consistent theme in all medical comments about claimant's psychological condition, with the exception of Dr. Gnuechtel's, is the probability or possibility of manipulation and exaggeration. That possibility is graphically highlighted by this record. The person who appeared for examination by Dr. Storino in September 1980, which was claimant, could not stand without assistance, could not perform standard

range-of-motion and other diagnostic tests and almost fell off the examining table. The person who was filmed operating heavy equipment within about a month of that examination, which was claimant, performed all of the motions and movements necessary to do that sometimes strenuous work with apparent ease. With the exact status of claimant's psychological condition, and the relationship of that condition to claimant's industrial injury being basically unanswered questions, we are persuaded that there is a considerable conscious and volitional element to claimant's reported psychological distress.

To repeat, we understand SAIF's burden of proof in this case to be: What job is claimant presently capable of performing, with such capacity being indicated either by evidence of improvement in claimant's medical condition or by circumstantial evidence of claimant's employability. We conclude that SAIF has proven that claimant is presently capable of heavy equipment operation, well drilling, rototilling and similar work. This conclusion is supported by slight evidence of claimant's medical improvement -- unable to dress or walk without crutches previously, now able to dress and walk normally, at least when he does not know he is being observed. This conclusion is supported mainly by the circumstantial evidence of employability, i.e., that claimant has been able to perform all of these activities since he was granted an award for total disability.

ORDER

The Referee's order dated September 28, 1981 is reversed. The Redetermination Order dated November 3, 1980 is reinstated and affirmed.

CARROLL ROBERTS, Claimant
Kenneth Peterson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-00484
June 21, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Danner's order which affirmed the SAIF Corporation's January 10, 1983 partial denial whereby SAIF denied the compensability of claimant's cervical, right shoulder and arm problems. The issue for review is compensability.

As a preliminary matter, claimant points out that exhibits #12 and #18 were not admitted as evidence at the hearing and that they should be disregarded on review. Claimant is correct and we have not considered either of those exhibits in our de novo review of the record.

In addition to the above, claimant has made a motion to admit an additional medical report authored by Dr. Feinberg and dated June 15, 1983. The hearing in this matter was held on April 28, 1983 and the record was apparently closed on May 24, 1983. Motions for the admission of additional evidence presented during Board review are considered to be in the nature of a motion to remand to the Referee. Ora M. Conley, 34 Van Natta 1698 (1983).

When the hearing in this matter convened, a discussion was held with regard to the admission of exhibits. Claimant moved for

admission of a medical report from Dr. Feinberg dated April 14, 1983. Claimant represented he had mailed this medical report with an inclusion letter to the Referee and to counsel for SAIF more than 10 days prior to the hearing pursuant to former OAR 436-83-400(3). The Referee, however, apparently did not have a copy of the report or the inclusion letter, and counsel for SAIF indicated that he did not have any inclusion letter either.

It was agreed at the hearing that the record would be held open and that the Referee would conduct a search for the missing medical report and inclusion letter. The Referee indicated that if the letter was postmarked more than 10 days prior to the hearing, the report would be admitted with the proviso that SAIF be allowed to cross-examine Dr. Feinberg if it so desired.

In a letter dated April 29, 1983 claimant's counsel stated that the missing documents were actually sent with a group of documents pertaining to another, unrelated case. Claimant's counsel gave the name of the unrelated case he believed the documents had been sent with. By letter of May 5, 1983 the Referee stated that the missing documents had been located, and that the inclusion letter was postmarked April 18, 1983, exactly 10 days prior to the hearing. The Referee admitted Dr. Feinberg's April 14, 1983 medical report as Exhibit 25. Additionally, the Referee stated:

> "I have considered Dr. Feinberg's report, but irrespective of same, it will be my finding that claimant has failed to carry his necessary burden of proof, and that the partial denial should be affirmed. My Opinion and Order will so read. I mention this at this time, as possibly it will expedite the closing of the record . . . ."

Not surprisingly, SAIF waived cross-examination of Dr. Feinberg and requested the record be closed.

Claimant contends that the Referee's announcement of his decision of the merits of the case in his May 5, 1983 letter was prejudicial as the record was still open. Claimant alleges that a result of this was "the fact-gathering process which had been set in motion at the hearing concerning the cross-examination of Dr. Fienberg was derailed." Claimant states that the only way to ameliorate this "injustice" would be to admit the June 15, 1983 report of Dr. Feinberg (the report indicates that it was solicited by claimant's attorney on June 13, 1983).

Although the Referee's desire to close the evidentiary record as rapidly as possible is certainly a laudable goal, it would have been preferable had he not "shown his hand" prior to the publication of his formal order. Nevertheless, we are not convinced that claimant has been prejudiced by the Referee's action and we do not believe that a remand would be appropriate.

As SAIF correctly points out, claimant's arguments ignore the basic reason for the record being held open. The record was held open to allow SAIF the right to cross-examine Dr. Feinberg in relation to the contents of his April 14, 1983 report, not claimant. This was the only purpose for which the record was held open. Additionally, the need for the record being held open in the first

place was apparently the result of claimant's counsel having sent Dr. Feinberg's April 14, 1983 report to this agency with a group of documents which pertained to another totally unrelated file. The possibility of a cross-examination of Dr. Feinberg never even would have arisen had it not been for this error on the part of an employe of claimant's attorney. Considering those circumstances, it is surprising that claimant's attorney should feel that it was he who was prejudiced. It was an apparent error on his part that caused the problem in the first place.

In any event, even if the Referee had not indicated what his decision would be prior to the time SAIF indicated it would waive cross-examination of Dr. Feinberg, there is no indication in the record that SAIF would have even exercised this option. Again, it must be emphasized that the record was left open for SAIF's benefit in this instance, not claimant's. It would be difficult to believe that claimant's attorney prepared his case anticipating that it would be necessary for him to prove his case by relying on whatever information would be solicited by counsel for SAIF on cross-examination of Dr. Feinberg.

After disposing of claimant's arguments in relation to prejudice, it becomes apparent that claimant's request for remand and admission of Dr. Feinberg's June 15, 1983 report is nothing more than a standard request for admission of evidence generated post-hearing. Considering the record as a whole, we cannot say that it has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5); Bailey v. SAIF, 296 Or 41 (1983).

Claimant also takes issue with SAIF's failure to supply him with a copy of a taped interview of claimant taken by the insurer. Claimant's argument on this point merits little discussion. SAIF's counsel stated in its letter of June 9, 1983 that he had not even been aware of the tape-recorded statement himself until the matter was brought up by claimant's attorney. After being contacted by claimant's attorney and being advised about the existence of the tape, SAIF made a copy available for his use. By letter of June 21, 1983 claimant's attorney informed the Referee that the content of the tape was "cumulative and repetitive [and] I do not believe its addition to the record is necessary." We do not believe that such a situation warrants the imposition of a penalty.

With regard to the question of the compensability of claimant's neck, right shoulder and arm conditions, we affirm and adopt the order of the Referee.

ORDER

The Referee's order dated July 18, 1983 is affirmed.

CHARLES G. TALLARD, Claimant
Allen & Vick, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-05025
June 21, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Braverman's order which granted claimant 128° for 40% unscheduled disability in addition to the 32° for 10% previously awarded by Determination Order. Extent of disability is the only issue.

Claimant is a 59 year old machinist who compensably injured his back on February 10, 1981. The evidence establishes that claimant has a cervical strain superimposed on preexisting degenerative osteoarthritis as well as a lumbar strain which is also superimposed on degenerative osteoarthritis. The Referee, in error, considered claimant's total impairment due to both the preexisting osteoarthritis as well as the compensable strain in rating the extent of claimant's disability. ORS 656.214(5) provides that in permanent partial disability cases, "the criteria for rating of disability shall be permanent loss of earning capacity due to the compensable injury." In rating the extent of claimant's permanent partial disability, only those conditions due to the compensable injury are considered.

The evidence in this case indicates that the impairment due to claimant's compensable injury is minimal. Considering that impairment, as well as the relevant social and vocational factors, we conclude that, compared to similar cases, claimant would be adequately compensated by an award of 80° for 25% unscheduled disability in addition to the 32° for 10% unscheduled disability previously awarded by Determination Order.

ORDER

The Referee's order dated November 23, 1983 is modified. Claimant is awarded 80° for 25% unscheduled disability in lieu of the 128° for 40% unscheduled disability awarded by the Referee's order. Claimant's attorney fee shall be adjusted accordingly.

CHARLENE M. CARROLL, Claimant
Coons & McKeown, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-04036
June 22, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Wilson's order which: (1) Affirmed the April 15, 1982 Determination Order; (2) affirmed the insurer's denial of medical treatment from Drs. Brink, Roy and Schmitz; and (3) approved denial of payment for mileage from claimant's home in Oregon to visit Dr. Hook in California. The insurer contests that portion of the Workers' Compensation Department's order which approved claimant's selection of Dr. Roy as her attending physician and Dr. Singer as a consultant.

The Board affirms the order of the Referee except for his affirmance of the insurer's denial of Dr. Roy's medical treatment. It appears that this holding was made in error,

considering the Referee's approval of the Department's order which allowed Dr. Roy's treatment.

ORDER

The Referee's order dated November 7, 1983 is modified in that the insurer's denial of medical treatment from Dr. Roy is disapproved. The remainder of the order is affirmed.

DIXIE FITZPATRICK, Claimant
English & Metcalf, Claimant's Attorneys
Welch, et al., Attorneys
Cheney & Kelley, Defense Attorneys

WCB 81-06326
June 22, 1984
Order on Remand

On review of the Board's order dated December 30, 1982 the Court of Appeals reversed the Board's order.

Now, therefore, the above-noted Board order is vacated, and this claim for medical benefits is remanded to the insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

JOHN A. LOMAX, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-06937
June 22, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Fink's order which increased claimant's scheduled permanent disability award from 7.5° (5%) granted by Determination Order dated March 23, 1982 to 75° (50%) for injury to claimant's right leg (knee); ordered the insurer to reimburse claimant for amounts previously paid by claimant to the insurer in partial satisfaction of an overpayment; and in lieu of imposing a penalty as a percentage of the partially recouped overpayment, prohibited the insurer from taking a credit against claimant's increased permanent disability award. The issues on review are: (1) the extent of claimant's scheduled permanent partial disability; and (2) the propriety of the Referee's directing that the insurer reimburse claimant and "pay" a penalty.

I.

We first address the issues surrounding the Referee's conclusion that the insurer's partially successful effort to recover an overpayment of temporary disability benefits directly from claimant is not permitted by the statutory or regulatory provisions of the Workers' Compensation Law.

Claimant's claim was closed by Determination Order dated March 23, 1982, which awarded compensation for temporary disability from October 22, 1980 through May 10, 1981, and 7.5° scheduled permanent partial disability for a 5% loss of the right leg (knee). Claimant's permanent disability award was equivalent to $750. After the Determination Order issued, the insurer sent claimant a letter dated April 5, 1982, which was signed by one of the insurer's claims adjusters, Rosalind K. Newbury. That letter states in full:

"We have received a copy of the . . . Determination Order dated March 23, 1982 which grants you an award of $750.00 for your injury of October 10, 1980.

"The Determination Order also terminates your entitlement to temporary total disability as of May 10, 1981.

"The workers' compensation law provides that if any temporary total disability payments paid were for the time after the termination date specified in the Determination Order, such amounts are to be considered payments on the award. In your case, $3,786.78 paid to you as temporary total disability after the above termination date is payment on the $750.00 ordered you by the [Determination Order], leaving a balance of $3,036.78 which has still been overpaid to you. We would appreciate it if you would make your personal check or draft payable to American Mutual Liability Insurance Company c/o Crawford and Company in the above amount and return it to our office in the enclosed envelope.

"If you are unable to pay this total amount at this time, we would appreciate it if you would contact our office regarding repayment on a monthly basis.

"Thank you for your time and cooperation in this matter. If you have any further questions, please do not hesitate to contact our office."

Ms. Newbury testified at the hearing. She stated that, after sending a standard letter such as the one sent to this claimant, it is not the practice or policy of the insurer to make any further effort to recover an overpayment from a claimant. According to Ms. Newbury, after letters of this nature are sent, the file is diaried for 30 days, after which time and in the absence of a response from the claimant, the file is closed. In this case, unlike most others, the insurer received a call from claimant, who stated that he was unable to pay the amount in full and wanted to arrange a payment schedule. Ms. Newbury did not inform claimant when he called that there might be other ways in which the overpayment could be collected, such as from future disability payments.

Claimant testified that when he received the insurer's letter he was somewhat surprised to be informed that he owed the insurer money. He called and advised that he was unable to repay the sum in full but was able to repay approximately $1,000 with an agreement to pay $100 each month thereafter until the "obligation" was satisfied. Claimant paid $1,036.78 in a lump sum. He testified that in order to pay this sum it was necessary to sell some personal belongings, including tools and an old automobile.

Claimant testified: "I don't like to owe money, I decided I'd pay it off quick as I could." Claimant testified that it was his impression that payment in accordance with the insurer's letter was not voluntary, but that it was mandatory. He was not aware of alternative methods for the insurer's possible recovery of the overpayment. After making the first payment of $1,036.78, claimant made two monthly installment payments of $100 each. He apparently was unemployed during this period.

Ms. Newbury testified that it was her understanding that the practice of sending overpayment letters to claimants is standard operating procedure followed by all companies in the workers' compensation insurance industry, an understanding which she acquired in speaking with fellow employes who had worked for other insurance companies. She further testified that, during her years as a claims adjuster, no attorney or agency official had ever registered a complaint about the collection letter used by the insurer.

The Referee concluded that there is no statutory or regulatory authority which allows the insurer to send the letter in issue and thereby solicit a claimant's voluntary repayment of overpaid benefits. He found the "demand letter" improper and, therefore, ordered that the insurer reimburse claimant for the $1,236.78 claimant had paid to the insurer. Analogizing to our decision in Mark L. Side, 34 Van Natta 661 (1982), the Referee also prohibited the insurer from taking a setoff of this amount against claimant's increased permanent partial disability award.

On review claimant defends the result reached by the Referee by expanding upon the basic premise underlying the Referee's rationale: That there are specific statutory and regulatory procedures, such as OAR 436-54-320, stating the manner in which an insurer may recover overpaid benefits, and that these provisions provide the exclusive method for such recovery. The insurer's argument in support of its solicitation and in opposition to the Referee's finding of impropriety is, essentially, that no statute or administrative rule prohibits what it did.

Matters are somewhat complicated because, since the date of the Referee's order and the filing of the parties' briefs: (1) the Court of Appeals invalidated OAR 436-54-320, upon which claimant relies in part, in Forney v. Western States Plywood, 66 Or App 155 (1983); and (2) the Board overruled Mark L. Side, supra, upon which the Referee relied in part, in Joel I. Harris, 36 Van Natta 829 (June 15, 1984). Despite some facets of this case thus involving some areas of relative legal volatility, we do not think that volatility has much bearing on the ultimate question here presented.

The ultimate question and the parties' respective arguments on it represent the varying philosophical attitudes concerning the relationship between regulated entities, in this instance employers and their workers' compensation insurers, and that entity by which they are regulated, government. Claimant argues that the regulated entity is not permitted to take any action unless that action is authorized by the regulator. The insurer argues that any action is permissible on the part of the regulated entity in the absence of an express prohibition. At least in the context of the specific issue presented in this case, we tend to agree more with the position advocated by the insurer.

The Board and court decisions discussing the issue of recovery of overpayments have all dealt with the unilateral effort of an employer/insurer to recover overpaid benefits by withholding, in whole or in part, compensation to which a claimant was entitled. See Telphen N. Knickerbocker, 33 Van Natta 568 (1981); Charles C. Rooker, 9 Van Natta 103 (1972); Hicks v. Fred Meyer, Inc., 57 Or App 68 (1982); Wilson v. SAIF, 48 Or App 993 (1980); Taylor v. SAIF, 40 Or App 437 (1979). The only "unilateral" act involved in this case was the insurer's written communication with claimant notifying him of the fact that he had received more benefits than he actually was entitled to receive. The accuracy of the insurer's communication with claimant is not disputed -- at least in the sense that it is, in fact, true that claimant received more benefits than he actually was entitled to receive. No statutory, regulatory or case law prohibits this type of factually correct communication between an insurer and an injured worker.

In support of his contention that this type of communication is and should be prohibited, claimant relies upon the policy expressed by ORS 656.313. This statute relates primarily to the effect of a request for Board or judicial review upon an outstanding order requiring an insurer to pay claimant compensation and otherwise process a claim. In Wisherd v. Paul Koch Volkswagen, 28 Or App 513, 517 (1977), in discussing the interests furthered by ORS 656.313, the court stated: "Often when an employe is injured, it may be years before the claim is finally adjudicated. ORS 656.313 seeks to provide injured employes with a means of support . . . while an employer appeals an adverse decision." ORS 656.313(2) expresses a legislative policy that those amounts paid pending review or appeal are not recoverable by the insurer.

We find nothing in ORS 656.313, or in the Supreme Court's decision in Jones v. Emanuel Hospital, 280 Or 147 (1977), that supports the claimant's contention that the insurer is prohibited from merely asking a claimant to voluntarily repay a windfall. Claimant's reliance upon the Court of Appeals' passing phrase in Boise Cascade Corp. v. Jones, 63 Or App 194, 198 (1983), that "[w]hen there is no permanent disability award against which to offset, an employer is obliged to absorb the temporary disability paid after claimant's completion of the rehabilitation program," is not persuasive. That case dealt with the employer's unilateral termination of temporary disability payments after the claimant's completion of a vocational rehabilitation program. As previously stated, we do not deem the insurer's conduct in this case to be "unilateral" in that sense.

In Wilson v. SAIF, supra, the court discussed the "competing policy considerations" involved in deciding whether the insurer's manner of recovering an overpayment was permissible:

> "On the one hand, there is a patent unfairness in permitting the claimant to retain over $2,800 to which he was not entitled. On the other hand, there is the desirability of maintaining an orderly compensation process, wherein not only amounts of awards but also any deductions

> to be made from those awards are established by an appropriate action by the Board or its representative, rather than by the unilateral decision of a workers compensation carrier." 48 Or App at 997.

In weighing these competing policy considerations in the context of the specific issue of whether an employer/insurer is entitled to merely ask that overpaid benefits be voluntarily repaid, we find no infringement upon the "orderly compensation process" occasioned by this insurer's actions. Indeed, the only possible misfeasance on the insurer's part in this case is the failure to advise claimant that repayment was not mandatory, and the failure to advise claimant that there were (or might be) alternative (albeit contingent) methods for the insurer to recover its overpayment. It would certainly be preferable, when soliciting voluntary repayment of overpaid benefits from a claimant, for the insurer to advise that there are alternative methods for the insurer's recovery of the overpaid benefits, so that the claimant may make a truly informed decision about whether to reimburse the overpaid benefits immediately or to have future compensation to which he or she may become entitled possibly reduced by the amount of the overpayment. We do not agree with the Referee, however, that the insurer's failure to advise claimant of all of these various details and alternatives dictates the conclusion that the insurer's request for repayment was impermissible.

It follows that, because we find the insurer did not engage in any wrongful or illegal conduct, it was error for the Referee to impose a penalty. Even if we are wrong in our conclusion, however, and ultimately it is determined that workers' compensation insurers are not permitted to engage in this conduct, there is still no authority for imposition of a penalty under these circumstances. The Board's statutory authority for imposition of a penalty essentially is limited to penalizing an employer/insurer for unreasonably refusing, resisting, or delaying payment of compensation. ORS 656.262(10), 656.382(1). Even if it was wrong and unreasonable for the insurer to attempt to recover overpaid benefits from claimant, this action does not constitute unreasonable refusal, resistance, or delay in the payment of compensation. Accordingly, there would be no authority for imposition of a penalty as a percentage of the amounts in issue.

II.

Turning to the issue of the extent of claimant's permanent disability, we find that the Referee's award was excessive. Claimant's injury is to his right knee, a scheduled member. The criterion for rating scheduled disability is permanent loss of use or function of the injured member. ORS 656.214(2). Dr. Thomas, claimant's treating physician, has twice stated that the permanent impairment of claimant's right knee is in the range of 15%. In a November 12, 1981 report to the insurer, Dr. Thomas stated that this evaluation was based upon the fact that claimant's knee required a partial meniscectomy and that x-ray indications of early osteoarthritis were present in the knee. On January 7, 1983, in a report to claimant's attorney, Dr. Thomas reiterated his impression of 15% impairment based on the x-ray findings of narrowing of the femoral condyles, quadriceps weakness and claimant's intermittent pain.

It is quite clear from the statements of Dr. Thomas, paraphrased above, that he did not limit his consideration to "mechanical impairment" in offering his expert medical opinion on the extent of claimant's permanent physical impairment. Dr. Thomas obviously took into account claimant's evident loss of strength and subjective pain complaints and apparently included consideration of his findings on x-ray examination. Claimant's testimony seems to substantiate disabling pain greater than that reflected by Dr. Thomas' reports. In any event, considering claimant's medical situation in light of other injured workers with similar limitations, we find that the Referee's award is excessive. Accordingly, we modify the Referee's award of permanent disability.

ORDER

The Referee's order dated February 16, 1983 is reversed in part and modified in part. Those portions of the order which require the insurer to reimburse claimant in the amount of $1,236.78 and which impose a penalty are reversed. Under the terms of this order, the insurer is not required to repay to claimant the aforementioned sum. That portion of the Referee's order which awarded 75° scheduled permanent partial disability for 50% loss of claimant's right leg (knee) is modified. In lieu thereof, claimant is awarded 30° (20%) scheduled permanent partial disability in addition to the 7.5° (5%) awarded by Determination Order dated March 23, 1982, for a total award to date of 37.5° for a 25% loss of claimant's right leg (knee). Claimant's attorney is allowed 25% of this additional permanent partial disability (30°) as a reasonable attorney's fee, not to exceed $2,000, in lieu of the fee allowed by the Referee.

CHARLES R. WRIGHT, Claimant
Aspell, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-00470
June 22, 1984
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests and claimant cross-requests review of Referee Quillinan's orders which remanded claimant's occupational disease claim to the Evaluation Division for the issuance of a new Determination Order, ordered SAIF to pay for certain unspecified medical bills and awarded claimant's attorney a fee of 25% of those unspecified medical bills.

The issues, according to SAIF, are: (1) Whether a May 3, 1979 Determination Order is res judicata; (2) whether claimant filed an aggravation claim; (3) whether claimant proved aggravation; and (4) whether claimant proved that any medical bills were not paid. Claimant contends that he is entitled to penalties, attorney fees and an award of permanent total disability.

The background facts can best be stated chronologically:

November 3, 1976: Claimant filed a claim for an occupational disease apparently diagnosed at that time as pleural pericarditis.

November 13, 1978: In a prior proceeding, Referee Danner issued an order which set aside SAIF's denial of claimant's

occupational disease claim.

May 3, 1979: A Determination Order was issued which awarded claimant 25% unscheduled permanent partial psychological disability.

May 4, 1979: The Board issued an Order on Review which found that claimant's occupational disease claim was compensable and thus affirmed Referee Danner's order.

November 26, 1979: The Court of Appeals reversed the Board and found the claim was not compensable. Wright v. SAIF, 43 Or App 279 (1979).

July 28, 1980: The Supreme Court reversed the Court of Appeals and remanded for further consideration. Wright v. SAIF, 289 Or 323 (1980).

October 20, 1980: On remand, the Court of Appeals found that the claim was compensable and affirmed the Board's order. Wright v. SAIF, 48 Or App 867 (1980).

December 19, 1980: Claimant requested a hearing on SAIF's alleged failure to pay medical bills and failure to pay temporary total disability "as ordered by the Court of Appeals."

January 28, 1981 and March 4, 1981: Claimant filed additional requests for hearing alleging failure to pay time loss and medical expenses, failure to process the claim to a new Determination Order and various penalty and attorney fee issues.

December 9, 1981: SAIF voluntarily reopened claimant's claim on the basis of aggravation.

May 4, 1982: SAIF issued a denial stating that its "earlier reopening of [the] claim was in error."

May 14, 1982: Claimant requested a hearing on the denial of his aggravation claim.

This proceeding involves claimant's December 1980, January 1981, March 1981 and May 1982 hearing requests. We note that claimant failed to file a timely request for hearing in relation to the May 3, 1979 Determination Order.

The hearing in this proceeding convened before Referee Quillinan on May 3, 1983. In opening statements, claimant's attorney said that the issues for determination were: (1) Permanent total disability; (2) claimant's entitlement to temporary total disability benefits from April 9, 1979 (the date on which the May 1979 Determination Order terminated such benefits) to the date of the hearing -- apparently, in other words, a premature claim closure issue; (3) penalties and attorney fees for "failure to accept the claim on mandate from the Oregon Court of Appeals and for unreasonable delay and refusal in submitting the matter for Determination Order on the judgment of the mandate"; (4) failure to pay medical bills; and (5) various other penalty and attorney fee issues which are mostly now irrelevant. Claimant's attorney made no reference to the May 1982 denial of claimant's aggravation claim.

Counsel for SAIF strenuously objected to the issues as framed by claimant. SAIF argued that the Referee lacked jurisdiction to hear any issue related to the May 1979 Determination Order because claimant failed to file a timely request for hearing following the issuance of that Determination Order. It was SAIF's position that the only potentially viable issue before the Referee was the question of the May 1982 denial, on which claimant had filed a timely request for hearing.

In her initial order, the Referee set forth her understanding of claimant's theory regarding the jurisdictional question:

> "We understand claimant to contend that the one-year appeal period for the Determination Order was suspended during the appeal of the compensability issue to the courts. If this is so, then the appeal period would be reinstated and would run from the date of remand to the Board and reinstatement of the finding of compensability by the Court of Appeals in 1980."

The Referee concluded in her initial order:

> "First, under SAIF v. Maddox, [60 Or App 507 (1982)], claimant was entitled to receive any compensation awarded by Determination Order of May 1979. Second, the effect of the appeal of the compensability issue and of all the court proceedings was to stay the operation of the one-year time period of the Determination Order. * * * Third, the one-year period was reinstated on January 5, 1981, the date of remand from the Court of Appeals. Finally, claimant appealed the Determination Order on March 4, 1981 within the one-year period from the date of remand.

The Referee concluded that she had jurisdiction over the 1979 Determination Order and awarded claimant permanent total disability benefits. The Referee also awarded claimant temporary total disability benefits from April 9, 1979 through December 9, 1981, ordered SAIF to pay for certain unspecified medical bills and denied claimant's request for penalties and attorney fees.

Both SAIF and claimant petitioned the Referee for reconsideration of her order.

Apparently it was claimant's theory that the Court of Appeals' ultimate decision on remand, which affirmed the Board's order finding the claim compensable, was actually an order of remand to SAIF requiring SAIF to submit this claim to the Evaluation Division again for the issuance of a second Determination Order. Claimant believed that since the May 1979 Determination Order's award was on the basis of psychological disability, the decision of the Court of Appeals entitled him to an "additional" award based on his physical conditions.

On reconsideration, the Referee apparently accepted this theory. Her order states in part:

> "By strictly construing ORS 656.319 the insurer would limit claimant to a reassessment of his psychological condition. Such an approach would preclude any rating of those conditions, namely his cardiac and bronchial problems arising from his employment as a fire fighter and which the Supreme Court has found compensable. I do not believe the law contemplates such a result. A Determination Order has never issued on those conditions."

The Referee further stated on reconsideration:

> "This case is, in effect, still in the hands of Closing and Evaluation. No Determination Order has yet issued with regard to claimant's cardiac and pulmonary conditions . . . The claim, with respect to extent of disability, is therefore still in an open status, and must remain so until closed by Determination Order pursuant to ORS 656.268. That being the case, the Referee lacks jurisdiction to hear the issue of extent of disability until Closing and Evaluation has made its initial decision."

For these reasons, Referee Quillinan "remanded" this claim to the Evaluation Division for the issuance of a new Determination Order.

All of the Referee's analysis and conclusions that we have quoted above are simply wrong.

In compliance with Referee Danner's November 1978 order in the prior proceeding, finding this occupational disease claim compensable, SAIF immediately began processing the claim, despite the fact that it requested Board review of the Referee's order, and despite the fact that it appealed the Board's order as well. SAIF's actions were completely correct and fully in accord with ORS 656.313.

The Referee's conclusion in her original order in this proceeding -- that the appeal of the compensability issued tolled the statute of limitations in relation to the May 1979 Determination Order -- is inconsistent with the courts' conclusions in SAIF v. Maddox, 60 Or App 507 (1982), and SAIF v. Maddox, 295 Or 448 (1983). Both the Court of Appeals' and Supreme Court's decisions in Maddox interpreted ORS 656.313(1) as providing that a determination of the extent of a claimant's disability should not be stayed pending appeal of the question of whether the claim is compensable. 295 Or at 454; 60 Or App at 510-11. Thus, since claimant failed to file a timely request for hearing in relation to the May 1979 Determination Order, that Determination Order has now become final and claimant is precluded from litigating any issue related to that Determination Order. Following a final determination of extent of disability, a claimant's disability usually cannot be reexamined except in the case of redetermination following termination of a program of vocational rehabilitation pursuant to ORS 656.268(5), or a

worsening of his or her condition pursuant to ORS 656.273(1). Johnson v. Industrial Indemnity, 66 Or App 640 (1984). This conclusion disposes of claimant's permanent total disability arguments.

The Referee's conclusion in her order on reconsideration that the decision of the Court of Appeals was an order of remand requiring SAIF to process the claim to another closure with regard to claimant's cardiac and pulmonary conditions because "a Determination Order has never issued on those conditions," is also incorrect. The principal flaw in this analysis is the fact that the Court of Appeals' decision was not an order of remand. The ultimate 1980 decision of the Court of Appeals simply stated: "The order of the Workers' Compensation Board is affirmed." 48 Or App at 872. There is nothing in the court's opinion indicating that the matter was remanded for anything. Since SAIF had already processed the claim to closure pursuant to Referee Danner's order, there is nothing more for it to do in order to comply with the ultimate decision of the Court of Appeals.

Another weakness in the Referee's reasoning is her conclusion that claimant was entitled to a determination of the extent of his cardiac and pulmonary disability because the May 1979 Determination Order's award was only for psychiatric disability. The Referee apparently believed that claimant's cardiac and pulmonary difficulties were not evaluated when the 1979 Determination Order was issued. The record shows otherwise.

The exact nature of claimant's disease was not known at the time of the issuance of the 1979 Determination Order and is not now known. Claimant has been examined by a multitude of physicians and undergone extensive testing. He has been treated at the University of Oregon Health Sciences Center, the Portland Pain Center, the Stanford University Medical Clinic and the Mayo Clinic. Claimant had undergone electrocardiograms, x-rays and exploratory surgery prior to the issuance of the 1979 Determination Order. His heart and lungs were found to be normal. As the Court of Appeals noted, "All these procedures left the medical specialists with one general conclusion: his condition was idiopathic (of unknown origin)." 48 Or App at 871. However, several of the physicians who examined claimant were of the opinion that his cardiac and pulmonary difficulties were psychological in nature. For example, Dr. Maltby, a psychiatrist who examined claimant shortly before the closure of the claim, reported that claimant was actually suffering from a neurotic disorder.

In any event, whether the Determination Order labeled claimant's permanent disability award as being for psychological or physical conditions is irrelevant. See Bonnie B. Cave, 34 Van Natta 1149 (1982). It is clear to us that, whatever condition claimant was actually suffering from, it was considered as a whole and was the basis of the award of 25% unscheduled permanent disability that claimant received.

It follows that the Referee's action in "remanding" the claim to the Evaluation Division for issuance of another Determination Order was improper. As it would appear that claimant's arguments concerning penalties and attorney fees are all inextricably tied to his theory that the Court of Appeals remanded the claim for additional processing, these arguments also necessarily fail.

We next address SAIF's contention that the Referee erred in ordering it to pay for certain unspecified medical bills. SAIF argues claimant failed to establish the existence of any unpaid bills. We agree. The only evidence in the record with regard to unpaid medical bills was the following exchange which took place at the hearing between claimant and his attorney:

> "Q. As a result of the hospitalizations for the chest or lung pains, can you indicate if, in fact, they were hospitalizations for bills incurred which you submitted to your own carrier?
>
> "A. Yes.
>
> "Q. Do you know when they were?
>
> "A. I think the last one was in September of last year, and the one in February or March of this year, I don't know if SAIF has paid it yet or not."

This establishes nothing.

As we see it, the only potentially viable issue there ever was in this case involves SAIF's May 1982 denial of claimant's aggravation claim. However, the Referee did not reach this issue. In view of this fact, and the monumental confusion that surrounded this matter at hearing, we conclude the best solution is to allow the parties to begin again with a clean slate and a well-defined issue. Therefore, we vacate the Referee's orders and remand this case for a determination of the merits of claimant's aggravation claim. The arguments SAIF has raised before the Board concerning the merits of claimant's aggravation claim should be addressed by a Referee on remand.

ORDER

The Referee's orders dated June 3, 1983 and August 17, 1983 are vacated and this matter is remanded for further proceedings consistent with this order.

JOHN H. DENTON, Claimant
Roy Dwyer, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 81-08510
June 25, 1984
Order on Remand

On review of the Board's order dated November 24, 1982, the Court of Appeals reversed in part, affirmed in part and remanded for a determination of the present value of the industrial insurer's lien for reasonably to be expected future expenditures in connection with this claim.

The Board has been advised that the issue on remand has been resolved by the parties' stipulation; therefore, there are no remaining issues in this proceeding. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

JAMES G. CANNON, Claimant
Ringo, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-04539
June 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seifert's order which upheld the insurer's denial of claimant's July 1983 back surgery. That surgery included a total diskectomy at L4-5 with wide decompression of the spinal canal and interbody fusion.

On January 5, 1981, while working as a nurse's aide, claimant suffered a back injury helping a patient into a chair. Dr. Tsai found left L5 radicular irritation due to a herniated nucleus pulposus at L4-5 on the left. Following a period of unsuccessful conservative treatment, Dr. Stanley considered surgery to be a reasonable alternative. Dr. Tsai reached the same conclusion following hospitalization of claimant from February 25 to March 7, 1981, and claimant was rehospitalized on March 23, 1981 for bilateral L4-5 laminotomies and diskectomy. Following surgery, claimant continued to experience chronic pain in his mid back and partially down the left leg. Claimant was then placed on a physical therapy program as an outpatient at Albany General Hospital from May 20, 1981 to June 15, 1981. Facet block injections were attempted without success in relieving claimant's pain in November 1981. Meanwhile, tests revealed few objective findings of ongoing pathology. However, in November 1981, Dr. Semon reported that a CAT scan showed a mild facet hypertrophy at the L4-5 level, and significant narrowing in the lateral recess at that level which could contribute to claimant's continuing discomfort.

In December 1981 Dr. Semon raised the possibility of follow-up surgery in the form of a facetectomy or fusion and referred claimant to Dr. McGee, neurosurgeon. Dr. McGee recommended evaluation at a pain center rather than proceeding with surgery at that time.

In June 1982 claimant entered the Northwest Pain Center where he spent the next three weeks in evaluation and rehabilitation efforts. He made no progress in his physical therapy program. Psychological testing found him to be a hysteroid passive-aggressive individual with hysterical conversion elements. There were also indications that secondary gain contributed significantly towards the maintenance of operate-type pain behaviors. At the time of discharge, it was believed unlikely that further medical treatment would significantly improve claimant's condition.

Claimant continued to complain of pain when he saw Dr. Semon again in August 1982, and he expressed a desire for surgery. Referral was again made to Dr. McGee, who saw claimant in September 1982 and again in November 1982. Dr. McGee suggested the surgical procedure of total disk removal and posterior interbody fusion. It was his opinion that, in light of the failure of conservative measures and the continued severity of claimant's pain symptoms, surgical intervention would not be unreasonable. A repeat spinal canal evaluation was performed in November 1982 which revealed a slight posterior bulging of the L4-5 disc.

Given the lack of agreement in medical opinion as to whether further surgical intervention would be feasible, the insurer chose to utilize the procedure set out at OAR 436-69-501 to determine whether to authorize the surgical procedure. Claimant was subsequently seen in neurosurgical examination by Dr. Rosenbaum in December 1982 for an independent medical examination. Dr. Rosenbaum concluded that claimant had reached maximum improvement and would not be further benefited by surgery, either in the form of a nerve root decompression or fusion. He thought that further treatment would simply entrench claimant's pain complaints further.

Then, in accordance with the rules, a mutually agreeable third opinion was sought. Dr. Smith was found agreeable to both Dr. McGee and Dr. Rosenbaum and he examined claimant in April 1983. Dr. Smith found that surgery was not indicated. By letter of May 9, 1983, the insurer denied Dr. McGee's request for authorization to perform the posterior lateral interbody fusion.

However, claimant wished to proceed with the surgical procedure and, in July 1983, claimant underwent the proposed surgery. At the time of surgery, moderate bulging of the anulus was encountered far laterally at the L4-5 level on the left. Dr. McGee concluded that the amount of degenerative disc observed at the time of surgery was a reasonable medical cause for claimant's low back left hip and leg pain. Given his findings, he stated:

"I would stress that the surgical intervention in this patient was medically necessary to treat his continued disabling pain symptoms."

At hearing claimant testified to significant post-operative improvements in his condition, including the ability to get out of a bed or a chair without assistance, the ability to put on and tie his shoes, to walk outside without need of a cane and the ability to ride in a car without difficulty. All those activities were limitations he experienced prior to the July 1983 surgery.

The Referee noted Dr. McGee's surgical findings and claimant's testimony, but held the surgery not compensable because:

> "Assuming that there is some purpose and reason for OAR 436-69-501 and that it is not a useless regulation, namely that in the case of elective surgery to be compensable it must reasonably be supported by medical opinion, and assuming that it is not contemplated that a treating doctor's decision to proceed with elective surgery is not controlling and binding, and considering the guidelines in [Joseph Nacoste, 7 Van Natta 21 (1971)] where much like this case the medical evidence contraindicated surgery and there is evidence that claimant's emotional pattern was such that surgery would run a distinct risk of further cementing his role as a chronic disabled individual, and the fact that he did not cooperate in efforts of rehabilitation, I find that the denial of authorization for surgery must be affirmed."

Claimant contends that the emphasis in this case should be placed upon the presently successful findings and results of the surgery, rather than upon past medical opinion, in determining whether the surgery was a reasonable and necessary medical expense.

In Nacoste, supra, the Board declined to approve back surgery where there were minimal physical findings and the claimant's emotional pattern contraindicated surgery. The facts in the present case differ from those in Nacoste, however, in that the Referee and Board in Nacoste did not have the benefit of seeing the results of the proposed surgery, whereas, in this case we have that advantage.

In John Aleskus, 35 Van Natta 1153 (1983), the facts presented a situation more similar to the one at hand. In Aleskus, the preponderance of medical evidence was that the back surgery recommended by the treating physician should not be performed. As here, the procedure for obtaining authorization for elective surgery in OAR 436-69-501 had been followed, and the insurer denied surgery as a result of that procedure. However, the claimant still desired that the surgical procedure be carried out and, with the treating physician's approval, surgery was performed. At surgery, objective findings were found which accounted for the symptoms relating to the claimant's compensable condition. Also, the claimant testified to relief from pain following the surgery. The Board held that the surgery was compensable, stating:

> "Admittedly, the objective evidence definitely weighs in favor of a finding that surgery was not necessary and/or reasonable. However, as the claimant argues, results should count for something. We would add that in this case the treating physician's opinion based simply on professional judgment in dealing with a particular patient, also should count for something. * * * Moreover, in this case we have the benefit of the fact that the surgery has been done, and the surgery revealed that there was scarring at the nerve root site of the former surgery and a bulging disc." 35 Van Natta at 115.

Similarly, in this case, the surgical findings revealed moderate bulging of the L4-5 disc accounting for claimant's complaints of back and leg pain. Also, claimant's testimony revealed significant improvement after the surgery. We conclude, therefore, that the July 1983 back surgery is compensable.

ORDER

The Referee's order dated November 7, 1983 is reversed. Claimant's attorney is awarded $1,000 for services at hearing and $600 for services on Board review, to be paid by the insurer.

JAMES W. FOUSHEE, Claimant
Galton, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-06050 & 81-10270
June 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Williams' order which upheld the denials of Consolidated Freightways (the insurer in August 1980, the time of his compensable injury) and of Freightliner Corporation (his employer which was self-insured at the time of the claim here in question). Compensability and responsibility are the issues on review.

Claimant compensably injured his low back on August 21, 1980. Consolidated Freightways was then on the risk. The claim was accepted and claimant received an award of 10% unscheduled disability. Claimant returned to work for the same employer doing light work. Claimant was able to work without significant problems until April 1982 when he was reassigned to heavier duty. Freightliner was then on the risk. Shortly after being reassigned, claimant began experiencing an increase in symptoms. He returned to his treating physician, Dr. Rusch, who took him off work. Freightliner has denied responsibility for a new injury claim and Consolidated Freightways has denied responsibility for an aggravation.

The Referee found that claimant's condition had not worsened and, therefore, affirmed both denials. We disagree.

Dr. Rusch reported on May 3, 1982:

> "While the amount of weight lifted is light (approximately 5 pounds), repetitive bending to the level of the floor and standing has resulted in an aggravation of Mr. Foushee's right leg numbness and his lumbar back pain. Because of the severity of the recurrence of his complaints, it was necessary for him to discontinue employment as of 4-28-82."

Dr. Rusch later stated that work activity was a material contributing factor in the increase of symptoms. On September 9, 1982 Dr. Rusch said:

> "Mr. Foushee has significant recurrence of pain in the buttock area as well as in the low back with radiation to the anterior thigh. He is now having complaints of pain and numbness in the anterior aspect of his leg, below the knee associated with walking. Following this, he has a skin hypersensitivity which is moderately to severely painful. The pain and paresthesias are relieved by rest. This, therefore, represents an element of neurological claudication."

There can be no doubt, based on these reports that claimant's

compensable condition worsened. The Referee's reasoning for finding that claimant's condition was neither an aggravation nor a new injury is:

> "The evidence is overwhelming that claimant did in fact suffer exacerbation of his symptoms when transferred to a new job in April of 1982. Claimant has failed, however, to prove a concomitant worsening of the underlying condition." (Emphasis in original.)

The Referee's order raises the question of what type of worsening is sufficient to establish a valid aggravation claim under ORS 656.273. The Referee seems to have applied the test of Weller v. Union Carbide, 288 Or 27 (1980), to an aggravation claim. In other words, he required claimant to prove a pathological change in the underlying compensable condition in order to establish a worsening under ORS 656.273.

Following the apparent trend of recent court cases, we hold that the Weller test does not apply to an aggravation claim.

We note at the outset that the reach of Weller has been limited recently. Both the Court of Appeals and the Board have held that Weller does not apply to cases involving industrial injuries. Boise Cascade v. Wattenbarger, 63 Or App 447 (1983); Jameson v. SAIF, 63 Or App 553 (1983); Paul Scott, 35 Van Natta 1215 (1983); but see, Cochell v. SAIF, 59 Or App 391 (1982) and Cooper v. SAIF, 54 Or App 659 (1981).

No court case or Board case has specifically decided the question of whether Weller applies to aggravation claims. However, in deciding that Weller does not apply to aggravation claims, we are guided by the fact that in responsibility cases similar to this case, both the Court of Appeals and the Board have found the earlier employer responsible for the increase in symptoms where there was no evidence of a worsening of the underlying condition. Wills v. Boise Cascade, 58 Or App 636 (1982); SAIF v. Baer, 60 Or App 133 (1982); Elbert E. Qualls, 35 Van Natta 112 (1983). The court in both Wills and Baer found that the claimants had not suffered a worsening of their underlying conditions. It, therefore, did not assign responsibility for the apparent aggravations to the respective claimants' last employers, but to the earlier employers. A reasonable interpretation of these cases is that the court does not require a Weller type worsening in order to establish a valid claim for aggravation. However, because the paramount concern in each of those cases was the question of responsibility, rather than compensability, the courts did not specifically decide that Weller does not apply to aggravation cases. In this case we are concerned both with responsibility and with compensability, so the issue must be squarely faced.

We have found no cases in which the Weller test has been applied to a situation in which the underlying condition was caused by a work-related injury or condition. In fact, the court has indicated that a very minimal showing is sufficient to establish a valid aggravation claim.

In Johnson v. SAIF, 54 Or App 179 (1981), the claimant sustained an industrial injury and was awarded 20% permanent partial disability. Claimant later filed a claim for aggravation. The evidence consisted in part, of claimant's testimony that his low back condition had been steadily deteriorating since his original injury. Claimant's physician found no objective change in claimant's condition other than some minimal limitations in ranges of motion. The court stated that the weakness of plantar flexion in claimant's foot and a sensory dermatome of L5-S1 was sufficient to establish an aggravation.

In Peterson v. Eugene F. Burrill Lumber Co., 57 Or App 476 (1982) aff'd 294 Or 537 (1983), the claimant sustained a low back injury for which he received 5% permanent partial disability. Claimant continued working, experienced increased pain and filed an aggravation claim. Although the court's statement of facts is scanty, it appears that the court sustained the aggravation claim based on subjective evidence of a worsening in the form of disabling pain.

In Bault v. Teledyne Wah-Chang, 53 Or App 1 (1981), the claimant suffered a low back strain. The claim was closed with no award for permanent disability. Claimant thereafter filed a claim for aggravation. Although the evidence was almost completely in the form of subjective complaints of increased pain and additional work restrictions on the part of claimant and his physician, the court stated:

> "The evidence establishes permanent disability where there was none after the original injury . . . . It is compensable as an aggravation. Lack of substantial objective signs of the condition...do not detract from our conclusion." 53 Or App at 6.

Thus, despite the fact that there was little objective evidence of a worsening, an aggravation was found to have been established where claimant demonstrated that some permanent disability existed, at least in terms of work restrictions, where none existed before.

Most recently, in Garbutt v. SAIF, 297 Or 148 (1984) the Supreme Court stated:

> "We allowed review in this case to make clear that a physician's report is not indispensable in a workers' compensation claim. In the case of an 'extent of disability' claim, such as this claim, as in the case of an aggravation claim, no physician's report is required to be statutorily sufficient. The worker's or other lay testimony may or may not carry the worker's burden of proving the extent of disability, but the law does not mandate a medical report. The same is true for an aggravation claim." 297 Or at ____.

These cases suggest that only a symptomatic worsening is necessary to establish an aggravation claim under ORS 656.273.

Accordingly, we hold that a symptomatic worsening may be sufficient to establish an aggravation claim under ORS 656.273. In this case, we find that it is.

We believe that this result is also the better policy. Weller is concerned with creating a line of demarcation between a non-compensable preexisting condition and a compensable worsening of that condition. An aggravation claim under ORS 656.273, on the other hand, is concerned with compensating a claimant for the worsening of a condition which was caused by a compensable injury or occupational disease. If a compensable condition symptomatically worsens and that worsening is causally related to the compensable injury or occupational disease, then claimant should be compensated for whatever further disability results from that symptomatic worsening. Accordingly, we reverse the Referee and find that claimant's symptomatic worsening is compensable.

On the issue of responsibility, we follow the Supreme Court's lead in Boise Cascade v. Starbuck, 296 Or 238 (1984), in which the Supreme Court stated:

> "In the situation where a compensable injury at one employment contributes to a disability occurring during a later employment, involving work conditions capable of causing the disability, but which did not contribute to the disability, the first employer is liable." 296 Or at 244.

We take this to mean that when the latter employment's contribution is in the nature of an occupational disease exposure, the latter employment must actually cause some change in the condition in order to hold the latter employer responsible. Consistent with these cases, we assign responsibility to Consolidated Freightways because there is no proof that claimant's exposure while Freightliner was on the risk independently contributed to claimant's disabling condition.

ORDER

The Referee's orders dated December 8, 1982 and December 15, 1983 are affirmed in part and reversed in part. Those portions of the Referee's orders affirming the denial by Freightliner is affirmed. Those portions of the Referee's orders affirming the denial of Consolidated Freightways is reversed. Claimant's attorney is awarded $1200 for services at hearing and $600 for services on Board review.

DENA G. McGEHEE, Claimant
Robert Chapman, Claimant's Attorney
Brian Pocock, Defense Attorney
David Horne, Defense Attorney

WCB 81-10063 & 83-07112
June 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Jeld-Wen requests review of Referee Brown's order which: (1) Set aside Jeld-Wen's denial of March 25, 1983 for aggravation and continuing treatment of claimant's October 10, 1979 low back injury; (2) affirmed Lumoco's July 29, 1983 denial for a new injury or occupational disease of the low back; and (3) modified

the July 17, 1983 Determination Order by awarding claimant 64° for 20% unscheduled permanent partial disability. The Determination Order had awarded no permanent disability benefits.

The Board affirms and adopts the order of the Referee.

Lumoco points out in its brief, and we agree, that even if we did not find on the facts that claimant had suffered an aggravation rather than a new injury or occupational disease, Jeld-Wen would still be the responsible employer because of the recent case of Bauman v. SAIF, 295 Or 788 (1983).

Claimant's low back condition worsened in April 1981. She underwent testing and eventually had surgery in September 1981. Jeld-Wen specifically accepted the aggravation claim and paid for the related benefits as evidenced by a 1502 form completed by Jeld-Wen's representative, Sandra Dunn, on August 28, 1981. Jeld-Wen did not deny this claim until March 25, 1983, which was almost two years after the aggravation claim.

In Bauman, supra, (decided subsequent to the Referee's order) the court held that, once an insurer officially notifies a claimant that a claim has been accepted, the insurer may not deny the disability of that claim once 60 days have elapsed after notice of the claim, unless there is a showing of fraud, misrepresentation or other illegal activity. 295 Or 788, 793. Jeld-Wen has made no such showing in this case.

ORDER

The Referee's order dated September 15, 1983 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

ROSEANNE RIDDLE, Claimant
Samuel Hall, Claimant's Attorney
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-05279 & 82-08058
June 26, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Terry Johnson's order which found that claimant's claim was prematurely closed.

Claimant compensably injured her right hand in October 1977 while EBI was on the risk. In July 1980 claimant again injured her right hand. SAIF was then on the risk. The Referee found SAIF responsible for claimant's current condition. SAIF has not appealed on the responsibility issue.

In November 1980 Dr. Karasek, claimant's neurologist, referred her to a psychologist, Dr. Forester, because of chronic pain syndrome. Dr. Forester concluded that claimant is not a malingerer nor a classic hypochondriacal-neurotic. He thought there was some complicated interaction between her pain and psychological dimensions which were not fully apparent to him. He recommended relaxation therapy, biofeedback and psychotherapy.

In June 1981 Dr. Forester reported significant progress. He

noted claimant was much less depressed and anxious. He did not believe she would improve much more in terms of reducing her pain, but would improve in her ability to function at work with the pain. In July 1981 Dr. Forester stated:

> "[Claimant] is reaching the point of becoming medically stationary; that is, not substantially improving nor getting much more painful symptoms. Currently, she has residual anxiety, depression and pain from the work injury...."

On September 8, 1981 Dr. Karasek stated that claimant was medically stationary. On September 15, 1981 Dr. Forester noted that claimant was continuing to improve psychologically.

On October 6, 1981 Dr. Holland, a psychiatrist, issued a report based on his examination of claimant. Dr. Holland stated:

> "It is my feeling that, from a psychiatric standpoint, this lady is certainly medically stationary from any psychiatric sequelae of her industrial injury."

On November 10, 1981 Dr. Karasek stated:

> "I believe that this patient is and has been for the last few months medically stable. I believe that further diagnostic or therapeutic measures are unlikely to be beneficial and are, in fact, in my view, contraindicated for the ultimate prognosis of this patient....I certainly feel that it is detrimental to this patient to prolong the closure of her claim."

On November 4, 1981 Dr. Forester indicated that he disagreed with Dr. Holland on the issue of whether claimant was medically stationary.

On December 4, 1981 Dr. Forester stated:

> "At this time [claimant] is approaching a medically stationary point in that she is reaching a plateau probably both physically and mentally, although she does continue to need psychotherapy from me in the next several months. If claim closure does not result in her losing of her right to receive psychotherapy, then I would be willing to consider declaring her medically stationary. From my point of view medically stationary means that she has been returned to pre-injury status, and is at that particular level, although I know there are different definitions of this term."

On April 16, 1982 Dr. Forester wrote claimant's attorney suggesting that she close the case.

"I believe it might be in her best interest now to close her case since she is becoming increasingly anxious about what her future is...."

On April 30, 1982 Dr. Degge performed an examination of claimant and opined that she was medically stationary. On May 5, 1982 Dr. Forester noted that he believed claimant could expect to continue to improve with continued treatment, but opined that closure in the near future would probably benefit claimant. On May 17, 1982 a Determination Order issued which found claimant medically stationary on April 30, 1982.

At hearing Dr. Forester indicated that he did not think further treatment would improve claimant's psychological condition. Rather, he indicated that his treatment was aimed at keeping claimant from losing ground psychologically. He testified that in his mind if there is room for improvement, then a claimant is not medically stationary.

Based on a preponderance of the evidence, we are convinced that claimant was medically stationary at the time of the Determination Order. There is no doubt that from a physical standpoint she was stationary. Drs. Karasek and Degge agree. Dr. Holland also opined that from a psychological standpoint claimant was stationary. Only Dr. Forester believed that claimant was not stationary. However, even Dr. Forester said claimant's condition had reached a plateau and thought claim closure would be beneficial to claimant. He also indicated that if claimant could continue to receive psychological treatment he would not object to finding her medically stationary. Furthermore, his definition of medically stationary is inconsistent with the accepted legal definition of the term. (ORS 656.005(17) states: "Medically stationary" means that no further improvement would reasonably be expected from medical treatment, or the passage of time.) He apparently believes that if there is some possibility of improvement, the claimant is not stationary. Finally, Dr. Forester testified that his treatment is no longer aimed at improving claimant's condition but merely at keeping her from losing ground. We find Dr. Holland's opinion on the issue of whether claimant was medically stationary more persuasive than the contrary opinion of Dr. Forester. Accordingly, we reverse those portions of the Referee's order finding the claim prematurely closed. We remand to the Referee for a decision on the extent of claimant's permanent disability.

ORDER

The Referee's order dated June 28, 1983 is affirmed in part and reversed in part. That portion of the Referee's order finding the claim was prematurely closed is reversed. The balance of the Referee's order is affirmed. The claim is remanded to the Referee to rate the extent of claimant's disability.

ETHEL C. SLIGER, Claimant
Robert Nelson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-08375
June 26, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Podnar's order which set aside its denial of claimant's claim for a myocardial infarction. Compensability is the only issue on review.

Claimant is a 66 year old job placement specialist with the Department of Employment. She experienced angina in 1977, but she had no further angina problems until about the middle of May 1981, when she again experienced angina pains while working in her yard at home. Claimant saw her treating internist, Dr. Intile, who prescribed nitroglycerine. On May 27, 1981 a co-worker brought to work a newspaper article which was critical of Department of Employment workers. Claimant suffered a myocardial infarction while reading the article.

SAIF denied the claim, stating:

> "You filed a claim for an industrial injury or occupational disease diagnosed as a myocardial infarction....It appears from information available that your heart condition is unrelated to your work activities...."

The Referee set aside the denial, stating: "I am persuaded that the reading of the article was the last straw in an already stressful situation."

It is unclear to us whether claimant is alleging that she sustained an industrial injury or an occupational disease. In either event, we find that she has failed to sustain her burden of proof and thus reverse the Referee's order.

Claimant has been an employe of the Employment Division for several years. The uncontroverted evidence at hearing was that her job is stressful and that it has become increasingly more stressful over the past few years. Claimant has a long history of hypertension. In addition, she has smoked for many years. Her family has a history of both hypertension and heart problems.

The medical evidence concerning the cause of claimant's myocardial infarction and her underlying atherosclerosis is mixed. Dr. Intile stated in a July 1981 report:

> "She states that there has been considerable stress at work, and it's fairly well accepted in medical circles and in the medical literature that physical and/or emotional stress frequently precipitate myocardial infarctions."

In his subsequent deposition, Dr. Intile testified that he was unaware that claimant was reading the newspaper at the time of her myocardial infarction. He testified, however, that he thought the stress of her job was a cause of the development of her

atherosclerosis. He was unable to say whether the job stress was the major cause of the development of her atherosclerosis.

Dr. Rush, the cardiologist who treated claimant at the time of her heart attack, stated flatly: "I do not feel her myocardial infarction was related to her work." He did not elaborate on that opinion and was not deposed.

Dr. Crislip, a cardiologist, performed an examination at SAIF's request. He noted claimant's reported stress at work and the history of claimant's reading the critical newspaper article at the time of her heart attack. He also noted her history of hypertension and smoking. He opined:

> "Patients who have coronary spasm often get their symptoms without any known precipitating event. On the day of the spell that brought her in the hospital she was doing her usual job. Her job has frustrations like all jobs seem to and it does not seem like anything out of the ordinary to me. I think her situation is the result of a natural progression of her disease problem and I don't feel there is enough evidence to state that her work activity was a material contributing cause to her condition."

Dr. Crislip testified at deposition:

> "A. Well, I think that it just happened to be that, you know, she was at work when this episode came on, would be the most likely thing....So that I think, you know, she had a basic underlying problem, it just happened to have the final episode occur when she was at work.
>
> "Q. And what does the fact of some instability nine days before add to your opinion, if anything?
>
> "A. Well, it just means that it was imminent that something was going to happen more likely if there is evidence of instability."

Dr. Griswold examined claimant at her attorney's request. He reported that claimant first experienced angina in 1980, and that she once smoked but had not smoked for the past twenty years. He recited the history of claimant's reading the critical newspaper article. He noted that claimant had recently experienced angina while working in her yard. He opined that "the work activity did contribute in a substantial and material way to her acute myocardial infarction."

Dr. Griswold testified at hearing. Although there was some confusion about whether claimant's angina attack while doing yard work was before or after her myocardial infarction, Dr. Griswold's opinion at hearing was essentially the same as in his written report. He testified:

> "[S]he was suffering stress and the specific incident that morning of the 27th of May, when she was shown the article, was the substantial contributing cause."

He also testified:

> "Q. I'd like to discuss the relative value of stresses you perceive in this lady's life. As I understand your report, the reading of this newspaper article was the precipitating cause for her infarction; is that correct?
> "A. I think the culmination of a great deal of anxiety and anger and stress in the preceding months. I recognize she's hypertensive, I recognize she was a smoker, I recognize there are other risk factors which undoubtedly contributed to her coronary artery disease. But I think the red flag was waved that morning and that was it."

If this is an occupational disease claim, in order to prove medical causation, claimant must prove that the stress of her job was the major cause of her atherosclerosis or the major cause of a worsening of her atherosclerosis. Dr. Intile opined that the work stress was a cause of a worsening of her atherosclerosis, however, he did not opine that it was the major cause. Neither Dr. Rush nor Dr. Crislip opined that claimant's work stress was the major cause of her atherosclerosis or its worsening. It is difficult to determine whether Dr. Griswold believed that the stress which claimant experienced during the period preceding the heart attack was the major cause of her heart problems. We conclude that claimant has failed to sustain her burden of proving that her work stress was the major cause of her heart problems.

If this is an industrial injury claim, claimant need only prove that the newspaper incident at work was a material cause of her heart attack in order to establish medical causation. Dr. Intile ventures no opinion on this issue because he was unaware of the incident. Dr. Rush apparently thought there was no relationship between the heart attack and the newspaper incident. Dr. Crislip also thought the heart attack was not causally related to the newspaper incident. Only Dr. Griswold believed that the newspaper incident was a material cause of the heart attack. Dr. Griswold's opinion is weakened by the fact that he incorrectly understood that claimant had stopped smoking twenty years previously.

We find Dr. Griswold's opinion in favor of compensability no more persuasive than the contrary opinion of Dr. Crislip. Accordingly, we conclude that claimant has failed to sustain her burden of proof on an injury theory as well.

ORDER

The Referee's order dated October 27, 1983 is reversed. The SAIF Corporation's denial dated August 27, 1981 is reinstated and affirmed.

CHARLENE V. DEVEREAUX, Claimant
Evohl Malagon, Claimant's Attorney
Miller, et al., Defense Attorney

WCB 83-03330
June 27, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Quillinan's order which set aside its denial of claimant's claim for bilateral carpal tunnel condition and assessed it a 25% penalty and attorney fee for failing to pay interim compensation within 14 days, for failing to accept or deny within 60 days and for an unreasonble denial.

Claimant had been working as a factory worker for her employer for approximately four months when she sought treatment. By chart note dated February 16, 1983 Dr. Wichser, claimant's family doctor, reported that claimant was lifting heavy boards and had sustained multiple contusions to her wrists which had precipitated recurrent pain and numbness in both of her hands. Dr. Wichser placed claimant on light duty and directed her to return in two weeks for a follow-up examination.

Also on February 16 Dr. Wichser directed a Form 827 to the insurer indicating that claimant's bilateral wrist and hand pain was work related. Dr. Wichser reported that claimant was released to modified work (light duty). The diagnosis was probable bilateral carpal tunnel. The insurer received this form on February 23.

On February 22 claimant filed a Form 801 with her employer, describing her condition as "hands asleep."

The insurer initially treated the claim as a deferred nondisabling claim. Ms. Wadley, claims examiner for the insurer, testified that the claim was originally set up as a "medical only" claim because the insurer had verified with the employer that claimant was working in a light duty capacity.

Claimant continued to work until early March, when she was laid off. By letter dated March 28 Dr. Wichser reported that nerve conduction tests were compatible with his diagnosis of carpal tunnel disease. Dr. Wichser advised that it was his information that claimant's employer had no light duty work for claimant. Therefore, it was Dr. Wichser's opinion that claimant was entitled to time loss benefits from February 16 until such time as she could return to her work.

Dr. Wichser referred claimant to Dr. Teal, surgeon, who examined claimant in late March. Dr. Teal recommended surgery, but claimant cancelled it in order to await the insurer's authorization.

On April 8 the insurer advised claimant that it was changing the status of her claim from deferred nondisabling to deferred disabling. The insurer reported that time loss would retroactively be paid back to March 9. Ms. Wadley testified that their investigation had revealed that this was the date claimant stopped working. Ms. Wadley further testified that the first payment of time loss would have been paid approximately within one or two days of April 8.

On May 19 the insurer described claimant's job duties to Dr. Teal and requested that he review claimant's file and report his opinion. The insurer asked Dr. Teal to take particular note of an October 6, 1981 chart note reference to "probable carpal tunnel" concerning claimant's left wrist and to claimant's May 1982 treatment for a compression fracture of the thoracic spine.

By letter dated July 27 Dr. Teal opined that "it sounds like the symptoms pre-existed her employment." Dr. Teal concluded that claimant's work had aggravated her symptoms but did not cause her condition.

The insurer issued its denial on August 11. Time loss payments continued until that time.

On August 19 Dr. Wichser reported that claimant was asymptomatic for approximately one year before claimant began her employment. Further, the reference to "probable carpal tunnel" concerned only claimant's left forearm and was a notation from a physician's assistant without a corresponding neurologic consultation. Dr. Wichser opined that the insurer's denial was inappropriate.

After receiving Dr. Wichser's letter, Dr. Teal stated that apparently claimant's condition was not preexisting. Further, Dr. Teal opined that "even if her symptoms had occurred in the past prior to her employment, this appears to be a fairly clear cut case of aggravation of a carpal tunnel syndrome by her work."

Claimant testified that she had experienced aching and numbness in her left forearm while working on a conveyor belt for another employer. These symptoms occurred in 1974 and 1975. She received ultrasound and heat treatments for this problem, which subsided when she changed employment. Claimant testified that the location of this discomfort was near her elbow on the top side of her arm. This location was different from her current problem, which emanated from her wrist and hand.

Claimant injured her left wrist in 1980 or 1981 when she fell while roller skating, causing a large woman to fall on her. Claimant experienced an achiness and numbness from her elbow to her fingers. In addition, her wrist became swollen. Her treatment included a wrist splint and arm elevation. The symptoms subsided in a few weeks. Unlike her current problem which concerned her thumb, index and long finger, claimant testified her whole hand ached after the roller skating incident.

Claimant also testified about an off work incident where her hands "went to sleep" while she held a pole in the air. She held the pole for approximately 20 minutes while assisting her neighbor, Mr. Davis, install a swimming pool cover. Once she placed her hands down, "they woke right back up." Mr. Davis, claimant's neighbor and a supervisor for claimant's employer, confirmed this episode. Mr. Davis testified that it occurred approximately in the summer of 1982. Mr. Davis also recalled during this same period of time that claimant had complained while playing cards that she had been "having trouble with her hands and arms going to sleep." Mr. Davis could not swear that claimant had specifically referred to both of her hands.

The Referee found the claim compensable and set aside the insurer's denial. In addition, the Referee assessed the insurer a penalty and accompanying attorney's fee for a failure to pay interim compensation within 14 days of February 16, 1983, failing to accept or deny within 60 days and for an unreasonable denial.

We disagree with the Referee's finding concerning compensability. Therefore, we reverse.

When a worker suffers from a symptomatic condition which preexists his or her employment, it must be shown that the work activity and conditions caused a worsening of the underlying condition resulting in an increase in pain to the extent it produces disability or requires medical services. Weller v. Union Carbide, 288 Or 27 (1979). In addition, claimant must also prove that her work activities were the major contributing cause of the worsening. SAIF v. Gygi, 55 Or App 570 (1982).

Both Drs. Wichser and Teal relate claimant's condition, or its worsening, to her work activities. A major basis for their conclusions was that claimant was asymptomatic prior to beginning her employment. However, both claimant's and Mr. Davis' testimony indicate that the doctors' assumptions were incorrect. Not only had claimant experienced similar symptoms some months prior to her employment, but she had sought treatment for similar problems in previous years.

Carpal tunnel syndrome presents a sufficiently complex medical question to require competent medical evidence on the issue of causation. Uris v. Compensation Department, 247 Or 420 (1967); David A. Kimberly, 35 Van Natta 532, 534 (1983). Medical evidence on causation is only as competent as the claimant's medical history upon which it is based. In the present case, the history provided by claimant to her doctors was far from complete and in some respects, inaccurate. Therefore, the opinions based upon this inadequate history are entitled to little probative weight.

Inasmuch as Drs. Wichser's and Teal's opinions compose the entirety of claimant's medical evidence concerning the issue of causation, we find that she has failed to meet her burden of proving that her work was the major contributing cause of her condition, or its worsening. Accordingly, the insurer's denial should have been approved.

Since we find the claim noncompensable, it follows that the denial was not unreasonable. Had the claim been found compensable, we still would not find the denial unreasonable. Dr. Teal's July 1983 letter and the October 1981 chart note gave the insurer an adequate and reasonable basis to deny the claim.

We agree that the insurer failed to pay interim compensation in a timely manner. However, we find that compensation was due from the date of notice of claim, February 22, not February 16 as the Referee found. Consequently, we modify that portion of the Referee's order.

The first installment of interim compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. ORS 656.262(4). Where an employer fails to accept or deny a claim within 14 days, claimant is

entitled under ORS 656.262 to interim compensation without any offset for time worked. Bono v. SAIF, 66 Or App 138, 143 (1983). When the underlying claim is determined not to be compensable, interim compensation is due only from the date of notice or knowledge of the claim. Stone v. SAIF, 57 Or App 808, 812 (1982); Donald Wischnofske, 34 Van Natta 664 (1982).

In the present case, the employer received notice of the claim on February 22. The claim was placed in deferred status until it was denied on August 11. We have upheld the insurer's denial. Under these circumstances, the first installment of interim compensation was due 14 days from the date of notice of the claim, February 22.

The insurer did not begin paying interim compensation until approximately April 8, paying retroactively to March 9. The first installment was more than one month late and approximately two weeks of time loss deficient. We agree with the Referee that a penalty is in order. ORS 656.262(10). However, the penalty should apply to the additional temporary total disability made payable beginning February 22, 1983, not February 16, 1983 as the Referee found.

We affirm that portion of the Referee's order which assessed the insurer a penalty for a late denial. We sympathize with the insurer's problems in obtaining Dr. Teal's July 27 opinion. However, we note that the insurer did not request his opinion until May 19. By this time the 60 day period had already elapsed. As with the penalty for failure to timely pay interim compensation, this penalty should apply to the additional temporary total disability made payable beginning February 22, 1983, not February 16, 1983 as the Referee found.

ORDER

The Referee's orders dated October 10, 1983 and December 12, 1983 are reversed in part, modified in part and affirmed in part. That portion which set aside the insurer's denial of August 11, 1983 is reversed. The insurer's denial is reinstated and affirmed. That portion of the order which found the denial unreasonable is reversed. That portion which found that interim compensation benefits should begin February 16, 1983 is modified to February 22, 1983. Those portions which assessed the insurer a 25% penalty for failure to pay temporary total disability within 14 days and for failure to deny within 60 days are affirmed, but the 25% penalty should be applied to the temporary total disability made payable beginning February 22, 1983.

THELMA M. JAQUES, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-00557
June 27, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Presiding Referee Daughtry's Order of Dismissal. The Board affirms the order of the Referee with the following comments.

Claimant had a compensable injury in 1973 which was closed by Determination Order dated August 22, 1975, whereby claimant's aggravation rights expired August 22, 1980. Claimant filed an

aggravation claim in November 1980 and a hearing was held before Referee Knapp, who set aside the aggravation denial. Referee Knapp's order was not appealed.

Thereafter the Board exercised its own motion authority under ORS 656.278, holding in its October 7, 1982 order that the Referee's consideration of claimant's "aggravation claim" and SAIF's "denial" was inappropriate. The Board ordered closure of the claim under ORS 656.278, rather than under ORS 656.268. In its NOTICE TO PARTIES, the Board stated, "The right to appeal this order is governed by ORS 656.278(3). If this order is appealable, the appeal must be filed in the Court of Appeals within 30 days."

On November 8, 1983 the Board received claimant's request for hearing which contended that the Board's exercise of its own motion authority was improper. Presiding Referee Daughtry dismissed claimant's request for hearing and claimant now seeks Board review.

Without deciding whether the Board's October 7, 1982 order was appealable by claimant, we hold that if it was, claimant's only appeal route was to the Court of Appeals. The Hearings Division is not the proper forum for review of the Board's own motion orders, therefore, Referee Daughtry's dismissal of claimant's request for hearing was proper.

ORDER

The Referee's order dated December 6, 1983 is affirmed.

PHILIP F. LYSTER, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 83-00589 & 82-10572
June 27, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer, Kienow's Food Stores, Inc., requests review of Referee Mulder's order which set aside its denial of claimant's aggravation claim for his neck and shoulder injury and upheld Royal Insurance Company's denial of claimant's new injury claim. On review the issue is responsibility.

With his brief, claimant enclosed an additional medical report dated after the hearing. Claimant and Kienow moved that the record be supplemented.

We have treated this motion as a motion to remand for the taking of further evidence. We deny the motion. Our review of the record reveals that this case has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

The Board affirms the order of the Referee.

ORDER

The Referee's order dated October 12, 1983 is affirmed.

JERRY L. KRAMER, Claimant
Velure & Bruce, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 83-0274M
June 29, 1984
Own Motion Order

Claimant, by and through his attorney, has requested that the Board exercise its own motion authority and "reopen this claim" to reconsider an Order on Review entered on October 29, 1982, in WCB Case No. 80-07376. In that case, Referee Knapp had dismissed claimant's request for hearing for the reason that claimant failed to appear at the scheduled hearing. Claimant requested review and the Board affirmed the Referee's Order of Dismissal and subsequent Order on Reconsideration. No appeal was taken from the Board's order and, therefore, it became final by operation of law.

Claimant's request for own motion relief states in part: "It would seem that the interests of justice would be served to reopen this claim and reconsider the Board's Order on Review to allow us to fully evaluate what, if any, good cause Mr. Kramer had for failing to show at the hearing(s)." It appears that claimant also had failed to appear at a hearing previously scheduled before another Referee.

In support of this request for own motion relief, claimant has submitted an affidavit which recites several reasons for claimant's failure to appear. Some of these assertions were made a matter of record during the proceeding in WCB Case No. 80-07376.

There is an interest in putting an end to litigation. Thus we have the principle of res judicata. Jarvy v. Mowrey, 235 Or 579, 583 (1963); see also Dean v. Exotic Veneers, Inc., 271 Or 188 (1975).

If claimant was dissatisfied with the disposition in WCB Case No. 80-07376, he had the option to petition for judicial review pursuant to ORS 656.298. Claimant chose not to do so. This request for own motion relief is, essentially, an attempt to relitigate the issue decided adversely to claimant in WCB Case No. 80-07376. We find nothing in claimant's petition or affidavit which warrants granting the relief requested, which would disturb the finality of the Order on Review in WCB Case No. 80-07376. To the extent that claimant's request for own motion relief is premised upon the suggestion of malfeasance, misfeasance or nonfeasance on the part of claimant's former attorney (i.e. at the time of the proceeding in WCB Case No. 80-07376), there are alternative remedies available to claimant which are not within the province of this Board.

In making our determination pursuant to ORS 656.278, we have considered claimant's petition and affidavit and, in addition, the record of the proceedings in WCB Case No. 80-07376.

ORDER

Claimant's request for own motion relief is denied.

CHARLES D. CAMPBELL, Claimant
David Force, Claimant's Attorney
A.J. Morris, Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03564
May 23, 1984
Order of Abatement

The Board entered its Order on Review herein on April 25, 1984. Claimant thereafter requested the Board to abate that order on the grounds that a copy of the Order on Review was not mailed to his attorney. Claimant's attorney states:

> "Claimant has indicated to me, through the referring attorney, his desire that I review the Order on Review and determine whether I would recommend an appeal to the Court of Appeals. I cannot advise the claimant as to these matters until I have seen a copy of the Order on Review."

Considering the circumstances, we see no reason to refrain from acting upon claimant's request for abatement of our Order on Reivew and allowing claimant's attorney a reasonable amount of time in order to more fully advise his client.

ORDER

The Board's Order on Review entered on April 25, 1984 is hereby abated.

RICHARD O. HAMPTON, Claimant
Robert Ehmann, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05869 & 82-05870
April 4, 1984
Order of Abatement

The Board has received the SAIF Corporation's request to reconsider our Order on Review dated March 8, 1984.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE SUPREME COURT OF THE STATE OF OREGON

CHRISTENSEN,
Petitioner on Review,
v.
MURPHY,
Respondent on Review.
(TC 14561, CA A20590, SC 28701)

On Review from the Court of Appeals.*

Argued and submitted October 4, 1982.

W. Eugene Hallman, Pendleton, argued the cause for petitioner on review. With him on the briefs were Mautz, Hallman and Teicher, Pendleton, and Pippin and Bocci, Portland.

Douglass M. Hamilton, Portland, argued the cause for respondent on review. With him on the response and brief were I. Franklin Hunsaker, and Bullivant, Wright, Leedy, Johnson, Pendergrass and Hoffman, Portland.

Darrell E. Bewley, Salem, filed a brief of Amicus Curiae in the Court of Appeals in behalf of State Accident Insurance Fund.

Will Aitchison, of Aitchison and Sherwood, Portland, filed a brief of Amicus Curiae in the Supreme Court in behalf of Oregon Council of Police Associations.

Before Justices Linde, Peterson**, Tanzer***, Campbell and Carson.

CARSON, J.

Reversed and remanded.

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* Appeal from Wasco County Circuit Court. John Jelderks, Judge. 57 Or App 330, 644 P2d 627 (1982).

** Justice Lent was Chief Justice when case argued; Justice Peterson was Chief Justice when decision rendered.

*** Tanzer, J. resigned December 31, 1982.

CARSON, J.

Plaintiff's decedent, a police officer, was killed in the course of his duties allegedly as the direct result of defendant's negligence. The trial court, however, held that plaintiff's wrongful death claim against defendant was barred by the "fireman's rule."[1] In so doing the trial court applied the "fireman's rule" to a police officer (*see Cullivan v. Leston,* 43 Or App 361, 602 P2d 1121 (1979), *rev den* 288 Or 527 (1980)) and extended it to bar recovery for injuries suffered away from the premises where the negligence allegedly occurred.[2] The

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[1] "* * * [A]n owner or occupier is not liable to a paid fireman for negligence with respect to creating a fire." *Spencer v. B.P. John Furniture Corp.,* 255 Or 359, 362, 467 P2d 429 (1970).

[2] In the trial court, plaintiff acknowledged the existence of the "fireman's rule" in Oregon, but argued that it should not be extended to bar recovery for off-premises injuries suffered by a police officer who encounters a situation allegedly created by defendant's negligence. In her Reply Brief to the Court of Appeals, plaintiff first raised the effect on the rule of the 1975 legislative abolition of the doctrine of implied assumption of risk, ORS 18.475(2), which provides:

"The doctrine of implied assumption of the risk is abolished."

Court of Appeals affirmed. *Christensen v. Murphy,* 57 Or App 330, 644 P2d 627 (1982).

We accepted review to determine whether the "fireman's rule" should be extended to off-premises injuries suffered by a police officer who encounters a situation allegedly created by defendant's negligence. As a general rule, parties to an appeal are restricted to the questions raised and preserved in the trial court. *Travelers Indemn. v. American Ins.,* 278 Or 193, 199, 563 P2d 684 (1977). However, having granted review on the issue of the extension of the "fireman's rule," we are compelled to examine any extension of the rule in light of the law as it existed at the time it was argued in the trial court, including legislative changes and caselaw interpreting the changes. The effect of the statutory change on the rule was discussed in the petition to this court and the response thereto and argued to this court by both parties. Upon examining the basis of the "fireman's rule," we conclude that an extension is inappropriate and the rule, itself, is not supportable as a rule of Oregon tort law. Thus, we hold that plaintiff's claim is not barred on these facts.

The judgment appealed from is based on an order granting defendant's motion for summary judgment. The entry of summary judgment is proper only where there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law. ORCP 47 C. Where plaintiff has cited the granting of the motion as error, the record must be viewed in the light most favorable to her. *Yartzoff v. Democrat-Herald Publishing Co.,* 281 Or 651, 655, 576 P2d 356 (1978).

On February 16, 1976, defendant, a night matron at the Northwest Regional Youth Center in Pendleton, permitted Daryl Thompson to enter the facility. Once inside, Thompson forced defendant to release Jeanne Nobel, a minor in custody there. Thompson and Nobel then fled to an automobile a short distance away. Thompson, however, had difficulty getting the automobile started. By coincidence, Pendleton Police Officer John Christensen, plaintiff's decedent, drove by while on duty. Without knowing of the recent escape, Christensen stopped and began to assist Thompson in starting the automobile. Nobel became nervous and fled, yelling to Thompson to "run." Christensen ran after Nobel and tackled her about 20 yards from the car. Thompson followed after the pair and, in his struggle to free Nobel, fatally stabbed Christensen.

Plaintiff alleges that defendant was negligent in several particulars[3] and that such negligence was the cause of

[3] In her third amended complaint, plaintiff alleged that defendant was negligent in one or more of the following ways:

"1. In allowing defendant Daryl Thompson to enter the Northeast Oregon Regional Youth Center after visiting hours in disregard of the rules of the Northeast Oregon Regional Youth Center.

"2. In failing to alert police officers that an unauthorized person was in the Northeast Oregon Regional Youth Center.

"3. In failing to properly supervise the activities and conduct of defendant Daryl Thompson and the female juvenile while in the Northeast Oregon Regional Youth Center.

"4. In allowing defendant Daryl Thompson and the female juvenile to escape from the Northeast Oregon Regional Youth Center.

"5. In failing to alert police officers to the whereabouts of defendant Daryl Thompson although she was aware that defendant Daryl Thompson had run away from home in violation of a prior juvenile court order."

her decedent's death. In an earlier decision by this court the threshold question of whether plaintiff's complaint stated a claim for negligence against defendant was decided. In *Christensen v. Epley* (hereinafter, "Christensen I"), 287 Or 539, 601

P2d 1216 (1979), this court, by an evenly divided vote,[4] affirmed that part of the Court of Appeals decision which held that the trial court erred in entering judgment on demurrer for defendant because plaintiff's complaint did state a claim for negligence against defendant. *Christensen v. Epley*, 36 Or App 535, 585 P2d 416 (1978). In *Christensen I*, the Court of Appeals held that plaintiff's complaint alleged sufficient facts to establish a legal duty owed Christensen by Murphy to take reasonable care to prevent escape and, upon escape, to alert the police. The Court of Appeals further held that the causal link between defendant's allegedly negligent conduct and Christensen's death was sufficiently alleged to survive demurrer and also that the intervening criminal act of Thompson was not a superseding cause of Christensen's death. The Court of Appeals then held that the issue of foreseeability presented a jury question. Because the question of legal duty has been decided in *Christensen I*, 36 Or App 535, 585 P2d 416 (1978), *aff'd in part by an evenly divided court, rev'd in part*, 287 Or 539, 601 P2d 1216 (1979), we will not reconsider it here.

The question this case presents is whether, notwithstanding any negligence on defendant's part which may have caused Christensen's death, plaintiff is barred from recovery because Christensen was a police officer acting within the scope of his duties when his death occurred.

Before deciding the present case, it is helpful to review the history of the "fireman's rule" in Oregon. *Spencer v. B.P. John Furniture Corp.*, 255 Or 359, 467 P2d 429 (1970), was the first and, until now, the only case in which this court decided the application of the "fireman's rule."[5] The facts

there presented the issue in its prototypical form: The decedent was a paid member of a public fire department who was called to fight a fire on the defendant's premises that had allegedly been caused by the defendant's negligence. The decedent was fatally injured while fighting that fire by an explosion caused by an accumulation of dust in the premises.

[4] Because this court was evenly divided on the issue, a majority decided that no opinion would be written on that question. However, three separate opinions, concurring in full or in part, were filed. *Christensen v. Epley*, 287 Or 539, 601 P2d 1216 (1979).

[5] The "fireman's rule" has engendered considerable commentary. For recent extended discussions of the rule and its history, *see Lipson, v. Superior Court of Orange County*, 31 Cal3d 362, 182 Cal Rptr 629, 644 P2d 822 (1982); *Armstrong v. Mailand*, 284 NW2d 343, 11 ALR4th 583 (Minn 1979); *Court v. Grzelinski*, 72 Ill2d 141, 19 Ill Dec 617, 379 NE2d 281 (1978); *Walters v. Sloan*, 20 Cal3d 199, 142 Cal Rptr 152, 571 P2d 609 (1977); Note, *Assumption of the Risk and the Fireman's Rule*, 7 Wm Mitchell L Rev 749 (1981); Comment, *Negligence Actions by Police Officers and Firefighters: A Need for a Professional Rescuers Rule*, 66 Cal L Rev 585 (1978); Note, *Walters v. Sloan: Policemen "Burned" by Firemen's Rule*, 5 West State U L Rev 235 (1978); Note, *Landowner's Liability to Injured Firefighters in Illinois*, 27 DePaul L Rev 137 (1977); Comment, *An Examination of the California Fireman's Rule*, 6 Pac L J 660 (1975); Comment, *The Fireman's Rule in California: an Anachronism?*, 4 USF L Rev 125 (1969); Annot., *Liability of Owner or Occupant of Premises to Fireman Coming Thereon in Discharge of his Duty*, 11 ALR4th 597 (1982).

The explosion was found to be a risk naturally inherent in such a fire, and the court observed, as a statement of the "fireman's rule," that:

> "[t]he authorities are almost unanimous to the effect that an owner or occupier is not liable to a paid fireman for negligence with respect to creating a fire." 255 Or at 362.

The result in *Spencer* — the plaintiff's claim in negligence against the owner of the premises was barred — was consistent with the weight of authority. In *Spencer,* this court dismissed traditional premises liability analysis, which early decisions in other jurisdictions had employed, and stated that a fire fighter enters a premises as a matter of right pursuant to his public employment. "Therefore, such classifications as trespasser, licensee, or invitee are irrelevant to owners' or possessors' duty to firemen." *Spencer v. B.P. John Furniture Corp., supra,* 255 Or at 362. The opinion quoted with approval from *Krauth v. Geller,* 31 NJ 270, 157 A2d 129, 130-31 (1960), wherein Weintraub, C.J., explained the basis of the "fireman's rule" as assumption of risk and as a policy decision:

> "* * * The rationale for the prevailing rule is sometimes stated in terms of 'assumption of risk,' used doubtless in the so-called 'primary' sense of the term and meaning that the defendant did not breach a duty owed, rather than that the fireman was guilty of contributory fault in responding to his public duty. [Citation omitted.] Stated affirmatively, what is meant is that it is the fireman's business to deal with that very hazard and hence, perhaps by analogy to the contractor engaged as an expert to remedy dangerous situations, he cannot complain of negligence in the creation of the very occasion for his engagement. In terms of duty, it may be said there is none owed the fireman to exercise care so as not to require the special services for which he is trained and paid.

> Probably most fires are attributable to negligence, and in the final analysis the policy decision is that it would be too burdensome to charge all who carelessly cause or fail to prevent fires with the injuries suffered by the expert retained with public funds to deal with those inevitable, although negligently created, occurrences. Hence, for that risk, the fireman should receive appropriate compensation from the public he serves, both in pay which reflects the hazard and in workmen's compensation benefits for the consequences of the inherent risks of the calling [citing cases]." 255 Or at 362-63.

This court in *Spencer* then held:

> "* * * We agree for the reasons set forth in the quotation from *Krauth* that there should be no liability on the part of a possessor or owner of the premises to paid firemen for injuries from negligently caused fires." 255 Or at 364.

We further held, however, that a fire fighter does not assume all risks encountered in fighting fires. He or she has a right to expect that the owner or possessor of premises will not imprudently permit an unusual, serious *hidden* danger of a totally unexpected kind. *Id* at 365.

> "A measure of protection resulting from training and experience can be taken against apparent, known, or to-be-anticipated risks. However, a fireman is completely vulnerable to such a hidden danger as described above, and we see nothing in the lack-of-duty concept of assumption of risk or in

public policy which precludes him from having a cause of action in such circumstances." *Id.*

Because the defendant in *Spencer* was the premises' owner and because most fires occur on premises, the holding was understandably limited to "owners or possessors" of premises. However, the reasoning of this court in *Spencer* clearly was not based on premises liability analysis, but on assumption of risk and policy rationales.[6]

Before reaching the question of the extension of the "fireman's rule" in this state to off-premises injuries, we are compelled to examine its very existence as a rule of tort law in Oregon.[7] As noted above, the rationale of the rule accepted in *Spencer* was not premises liability, but assumption of risk and policy considerations. For purposes of the "fireman's rule," assumption of risk is not used in the sense of "express" assumption of risk, where parties contract with each other that one accepts the risk of harm which is incident to the other's conduct, within the scope of the parties' relationship. *See* Restatement (2nd) of Torts § 496 B.; Prosser, Law of Torts § 68, 442-45 (4th ed 1971). In "express" assumption of risk situations, one party expressly and prospectively exonerates the other for any injuries the latter negligently may cause; or, stated differently, the former expressly limits the latter's duty of care towards him or her.

The rationale for the "fireman's rule" in Oregon has been "implied" assumption of risk in the "primary," as opposed to the "secondary," sense of the phrase. This meant

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[6] The only other Oregon appellate case concerning the "fireman's rule" is *Cullivan v. Leston*, 43 Or App 361, 602 P2d 1121 (1979) *rev den* 288 Or 527 (1980). *Cullivan* extended the coverage of the "fireman's rule" to paid public police officers. The essential factual elements in *Cullivan* tracked those of *Spencer:* The plaintiff police officer entered the defendant's premises (a tavern) in the course of his duties, for the purpose of attempting to break up a fight allegedly caused by the defendant's negligence in serving alcohol to visibly intoxicated patrons. The plaintiff was injured when he was assaulted by friends of the brawling patrons. This injury was judged a result of risks inherent in the situation. The Court of Appeals held that, for the reasons stated in *Spencer,* the plaintiff's injury was a normal risk of carrying out his official duties and the plaintiff was barred from recovery from the defendant in negligence. The court did not consider the 1975 enactment of ORS 18.475(2) which abolished implied assumption of risk.

[7] Some jurisdictions have expanded the "fireman's rule" to encompass a "professional rescuer's rule" which bars certain types of negligence actions by the rescuer irrespective of that person's status as a public employee or of where the injury occurs. This doctrine apparently originated in *Maltman v. Sauer,* 84 Wash2d 975, 530 P2d 254 (1975), which dealt with an action by the estates of the crew of an Army helicopter that crashed en route to the scene of an automobile accident allegedly caused by the defendant's negligence. The Washington court there stated:

> "* * * We conclude that the proper test for determining a professional rescuer's right to recover under the 'rescue doctrine' is whether the hazard ultimately responsible for causing the injury is inherently within the ambit of those dangers which are unique to and generally associated with the particular rescue activity. Stated affirmatively, it is the business of professional rescuers to deal with certain hazards, and such an individual cannot complain of the negligence which created the actual necessity for exposure to *those* hazards. When the injury is the result of a hazard generally recognized as being within the scope of dangers identified with the particular rescue operation, the doctrine will be unavailable to that plaintiff." 530 P2d at 257.

See also Gillespie v. Washington, 395 A2d 18 (DC Ct App 1978) (harbor patrol officer injured uprighting defendant's boat); *Black Industries, Inc. v. Emco Helicopters, Inc.,* 19 Wash App 697, 577 P2d 610 (1978) (helicopter crash while fighting forest fire); Comment, *Negligence Actions by Police Officers and Firefighters: A Need for a Professional Rescuers Rule, supra* n. 5.

that no duty was owed to exercise care to avoid the necessity of the special services of a paid public safety officer, not that the officer was guilty of contributory fault in responding to his or her duty. *Spencer v. B.P. John Furniture Corp., supra,* 255 Or at 362. In contrast to "secondary" assumption of risk, which is

a variant of contributory fault, "primary" is a derivative of "express" assumption of risk. That is, due to the nature of the parties' relationship, it was implied, despite the lack of any express agreement, that the plaintiff disclaimed or waived the duty of care the defendant might otherwise owe to him or her.

Implied assumption of risk in both primary and secondary forms statutorily has been abolished in this state since 1975, and thus it can no longer serve as an absolute bar to a plaintiff's recovery.[8] ORS 18.475(2); *Blair v. Mt. Hood Meadows Development Corp.,* 291 Or 293, 300, 630 P2d 827 (1981); *Thompson v. Weaver,* 277 Or 299, 560 P2d 620 (1977). That fact requires us to reexamine the "fireman's rule" to determine whether we can still hold that a fire fighter or police officer assumes the risk of another's negligence to the point of absolutely barring a public safety officer from recovering in a negligence action.

In *Blair v. Mt. Hood Meadows Development Corp., supra,* we discussed primary implied assumption of risk in light of ORS 18.475(2). The issue there was whether the plaintiff could recover for injuries received in the course of an inherently dangerous sporting activity, downhill skiing, in which he had voluntarily chosen to engage. Formerly, such a fact situation was analyzed under primary implied assumption of risk. *See Whipple v. Salvation Army,* 261 Or 453, 495 P2d 739 (1972) (tackle football). *Blair* makes clear, however, that it is really a question of whether negligence in fact occurred:

> "* * * Thus, the fact that a sport participant's injury results from a risk which is an element of the sport even when properly conducted may continue to defeat recovery for negligence because the defendant's duty in the context of the sport may not extend to protecting against such risks." 291 Or at 302.

In *Blair,* we noted that the same facts which formerly were analyzed under the doctrine of implied assumption of risk are still relevant in reducing or eliminating recovery for negligence. A defendant may still have a complete defense to

liability for negligence, independent of the now eliminated doctrine of implied assumption of risk, if, apart from the plaintiff's conduct, the plaintiff cannot establish that the defendant breached a duty owed in the circumstances, or if the defendant can show that the plaintiff's contributory fault was greater. However, "[ORS 18.475(2)] cannot be circumvented by restating as an absence of duty what was previously implied assumption of the risk." *Thompson v. Weaver, supra,* 277 Or at 305.

[8] Oregon law differs significantly from California and Minnesota where only the secondary, not the primary, form of implied assumption of risk has been abolished. For this reason, the California and Minnesota cases upholding the "fireman's rule," upon which defendant relies, are inapposite. *See e.g., Li v. Yellow Cab Co. of California,* 13 Cal3d 804, 119 Cal Rptr 858, 532 P2d 1226 (1975); *Armstrong v. Mailand,* 284 NW2d 343 (Minn 1979).

When we thus reexamine the "fireman's rule," we find that its major theoretical underpinning is gone. Therefore, because the rule is not sustainable under implied assumption of risk analysis, we must determine if any other supportable theory under the general rubric of "policy" will provide the foundation for the rule. The most often cited policy considerations include: 1) To avoid placing too heavy a burden on premises owners to keep their premises safe from the unpredictable entrance of fire fighters; 2) To spread the risk of fire fighters' injuries to the public through workers' compensation, salary and fringe benefits; 3) To encourage the public to call for professional help and not rely on self-help in emergency situations; 4) To avoid increased litigation. *See Walters v. Sloan,* 20 Cal3rd 199, 142 Cal Rptr 152, 571 P2d 609 (1977); Prosser, Law of Torts, *supra* at 397.

Frequently, the so-called policy reasons are merely redraped arguments drawn from premises liability or implied assumption of risk, neither of which are now available as legal foundations in this state. For example, policy consideration "1" above focuses on the fire fighter as a class from whom the premises owner needs immunity (akin to a licensee or trespasser), not on the reasonableness of the activity of the premises owner in the circumstances. Thus, it can be seen that the unusual hazard or hidden danger exception to the "fireman's rule" (allowing the fire fighter to recover under the old premises liability or the new foreseeability tests), discloses not a governmental policy concerning conduct of a landowner but a veiled form of assumption of risk analysis — usually characterized in language indicating that the fire fighter "* * * does not assume such risks." *Spencer v. B.P. John Furniture Co., supra,* at 365.

The remaining policy arguments are equally flawed. The weakness in the loss-spreading rationale, "2" above, is

obvious. By denying a public safety officer recovery from a negligent tortfeasor, the officer is not directed to recover his damages from the general public; rather the officer is totally precluded from recovering these damages from anyone. Contrast this with other public employees who are injured when confronting dangers on their jobs. The latter can recover workers' compensation and salary benefits from the public, but are also allowed additional tort damages from the third-party tortfeasors. Under the "fireman's rule" the injured public safety officer must bear a loss which other public employees are not required to bear.[9] Furthermore, this court previously has rejected loss-spreading as the sole rationale for recovery in products liability cases because we recognized that the logical extension of risk spreading would lead to absurd lengths. *Markle v. Mulholland's, Inc.,* 265 Or 259, 266, 509 P2d 529 (1973).

As for "3" above, Dean Prosser criticized as "preposterous rubbish" the argument offered to defend the "fireman's rule" that tort liability might deter landowners from

[9] *See e.g.,* discussions in *Walters v. Sloan, supra,* n. 5 (Tobriner, J., dissenting) and *Berko v. Freda,* 93 NJ 81, 459 A2d 663 (1983)(Handler, J., dissenting).

uttering cries of distress in emergency situations. Prosser, Law of Torts, *supra* at 397. We agree. Furthermore, we have previously rejected "4" above, avoidance of increased litigation, as a ground for denying substantive liability. *Norwest v. Presbyterian Intercommunity Hosp.*, 293 Or 543, 552, 652 P2d 318 (1982). In fact, the "fireman's rule" has come under attack recently on several fronts.[10]

As a result of statutory abolition of implied assumption of risk, we hold that the "fireman's rule" is abolished in Oregon as a rule of law and no longer can bar recovery of damages for personal injuries sustained by a public safety officer, in the course of his or her employment, as a result of a defendant's negligent conduct.[11] We thus expressly overrule

the holding in *Spencer v. B.P. John Furniture Corp., supra.* This case is remanded to the trial court for further proceedings in accordance with this opinion.

Reversed and remanded.

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[10] *See e.g.*, Comment, *The Fireman's Rule in California: an Anachronism? supra*, n. 5, and Note, *Assumption of the Risk and the Fireman's Rule, supra*, n. 5. In New Jersey, the birth state of the seminal case (*Krauth v. Geller*, 31 NJ 270, 157 A2d 129 (1960)), upon which we relied to enunciate the "fireman's rule", the rule has recently come under attack. In a 4-2 decision upholding the rule, the dissent by Handler, J. states that the "fireman's rule" is unsupportable on policy grounds. *Berko v. Freda, supra*, n. 9.

[11] The proper analysis of recovery by public safety officers for negligently caused injuries is shifted from the officers' implied assumption of risks inherent in their occupations, to the defendant's duty in the circumstances. The inquiry thus should be in each case: Did the defendant breach a legal duty causing the plaintiff's injury? As noted earlier, this court effectively found that a legal duty was owed to Christensen by Murphy to take reasonable care to prevent escape and, upon escape, to alert the police. *Christensen I*, 36 Or App 535, 585 P2d 416 (1978) *aff'd in part by an evenly divided court, rev'd in part*, 287 Or 539, 601 P2d 1216 (1979). This shift in analysis does not mean, of course, that every home or premises owner will be liable to every public safety officer for his or her injuries. As we said in *Blair v. Mt. Hood Meadows Development Corp.*, 291 Or 293, 300, 630 P2d 827 (1981), the question is whether actionable negligence, in fact, occurred. A defendant's duty may not extend to protecting against certain risks. Furthermore, where a plaintiff fails to act reasonably under the circumstances, his or her recovery will be diminished under the statutory mandate of comparative fault analysis. ORS 18.470.

IN THE SUPREME COURT OF THE STATE OF OREGON

MOUNTAIN FIR LUMBER CO., INC.,
Respondent on Review,
v.
EMPLOYEE BENEFITS INSURANCE CO.,
Petitioner on Review.

(TC A8005-02910, CA A22281, SC 29950)

On review from Court of Appeals.*

Argued and submitted December 5, 1983.

James N. Westwood, Portland argued the cause and filed the brief for petitioner. With him on the brief was Miller, Nash, Yerke, Wiener & Hagar, Frederic A. Yerke, and Bruce A. Rubin, Portland.

G. Kenneth Shiroishi, Portland, argued the cause and filed the briefs for respondent. With him on the briefs was Morrison, Dunn, Miller, Carney & Allen, Portland.

Before Peterson, C. J., Lent, Linde, Campbell and Carson, Justices.

CAMPBELL, J.

The decision of the Court of Appeals is reversed.

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* Appeal from Circuit Court, Multnomah County. Robert E. Jones, Judge. 64 Or App 312, 667 P2d 567 (1983).

CAMPBELL, J.

Plaintiff Mountain Fir entered into a contract with defendant Employee Benefits Insurance Co. for workers' compensation insurance coverage which plaintiff alleges included defendant's oral promise for the rebates of premiums. Defendant refused to pay these rebates and plaintiff filed two amended complaints. In the first it sought to recover damages, alleging damages for breach of contract and two fraud claims. In the second it asked for reformation and damages for breach of the reformed contract. Defendant argues that neither amended complaint stated facts sufficient for valid claims of relief because the alleged contract was in violation of statute and, therefore, unenforceable. The trial court agreed and granted judgment for defendant. The Court of Appeals reversed. *Mountain Fir Lbr Co. v. EBI Co.*, 64 Or App 312, 667 P2d 567 (1983). We reverse the Court of Appeals.

The parties entered into a three year contract for workers' compensation insurance in October of 1975. In addition to the written contract, plaintiff alleges an oral agreement that defendant would rebate some money, that is,

return part of the premium to plaintiff in some circumstances.[1] Plaintiff alleges that defendant breached this part of the contract by failing to pay these rebates, and further alleges that it only entered into this contract because of defendant's fraudulent misrepresentations.

In response defendant filed an ORCP 21 motion to strike or dismiss the complaint[2] because the contract was

illegal and should not be enforced, and the fraud action cannot stand because one may not rely on an illegal promise. The trial court granted defendant's motion to dismiss, holding that plaintiff failed to state facts sufficient for valid claims of relief.

Plaintiff then filed a second amended complaint seeking the reformation of the parties' written contract to include the oral promise for rebates and claiming breach of the contract as reformed. The trial court again granted defendant's motion to dismiss, evidently holding that equity would not reform or enforce a contract if the reformed contract would be unlawful and unenforceable.

Plaintiff appealed. The Court of Appeals held that although the contract was in violation of statutes, it was still enforceable because there was no clear legislative intent that

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[1] Plaintiff alleges this oral agreement was as follows:

"1. That the cost to plaintiff for the described insurance coverage would be based upon a premium determined as the sum of:

"a. 20.7% of the Standard Premium

"b. Claims paid plus a reserve for open claims, multiplied by a Loss Conversion Factor of 1.10.

"2. That any amount of premium paid by plaintiff to defendant in excess of the above determined earned premium would be returned to plaintiff.

"3. That defendant would return amounts paid by plaintiff in excess of the earned premium one (1) year after the specific policy year, and a final computation and return would occur one (1) year after the expiration of the three year policy period."

[2] ORCP 21 states in part:

"A. How presented. Every defense, in law or fact, to a claim for relief in any pleading, whether a complaint, counterclaim, cross-claim or third party claim, shall be asserted in the responsive pleading thereto, except that the following defenses may at the option of the pleader be made by motion to dismiss: * * * (8) failure to state ultimate facts sufficient to constitute a claim, * * *. A motion to dismiss making any of these defenses shall be made before pleading if a further pleading is permitted. The grounds upon which any of the enumerated defenses are based shall be stated specifically and with particularity in the responsive pleading or motion. * * *.

"* * * * *

"E. Motion to Strike. Upon motion made by a party before responding to a pleading or, if no responsive pleading is permitted by these rules, upon motion made by a party within 10 days after the service of the pleading upon such party or upon the court's own initiative at any time, the court may order stricken: (1) any sham, frivolous, or irrelevant pleading or defense or any pleading containing more than one claim or defense not separately stated; (2) any insufficient defense or any sham, frivolous, irrelevant or redundant matter inserted in a pleading. If, on a motion under this section, the facts supporting the motion do not appear on the face of the pleading or defense and matters outside the pleading or defense, including affidavits and other evidence, are presented to the court, all parties shall be given a reasonable opportunity to present evidence and affidavits and the court may determine the existence or nonexistence of the facts supporting such motion if such facts are not materially disputed or may defer such determination until further discovery or until trial on the merits."

the statutes forbidding oral agreements for rebates would render the contract unenforceable. It held that dismissal of the reformation claim was error because the contract was *enforceable. It also held that plaintiff* may proceed on the fraud claims and should be permitted to prove that it relied on and was induced by defendant's alleged false and misleading representations.

We granted defendant's petition for review and reverse.

The oral agreement for rebates, alleged by plaintiff and not denied by defendant, violates both ORS 746.035 and ORS 746.045:

ORS 746.035:

> "Except as otherwise expressly provided by the Insurance Code, no person shall permit, offer to make or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the policy issued thereon."

ORS 746.045:

> "No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy or the agent's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue on or from the policy, or any other valuable consideration or inducement to or for insurance on any domestic risk, which is not specified in the policy."

Courts generally refuse to help someone who complains that an illegal promise has not been performed. *Hendrix v. McKee,* 281 Or 123, 128, 575 P2d 134 (1978). If all contracts that violate a statute were unenforceable per se, or if the above statutes indicated whether contracts made in violation thereof are either void or enforceable, we would need to look no further. But this is not the case.

The general rule is from *Uhlmann v. Kin Daw,* 97 Or 681, 689, 193 P 435 (1920):

> "If a statute having a penalty and a prohibition, express or implied, or only a penalty or only a prohibition, is silent and otherwise contains nothing from which the contrary is to be inferred, then an agreement which conflicts with the statute is void."[3]

The statutes with which we are concerned are prohibitions, and ORS Chapter 731 lists possible penalties for violations thereof. The statutes are silent as to whether agreements in violation of them are unenforceable. The statutes, by themselves, contain nothing from which we can infer

[3] The word "void" when applied to legally questionable agreements or other transactions may be overly broad, if it is taken to mean that such agreements have no legal effects. Ordinarily what is meant is that the illegal contract is not enforceable between the parties (or, if "voidable," can be set aside by either of them). The substance and purpose of the rule that makes the agreement illegal determines in what respect the agreement cannot be effective. In this case, for instance, we do not imply that Mt. Fir's employees were not covered under the contract.

that the legislature intended that such agreements should be enforceable. Applying the general rule, we find that this agreement made in violation of statutes should not be enforced.

In *Hunter v. Cunning,* 176 Or 250, 287, 154 P2d 562, 157 P2d 510 (1945), we summarized our holding from *Uhlmann:*

> "* * * We derived therefrom the fundamental distinction between the Uhlmann case and the case at bar, viz., that the rule, which avoids a contract made in contravention of a statute, will *always* be applied when the statute is intended for the protection of the public against those evils which we know from experience society must be guarded against by protective legislature. The statute under consideration is such a one."

We followed this rule in *Bronson v. Moonen,* 270 Or 469, 478-81, 528 P2d 82 (1974), in which vendors of property did not comply with a administrative rule requiring a written statement by the public health officer concerning the proposed method of sewage disposal. This failure to comply rendered the contract at least voidable because the rule was for the protection of the public.

In *Huff v. Bretz,* 285 Or 507, 518, 592 P2d 204 (1979), after review of the above cases, we suggested that a lease provision that would require a lessor to violate Oregon statutes relating to water rights might well have been voidable, because these statutes were designed for the protection of the public. We have the same situation in the present case; the statutes violated were enacted for the protection of the public.

We find nothing in the facts of this case that would require us to modify or depart from this general rule. Plaintiff makes extensive arguments based on the "equities" of its case. It urges us to allow it to proceed in this action, so that defendant does not benefit from its illegal bargain. We note,

however, that ORS 737.265(2),[4] as it was at the time of this contract, required all insurers to adhere to rates, rating systems and policy forms of the rating organization. Statutes at that time restrict competition in the field of workers' compensation insurance to services offered by the competing companies, rather than allowing an insurer to compete by undercutting other companies with lower premiums. This evidently was done to guarantee that all insurers would have sufficient funds to cover claims filed by the injured workers. Plaintiff in essence argues that it was an innocent victim in the making of this illegal contract. However, it cannot avoid the fact that the statutes not only forbid an insurer from offering inducements and rebates that are not included in the

[4] ORS 737.265(2):

> "All insurers required by subsection (2) of ORS 737.560 to be members of a workmen's compensation rating organization shall adhere to the rates, rating systems and policy forms of the rating organization." *Amended by* Or Law 1977, ch 333 § 1.

written contract, but also specifically forbid the insured from receiving these inducements and rebates if they are not in writing. To allow plaintiff to enforce this agreement would be to read out of ORS 746.045 the word "receive," and ignore much of ORS 746.035. It would also allow plaintiff to benefit from the illegal bargain. This we will not do.

We further note that to deny plaintiff the right to enforce this contract will not result in any sort of forfeiture. Plaintiff paid for and received workers' compensation insurance coverage for the three year period of the contract. It does not allege that defendant failed in any respect to provide the coverage that the parties agreed upon. We also note that the portion of the contract that violates the statute is in no sense collateral to the oral agreement sought to be enforced; it is directly connected and an integral part. The situation would be different if plaintiff had paid premiums and defendant refused to pay claims, arguing that because of the rebate provisions the contract was illegal and unenforceable, because in that instance the illegal portion of the contract possibly might be severed. Nothing can be severed here, for plaintiff is asking us to enforce the illegal provision itself.

Plaintiff argues that if we refuse to enforce this contract, we will encourage insurers to engage in this sort of

conduct in the future. We think not. When purchasers of insurance are aware that if they have entered into insurance contracts in violation of the statutes, the courts of Oregon will refuse to come to their aid if the insurer asserts a defense of illegality, we believe that they will avoid this sort of contract in the future. At the time the parties made this contract, the legislature determined that for the good of the workers in the state the entire contract for workers' compensation insurance must be in writing and there would be no competitive rates in the workers' compensation field; to allow the enforcement of this agreement for illegal rebates that are not contained in the written contract would be to negate that decision. Such action would condone the very evil the legislature condemned.

Plaintiff also attempted to bring two counts of fraud, one seeking the amount of the promised rebates and the other seeking the money it spent in excess of what it would have paid had it continued with its less expensive insurance coverage with SAIF. It also requested punitive damages. The right to rely is an essential element of fraud. This is a conclusion of law and therefore, need not be pleaded as ultimate fact. *U.S. National Bank v. Fought,* 291 Or 201, 222, 630 P2d 337 (1981). One does not have the right to rely on a promise made in violation of a statute in an action for deceit. *Bond v. Graf,* 163 Or 264, 270, 96 P2d 1091 (1939); *Thielsen v. Blake, Moffitt & Towne,* 142 Or 59, 65, 17 P2d 560 (1932). *Burgdorfer v. Thielemann,* 153 Or 354, 55 P2d 1122 (1936), on which plaintiff relies, is not in point because the underlying agreement there was legal; the only conflict was with the Statute of Frauds.

The reasoning in *R.D. Reeder Lathing Co. v. Cypress Insurance Co.,* 3 Cal App3d 995, 84 Cal Rptr 98 (1970), a

similar case in which the court allowed a fraud action, is not compelling because the court ascribed a different purpose to its antirebate statute and failed to address the question of the right to rely on an illegal promise in an action for deceit.

Plaintiff's final complaint requested reformation of the contract and damages for the breach thereof. If we were to reform the contract so that the oral agreement became part of the written contract, the contract would no longer violate ORS 746.035 and 746.045. We note, however, that other

statutes would be implicated. ORS 737.265(2),[5] 737.330(1),[6] and 743.006[7] required that a workers' compensation insurance contract adhere to set rates and be approved by the Insurance Commissioner. Just as ORS 746.035 and 746.045 forbid covert agreements for reductions of premiums, these three statutes forbid such overt agreements. We refused to reform a contract legal on its face into one that would be unlawful in *Mitchell v. Chernecki,* 286 Or 285, 292, 593 P2d 1163 (1979). We also decline to reform an agreement unlawful in one way so that it is unlawful in another.

Reversed.

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[5] See n. 4.

[6] ORS 737.330(1):

"No insurer shall make or issue a policy except in accordance with the filings which are in effect for the insurer as provided in this chapter."

[7] ORS 743.006:

"(1) Except where otherwise provided by law, no basic policy form, or application form where written application is required and is to be made a part of the policy, or rider, indorsement or renewal certificate form shall be delivered or issued for delivery in this state until the form has been filed with and approved by the commissioner. This section does not apply to:

"(a) Forms of unique character which are designed for and used with respect to insurance upon a particular risk or subject;

"(b) Forms issued at the request of a particular life or health insurance policy owner or certificate holder and which relate to the manner of distribution of benefits or to the reservation of rights and benefits thereunder; or

"(c) Forms of group life or health insurance policies, or both, which have been agreed upon as a result of negotiations between the policyholder and the insurer.

"(2) The commissioner shall within 30 days after the filing of any such form approve or disapprove the form. The commissioner shall give written notice of such action to the insurer proposing to deliver such form and when a form is disapproved the notice shall show wherein such form does not comply with the law.

"(3) The 30-day period referred to in subsection (2) of this section may be extended by the commissioner for an additional period not to exceed 30 days if he gives written notice within the first 30-day period to the insurer proposing to deliver the form that he needs such additional time for the consideration of such form.

"(4) The commissioner may at any time request an insurer to furnish him a copy of any form exempted under subsection (1) of this section."

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Lawrence McLees, Claimant.

AMERICAN BUILDING MAINTENANCE,
Petitioner on Review,

v.

McLEES,
Respondent on Review.

(WCB 81-02113; CA A25521; SC S30082)

In Banc*

On Review from the Court of Appeals.**

Argued and submitted January 26, 1984.

Allan M. Muir, Portland, argued the cause for petitioner on review. With him on the brief were Ridgway K. Foley, Jr., P.C., Schwabe, Williamson, Wyatt, Moore & Roberts, and Paul R. Bocci, Portland.

Evohl F. Malagon, Eugene, argued the cause for respondent on review. On the brief was David C. Force, Eugene.

ROBERTS, J.

The decision of the Court of Appeals is affirmed.

* Peterson, C. J., did not participate in this decision.

** Judicial Review from Workers' Compensation Board. 64 Or App 602, 669 P2d 375 (1983).

ROBERTS, J.

We accepted review in this case to determine whether Oregon's workers' compensation law requires consideration of a previous Veterans' Administration (VA) disability award when determining the amount of a later Oregon workers' compensation award for injury to the same part of the body. The referee, Board and Court of Appeals all concluded that VA compensation should not be considered in calculating claimant's disability award. Four members of the Court of Appeals dissented. We affirm the Court of Appeals.

Claimant suffered a compensable injury to his right knee in 1977 when he slipped while working as a waxer for American Building Maintenance (ABM). He was awarded 67.5 degrees, which is 45 percent, scheduled permanent partial disability. ORS 656.214(2)(c).[1] Prior to this injury he had not received any awards of compensation through the Oregon workers' compensation system or through the workers' compensation system of any other state. He had, however, pre-

[1] Scheduled disabilities are those described in ORS 656.214(2) through (4); unscheduled disabilities are all others. The criteria for rating unscheduled disabilities is set forth in ORS 656.214(5).

viously injured his knee while in the military service and had received a disability award from the VA for the original injury and subsequent aggravations.

ORS 656.222 provides:

> "Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been paid or awarded compensation for a permanent disability, his award of compensation for such further accident shall be made with regard to the combined effect of his injuries and his past receipt of money for such disabilities."

We have addressed this provision in three previous cases. In all these cases the first compensation was awarded under the Oregon workers' compensation law and we had to decide whether the statute required that compensation from this source should reduce a subsequent award. In *Cain v. State Ind. Acc. Comm.*, 149 Or 29, 37 P2d 353 (1934) and *Green v. State Ind. Acc. Comm.*, 197 Or 160, 251 P2d 437, 252 P2d 545 (1953), we held that the statute did not require reduction of an

unscheduled disability award when a worker sought compensation for injury to the same part of the body for which he previously had been compensated. In *Nesselrodt v. Compensation Department*, 248 Or 452, 435 P2d 315 (1967) we reduced an award for a scheduled disability by the percentage of Oregon compensation benefits received for a prior injury to the same part of the body. We distinguished *Green* and *Cain* from *Nesselrodt* because they involved unscheduled disabilities.

In the instant case, prior benefits came from another source of compensation, the Veterans' Administration. We must decide for the first time whether benefits from another compensation system must be considered in an award for disability for a subsequent injury to the same part of the body.

ORS 656.005(9) provides:

> " 'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by a direct responsibility employer or the State Accident Insurance Fund Corporation pursuant to this chapter."

A majority of the Court of Appeals held that the "compensation" by which a subsequent award must be reduced included only benefits received pursuant to Chapter 656, the Oregon workers' compensation law, and excluded the VA benefits at issue in this case. The four dissenters would decide this case under *Harris v. SAIF*, 55 Or App 158, 637 P2d 1292 (1981).[2]

In *Harris* the issue was the extent of an unscheduled disability for a low back injury. The claimant had a prior disability award from California. The Board reduced the referee's award because it considered the referee's award "excessive for the residual effects of [the California injury] and its relationship to claimant's loss of wage earning capac-

[2] No review was sought in *Harris v. SAIF*, 55 Or App 158, 637 P2d 1292 (1981).

ity." The Court of Appeals reinstated the larger award because it found that while claimant's earning capacity may have been somewhat diminished after the California injury, he had, nonetheless, returned to the type of job in which he was most experienced and upon which his pre-injury earnings were calculated. Prior to making this determination, however, the Court of Appeals cited ORS 656.222 and said that the statute

requires consideration of the combined effect of claimant's prior injuries and his past award from the California compensation system for any previous disability.

We agree with a majority of the Court of Appeals that *Harris* is doubtful authority. *Harris* did not cite *Green* or *Nesselrodt.* Nor did *Harris* consider whether sources of compensation other than our own state workers' compensation system were properly within the contemplation of ORS 656.222. It merely assumed that benefits from a source other than Oregon's workers' compensation system, in that case another state's compensation system, should be considered in a subsequent award. This conclusion was error.

ORS 656.222 refers to "compensation," a word defined at ORS 656.005(9) as "* * * benefits * * * provided * * * to a subject worker * * * pursuant to this chapter." At oral argument counsel for ABM put forth a position not previously presented in the briefs. ABM points out that the definition section of the workers' compensation statutes, ORS 656.005, uses different words in introducing the various definitions. In most instances the statute employs the words "mean" or "means" before defining the words; in three instances the word "is" is used; in three instances the word "includes" is used. The three terms that are followed by the word "includes" are "child," ORS 656.005(6), "person," ORS 656.005(21) and "compensation," ORS 656.005(9).

ABM points out that in both the statute defining "child" and the statute defining "person," the most obvious and universally accepted definition is omitted, *i.e.,* in ORS 656.005(6) a natural born child of the worker is not included, and in ORS 656.005(21) a natural person is not included. The definitions do, in fact, include those omitted individuals. ABM argues from this that, because the word "includes" is also used to define "compensation," that definition is not complete just as the definitions of "child" and "person" are not complete. Therefore, compensation means something more than "* * * all benefits * * * provided * * * to a subject worker * * * pursuant to this chapter." ABM maintains that the use of the word "includes" indicates there are other benefits which a worker may receive that should be considered compensation within this statute, and that VA benefits are among them. We cannot accept ABM's argument.

First, the terms "child" and "person" are generic terms recognized to have a common, discrete meaning. Those terms so obviously mean a natural born child and a natural person that if there was an intent to exclude that meaning the statute would have to state it specifically. The inclusion of

those persons within the respective definitions is self-evident and the statute need only address the less obvious inclusions. The word "compensation" has no comparable common meaning. The word standing alone does not convey a meaning that would be unquestioned in all circumstances. As used in ORS chapter 656, "compensation" is a term of art, a word with a meaning peculiar to the workers' compensation laws.

Second, we conclude the word "includes" as it relates to compensation is intended to explain the term "all benefits" which follows the word "includes." The word does not mean "in addition to" as it does in the definition of child, ORS 656.005(6), and person, ORS 656.005(21); it is intended to describe the range of benefits within the meaning of the term "compensation."

Under ORS 656.005(9) "compensation" means benefits for a compensable injury as well as benefits payable to particular individuals. The statute uses the words "subject worker." We interpret this to mean a worker who is subject to the provisions of the Oregon workers' compensation laws and who is to be paid by a direct responsibility employer or the State Accident Insurance Fund Corporation pursuant to the Oregon workers' compensation laws.

Applying this interpretation to ORS 656.222, we conclude, and now hold, that the provisions of this statute requiring that an award of compensation for a subsequent disability shall be made with regard to the combined effect of his injuries and his past receipt of money for such disabilities refers only to previous compensation paid a worker under the Oregon workers' compensation system.

This holding is not inconsistent with the fact that the legislature has demonstrated that when it chooses to require the consideration of other sources of compensation, it does so specifically. ORS 656.209, for example, provides for an offset for permanent total disability awards when a worker is also

receiving Social Security benefits. The legislature has not chosen to enact a similar provision respecting veterans' disability awards or awards made under other states' compensation systems.

For these reasons we affirm the Court of Appeals.

IN THE SUPREME COURT OF THE STATE OF OREGON

May 1, 1984

In the Matter of the Compensation of
Mark L. Rosera, Claimant.

MARK L. ROSERA,

Petitioner on Review,

v.

SAIF CORPORATION,

Respondent on Review.

WCB 81-11753, CA A28548, SC S30503

In Banc.

On claimant's petition for review, filed March 30, 1984, of a decision of the Court of Appeals.*

David C. Force, Eugene, for petitioner on review. On the brief in the Court of Appeals was Martin J. McKeown, Eugene.

On the brief in the Court of Appeals for respondent on review was Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation.

MEMORANDUM OPINION.

Petition for review allowed. Reversed and remanded to Workers' Compensation Board to reconsider in light of Harwell v. Argonaut Insurance Co., 296 Or 505, ___ P2d ___ (1984).

* Appeal from order of Workers' Compensation Board. 66 Or App 972, 675 P2d 520 (1984).

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Norman Garbutt, Claimant.

GARBUTT,
Petitioner on review,

v.

SAIF CORPORATION,
Respondent on review.

(WCB No. 80-11364; SAIF No. D 4992; CA A27709; SC S30281)

In Banc

On review from the Court of Appeals.*

Argued and submitted May 2, 1984.

James S. Coon, of Welch, Bruun & Green, Portland, argued the cause and filed the briefs for petitioner on review. With him on the petition was Douglas S. Green, Portland.

Darrell E. Bewley, Appellate Counsel, Salem, argued the cause and filed the brief for respondent on review.

JONES, J.

The Court of Appeals is reversed and this case is remanded to the Workers' Compensation Board for further proceedings consistent with this opinion.

Peterson, C. J., filed a dissenting opinion.

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* Judicial review from order of Workers' Compensation Board. 65 Or App 568, 671 P2d 1210 (1983).

JONES, J.

The claimant petitioned for judicial review of the Workers' Compensation Board's order awarding him 30 percent permanent partial unscheduled disability for injury to his left shoulder. The Board's order reduced the referee's award of permanent total disability. The Court of Appeals affirmed without opinion.

After reviewing the very complicated medical history of the claimant, the Board stated in its order: "The medical evidence does not support any conclusion other than that claimant has suffered a very minor impairment to his left shoulder" and that "[w]e do not believe that it is an uncomplicated matter such that lay testimony alone would be sufficient to resolve the issue." The claimant and his wife had testified that he was no longer able to do very much with his shoulder and that the injury, coupled with other non-job related injuries, left him unable to work at any suitable employment.[1]

SAIF contends in its brief:

"* * * Petitioner asserts that since * * * medical opinions

were issued, and since the last arrangement of compensation * * *, his left shoulder has worsened. There is no medical evidence to support his testimony. He says he needs none. The law says he does. In *Oakley v. SAIF,* 63 Or App 433, 664 P2d 431 (1983), the Court held 'An aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient.' * * *"

The claimant responded that his claim was not an aggravation claim, but an "extent of unscheduled permanent disability" claim and that *Oakley v. SAIF,* 63 Or App 433, 664 P2d 431 (1983), upon which SAIF and apparently the Board relied, is irrelevant.

Oakley involved a claim for aggravation under ORS 656.273, which provides:

"(1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

Although the statute mentions that a claim may be commenced by filing a physician's report:

"(3) A physician's report indicating a need for * * * additional compensation is a claim for aggravation."

It further provides that a physician's report is not a jurisdictional requirement for an aggravation claim:

"(7) * * * Adequacy of the physician's report is not jurisdictional. If the evidence as a whole shows a worsening of the claimant's condition the claim shall be allowed."

The Court of Appeals in *Oakley* was incorrect when it stated: "An aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient."[2] 63 Or App at 436. The statute as amended in 1973 does not require a physician's report to support such a claim. The cases cited in *Oakley, Larson v. Compensation Dept.,* 251 Or 478, 445 P2d 486 (1968), and *Collins v. States Veneer, Inc.,* 14 Or App 114, 119, 512 P2d 1006 (1973), were based on ORS 656.271 which required such medical evidence. However, ORS 656.273 was enacted in 1973 in lieu of ORS 656.271.[3]

We allowed review in this case to make clear that a

[1] ORS 656.206(1)(a):

" 'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is 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."

[2] The Court of Appeals in *Oakley v. SAIF,* 63 Or App 433, 436, 664 P2d 431 (1983), also stated that "[a]ggravation of a chronic lumbosacral strain presents a complicated question requiring expert medical advice." We assume that the court, in its role as trier of fact, made that statement with respect to the *Oakley* case itself, for if the statement was meant to be a rule of law, it was erroneous. Aggravation claims for chronic lumbosacral strains do not, as a matter of law, require medical testimony.

[3] ORS 656.271 (1971) required that "[t]he claim for aggravation must be supported by a written opinion from a physician that there are reasonable grounds for the claim." Or Laws 1983, ch 420, §§ 4 and 5.

physician's report is not indispensable in a workers' compensation claim. In the case of an "extent of disability" claim, such as this claim, as in the case of an aggravation claim, no physician's report is *required* to be statutorily sufficient. The worker's or other lay testimony may or may not carry the worker's burden of proving the extent of disability, but the law

does not mandate a medical report. The same is true for an aggravation claim.

In reviewing the Board's order in this case, we cannot determine if the Board, as did SAIF, believed medical testimony was statutorily required or simply that the Board was unconvinced by the lay testimony and without medical evidence could not resolve the issue. If based on the latter, the Board's decision is legally correct; if based on the former, the Board should reevaluate its decision in light of all the credible lay and expert or professional medical evidence.

The Court of Appeals is reversed and this matter is remanded to the Workers' Compensation Board for further proceedings consistent with this opinion.

PETERSON, C. J., dissenting.

Before 1973, ORS 656.271 contained the jurisdictional requirement that when a claim for aggravation was filed it"must be supported by a written opinion from a physician that there are reasonable grounds for the claim." The requirement of a "written opinion from a physician" as a condition to filing a claim for worsening is to be distinguished from the rule that "where injuries complained of are of such character as to require skilled and professional persons to determine the cause and extent thereof, the question is one of science and must necessarily be determined by testimony of skilled, professional persons." *Uris v. Compensation Department,* 247 Or 420, 424, 427 P2d 753, 755, 430 P2d 861 (1967). The former rule related to the jurisdiction to hear a claim; the latter rule relates to the sufficiency of proof.

ORS 656.271 was repealed in 1973, Or Laws 1973, ch 620, § 4, and replaced by ORS 656.273, which deleted the requirement that the claim for aggravation be supported by a written opinion from a physician. The *Uris* proof requirement stated above remains the law in Oregon.

I agree with the majority that the Court of Appeals erred in *Oakley v. SAIF,* 63 Or App 433, 436, 664 P2d 431, 433 (1983), when it stated that "[a]n aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient." The Court of Appeals cited *Larson v. Compensation Department,* 251 Or 478, 482, 445 P2d

486, 488 (1968), for that proposition. *Larson* may stand for that proposition, but the 1973 amendment changed the rule.

In the case at bar, the Board reviewed the medical evidence, including the medical reports, and then stated:

"While noting that the medical evidence offered no direct support that claimant's left shoulder condition was worse at the time of the hearing than at the time it was found to be medically stationary, the Referee nevertheless concluded that it had worsened. The medical evidence in favor of this proposition is both scanty and inconclusive. Prior to the hunting accident, claimant's left shoulder was being treated with rest and heat treatments and was improving to the point where claimant was capable of going elk hunting, riding a horse and apparently using a high-power rifle. By October of 1981, the pain had increased to the point where injections were necessary and an arthrogram was suggested but refused. We do not find a sufficient basis in the record for concluding that claimant's left shoulder condition had worsened. *We do not believe that it is an uncomplicated matter such that lay testimony alone would be sufficient to resolve the issue.*

"Claimant argues that the vocational evidence contained in the record strongly supports the conclusion that he is permanently and totally disabled. The vocational evidence does indeed point toward such a conclusion. However, we think it is obvious that the vocational reports were considering claimant's entire physical disabilities including the non-related psychological condition and the non-compensable hunting injury which, as we have previously pointed out, may not be properly considered. We cannot conclude that the evidence as a whole supports the proposition that prior to the hunting accident, claimant was permanently and totally disabled. We are not even completely convinced that the medical evidence supports a conclusion that, prior to that hunting accident, claimant would have been precluded from his job as a small engine mechanic." (Emphasis added.)

I do not read the Board's order as does the majority. I read the Board's opinion to say that the question of whether the plaintiff's disability was due to a compensable worsening or to a noncompensable hunting accident (a bullet fired from a 30/30 rifle struck claimant in the hip causing partial paralysis in the left leg) was of such character that an expert medical

opinion would be required. Such a determination by the Board is permissible under *Uris v. Compensation Department, supra.*

Because the Court of Appeals likely affirmed the Board for that reason, I would affirm the Board and the Court of Appeals.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Julie Ristick, Claimant.

PACIFIC NORTHWEST BELL TELEPHONE COMPANY,
Petitioner,

v.

RISTICK,
Respondent.

(80-08650; CA A27041)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed December 22, 1983. Former decision filed November 23, 1983, 65 Or App 814, 671 P2d 1211.

Bruce K. Posey, Portland, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Petition for reconsideration granted; former decision withdrawn; reversed.

PER CURIAM

Pacific Northwest Bell Telephone Company (Bell) has petitioned for reconsideration of our decision, 65 Or App 814, 671 P2d 1211 (1983), affirming the Board's and the referee's decisions holding that claimant had a compensable claim. We grant the petition in the light of *McGarrah v. SAIF,* 296 Or 145, ___ P2d ___ (1983).

We are now convinced that the claim is not compensable. It is unclear from the evidence whether the stress that claimant attributed to her work was real, as required by *McGarrah,* or was merely based on her unfounded perceptions. We also conclude that, regardless of whether the work-related stress was real or merely perceived, it was not the major contributing cause of claimant's mental disability. Claimant had a strong susceptibility to tension arising out of her family relationships and was involved in several family-related crises during her employment at Bell. It was, in fact, the most recent of those crises, the death of her aunt, that precipitated an extended unauthorized leave of absence from Bell, resulting in her termination for voluntary job abandonment. The medical evidence also establishes that claimant's employment was not the major contributing cause of her mental disorder. Accordingly, her claim is not compensable. *McGarrah v. SAIF, supra; SAIF v. Gygi,* 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982).

Petition for reconsideration granted; former decision withdrawn; reversed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John H. Denton, Claimant.

DENTON,
Petitioner - Cross-Respondent,

v.

EBI COMPANIES,
Respondent - Cross-Petitioner.

(81-08510; CA A26737)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 30, 1983.

Clinton D. Simpson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs was Roy Dwyer, P.C., Eugene.

Jerald P. Keene, Portland, argued the cause for respondent - cross-petitioner. With him on the briefs was Wolf, Griffith, Bittner, Abbott & Roberts, Portland.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

RICHARDSON, P. J.

Remanded to determine present value of $40,361; provision of order requiring EBI to repay reimbursed time loss payments to Department reversed; affirmed in all other respects.

RICHARDSON, P. J.

In this workers' compensation case, claimant and his employer's compensation insurer (EBI) both appeal from an order distributing proceeds of a third party action. Claimant suffered a compensable injury January 24, 1978, when one leg was amputated above the knee and the other was crushed by machinery while he was working for Northside Lumber Company. He filed products liability actions against two manufacturers of equipment involved in the accident. By July, 1981, both actions were settled for a total of $275,000.

EBI, as the paying agency, claimed a lien on the settlement proceeds pursuant to ORS 656.593 (1)(c), which allows a carrier to retain certain amounts from third party recoveries. That statute provides in part:

> "* * * The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section and the total proceeds shall be distributed as follows:
>
> "* * * * *
>
> "(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is

compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. * * *"[1]

A dispute arose regarding the amount EBI was entitled to reserve for expected future expenditures on behalf of claimant, because claimant contended that the amount should be reduced to present value. Claimant requested that the Board order EBI to produce documents relating to interest

rates available to it; the request was denied. Following the settlement in the third party action, claimant and EBI entered into an "Agreement and Stipulation" which provided, *inter alia:*

> "Pursuant to ORS 656.593 Employee Benefit Insurance Company claims a lien in said settlement in the sum of $55,630.84 for monies advanced and $40,361 for expected future expenditures."

It was stipulated that claimant's counsel would retain $45,000 of the settlement proceeds in a trust account pending resolution of the dispute by the Workers' Composition Board.

Pursuant to ORS 656.593 (1)(d) the Workers' Compensation Board resolved the dispute. At the hearing, EBI claimed a distribution from the proceeds of the settlement in the amount of $68,545 in addition to the $55,630.84 already received pursuant to the agreement. The claimed amount includes $43,844 for future medical expenses and $24,701 for time loss payments made and expected to be made to claimant pursuant to ORS 656.728. $21,988.34 of the latter amount represents time loss payments made by EBI before the "Agreement and Stipulation." The Board found that EBI had proved anticipated future medical costs of $37,675 and held that EBI was not entitled to reimbursement for the claimed time loss payments made before the stipulation, because they were not included in the agreement as a part of the lien. EBI was entitled, the Board said, to reimbursement for any time loss payments made after the stipulation, but the total amount of the lien could not exceed the stipulated figure of $40,361 for future medical expenses and time loss. The Board also held that the reserve for future expenses did not have to be reduced to its present value.

Claimant assigns as error the Board's refusal to reduce the reserve to present value. EBI, it its cross-appeal, argues that it should be entitled to recover all time loss payments whenever made and that it is not bound by the stipulated amount of the lien or responsible to reimburse the

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[1] Claimant does not rely on ORS 656.593(3), which relates to *settlements*, as opposed to ORS 656.593(1)(c) and (d), which relate to recovery of *damages*. ORS 656.593(3) provides:

> "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 a just and proper distribution shall be resolved by the board."

See Schlecht v. SAIF, 60 Or App 449, 455, n 5, 653 P2d 1284 (1982).

Department. We have jurisdiction to consider appeals of Board orders regarding such distributions. *Schlecht v. SAIF*, 60 Or App 449, 653 P2d 1284 (1982).

We first consider claimant's appeal. He argues that the amount paid to the insurer as its "reserve" for expected

future expenditures should be reduced to present value, *i.e.*, the amount of money which, if invested now at available interest rates, would yield the total amount of money required for future expenditures relating to his claim. He relies principally on the wording of the statute, which provides that the insurer shall be paid

> "* * * the *present value* of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim * * *." ORS 656.593(1)(c). (Emphasis supplied.)

Claimant argues that fairness requires that the insurer only be paid as much now as it will cost to maintain a fund to meet future expenses. Without reduction to present value, claimant contends, the insurer could invest its reserve at a high rate of return and reap an amount far greater than required to meet its expenses, thereby receiving a windfall that properly belongs to claimant. He asserts that such a windfall should not be the result of a claimant's pursuit of a third party action.

EBI argues that the words "present value" in the statute mean "current cost." It contends that the current practice among carriers is for estimates of future expenses to be made according to the values of medical care and other expenses in today's market, without figuring in likely increases in the cost of such services due to inflation. It argues that, even if inflation were taken into account, figuring the reserve on a present value basis would produce substantial administrative problems. The length of claimant's course of medical treatment, EBI argues, is speculative, and the carrier bears the risk that the medical problems will be greater than or occur sooner than anticipated. It argues that claimant's interpretation of the statute will put the carrier to the further risk that available interest or investment return rates will drop and that unanticipated needs of claimant may consume the principal before it can yield a return sufficient to cover the carrier's expenses.

We conclude that the statute requires the reserve for future expenses to reflect a reduction to actuarial present value. The statute is clear; the words "present value" should be given their natural, plain and obvious meaning. *See Perez v. State Farm Mutual Ins. Co.*, 289 Or 295, 613 P2d 32 (1980). EBI's interpretation contradicts the normal meaning of the

term.[2] The statute refers to "present value," not "present cost."

[2] According to Webster's Third New International Dictionary 1794 (unabridged ed 1976), the term means:

> "The principal of a sum of money payable at a future date that drawing interest at a given rate will amount to the given sum at the date on which this sum is to be paid."

Such a reduction of damages is common practice. Although we are unaware of an Oregon case holding that the amount of a damage award for anticipated medical expenses should be reduced to present value, it has been held that other kinds of damage awards must be so reduced. *See, e.g. Osborne v. Bessonette/Medford Mtrs.*, 265 Or 224, 508 P2d 185 (1973) (loss of future earning capacity). Moreover, damages or settlements a claimant receives in his third party tort action may already have been reduced to present value.

EBI's policy arguments are unconvincing. It is true that, if the reserve is reduced to its present value, the carrier may be faced with some substantial risks. For example, the timing and extent of claimant's medical needs may be greater than anticipated, and the principal amount of the reserve could be dissipated sooner than expected. The interest rate might also be less than expected, and the carrier will be left with a reserve fund insufficient to cover the medical expenses. However, those risks are common in situations where the amount of damages to compensate for future loss must be estimated, for example, damages for loss of earning power or future medical care of an injured plaintiff.

The task EBI faced in estimating its future payments for claimant's medical care is conceptually little different from that of an injured plaintiff in a personal injury action, who must prove the gross amount of future loss and the formula to be used in reducing that amount to its present value. The risk of underestimating must fall on the party having the burden of proof. Under ORS 656.593, EBI has the burden of establishing the amount of the reserve fund. It is appropriate in estimating future payments to take into consideration anticipated increases due to inflation. That compensation carriers generally follow the practice of using current costs for estimating a reserve does not prevent EBI from utilizing estimated future costs. If the carrier estimates the future costs and that amount

is not reduced to its present value, it could enjoy a windfall by investing the fund. Under the statutory scheme relating to allocation of third party recoveries, the carrier is only entitled to reimbursement—not a profit.

The reserve for future medical expenses and other costs should have been reduced to its present value to determine the amount of the settlement distributable to EBI. As discussed *infra*, EBI is bound by the stipulation claiming $40,361 as the estimated amount for future expenditures. That is the maximum amount EBI can claim, and it must be reduced to its present value.[3] On remand, the Board must determine the appropriate formula for calculation of present value from evidence presented by the parties. The Board apparently denied claimant's motion to order EBI to produce certain investment information on the basis that the information would be irrelevant, because the reserve fund did not have to be reduced to its present value. In the light of our decision, the Board should reconsider its ruling on the motion.

[3] EBI does not contend that the stipulation bars claimant's request that the estimated future expenditures be reduced to present value.

We turn to EBI's cross-appeal. Its claim before the Board included $24,701 for time loss benefits paid or expected to be paid to claimant under ORS 656.268(1). The portion of the lien at issue on cross-appeal is the time loss benefits paid or expected to be paid while claimant is enrolled in a vocational rehabilitation program.

A claimant's entitlement to time loss payments ordinarily ceases once he is determined to be medically stationary. ORS 656.268(2). Benefits continue, however, if the claimant is enrolled and actively engaged in an authorized vocational program. ORS 656.268(1). The carrier continues to make time loss payments during the program, but the Workers' Compensation Department reimburses the carrier from the Rehabilitation Reserve. ORS 656.728(3). ORS 656.593(1)(c) requires the carrier to include in its lien an estimated amount for future benefits and "other costs" of the claim. In 1979 the legislature added the following language to ORS 656.593(1)(c):

> "* * * Such other costs include * * * any reimbursements made pursuant to ORS 656.728(3) * * *." Or Laws 1979, Ch 829, § 12.

The amendment was effective January 1, 1980. Or Laws 1979, Ch 839, § 33. Before the 1979 amendment, there was no express requirement that a carrier include in its lien on a third party recovery time loss payments for which it would receive reimbursement from the Department.

The Board held that time loss payments reimbursable by the Department were not includable in the lien if EBI had incurred them before the stipulation, because:

> "* * * These costs represent liquidated amounts of which EBI was aware, or should have been aware, at the time it entered into the stipulation with claimant and his attorney."

Time loss payments after the stipulation, the Board held, are part of the lien amount but only to the extent that all amounts recoverable for future expenses did not exceed the stipulated sum of $40,361. The Board then held:

> "* * * Regardless of whether EBI recovers any part of the reimbursable benefits paid to or in behalf of claimant from the proceeds of the third-party recovery, EBI is obligated to reimburse the Workers' Compensation Department for all such expenditures paid to EBI pursuant to ORS 656.728(3). EBI's waiver of the recovery of these expenditures by the terms of the Stipulation and Agreement is not binding on the Department, and the Department is obligated to recover these expenditures from EBI. Cf. ORS 656.593(1)(c)."

The Board included in its order a provision requiring EBI to repay any time loss payments which were reimbursed by the Department pursuant to ORS 656.728(3).

EBI argues that, because claimant's injury occurred in 1978, the statute in effect at that time applies. Consequently, it contends, it was not required to seek a lien on claimant's third party recovery for the time loss payments

reimbursed by the Department. It follows, EBI argues, that there was no reason to include those costs in the stipulation and that if it is required to repay the Department, it should be able to recover the amounts repaid from the third party recovery. The implication of EBI's argument is that it should not be required to repay the Department, because the statute, which arguably requires that result, was not in effect at the relevant time.

The Board, when it ordered EBI to repay the reimbursed costs to the Department, apparently assumed that the 1979 amendment was applicable and required carriers to reimburse the Department. We need not decide that issue. The question whether EBI had to repay the Department was not properly presented in this hearing, and the Department was not a party. The issue presented was the distribution of the third party settlement between claimant and EBI. The Board erred in ordering EBI to repay the Department, and we reverse that portion of the order.

We express no opinion on the application of the 1979 amendment to distribution of the proceeds of the settlement. The amendment went into effect on January 1, 1980; the stipulation was entered into in 1981. At that time EBI should have been aware that there was a risk that the statute would apply and could have included such a contingency in the stipulation. A compensation carrier must approve any third party settlement. Consequently, a claimant's attorney, in negotiating a settlement, is vitally interested in the amount of the lien the carrier will claim. Any amount the carrier claims will reduce the net amount of the settlement the claimant may retain. The obvious purpose of the stipulation was to determine, for settlement negotiation purposes, the total amount EBI claimed as a lien. EBI is bound by the stipulation as to the total amount it was asserting for costs already paid and estimated future costs. Its failure properly to perfect a lien for any amount not contained in the stipulation does not affect any obligation it may have to pay future time loss payments or reimburse the Department. Conversely, the fact that it may ultimately be required to repay the Department for reimbursed time loss payments does not entitle it to claim a distribution from the settlement not claimed in the stipulation. *SAIF v. Parker,* 61 Or App 47, 656 P2d 335 (1982). We agree with the Board that EBI has not perfected a lien for the time loss payments made before the stipulation. Claimant does not contest the award to EBI of a distribution for time loss payments made or to be made following the stipulation. The gross amount of EBI's claim may include those amounts, but not to exceed a total amount of $40,361. Consequently, the gross amount of EBI's claim is $40,361, and that amount must be reduced to its present value on remand.

Remanded to determine present value of $40,361; the provision of order requiring EBI to repay reimbursed time loss payments to the Department is reversed; affirmed in all other respects.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LOVE,
Appellant,
v.
NORTHWEST EXPLORATION CO.,
Respondent.
(82-04-02113; CA A27551)

Appeal from Circuit Court, Multnomah County.

Irving M. Steinbock, Judge.

Argued and submitted November 16, 1983.

Bradford J. Aspell, Klamath Falls, filed the brief for appellant.

Catherine Carroll, Portland, argued the cause for respondent. On the brief was Carrell F. Bradley, Hillsboro.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

In this personal injury action, plaintiff appeals a judgment entered against him after defendant's motion for summary judgment was granted. The issue is whether defendant Northwest Exploration Co. (Northwest) established that plaintiff's exclusive remedy against it is under the workers' compensation law. Plaintiff contends that there is an issue of fact whether Northwest is his employer for purposes of the workers' compensation act.

Plaintiff alleged that he was injured when he fell from a ladder with a missing rung while working as an oil rig driller. He alleged that Northwest was in actual or constructive control of the drilling platform and in charge of or responsible for the work. The complaint and answer allege that Northwest had contracted with third party defendants Fincher, dba J & N Drilling Co. (J & N), to drill an oil well and that plaintiff was an employe of J & N.[1] Northwest's affidavits established that J & N was neither a self-insured nor carrier-insured employer under Oregon's workers' compensation law. Northwest contends that under ORS 656.029 plaintiff is deemed Northwest's "subject worker," and because Northwest was a complying employer, under ORS 656.018 plaintiff's exclusive

[1] Northwest cross-claimed against J & N for indemnification should there be a judgment against it. That cross-claim was not determined by the motion for summary judgment, but the trial court found, pursuant to ORCP 67B, that there was no just reason for delay of entry of final judgment. The judgment is appealable. ORCP 67B.

remedy is under the workers' compensation law.

At the time of plaintiff's injury in 1980, ORS 656.029(1) provided:

> "If any person engaged in a business *and subject to this chapter as an employer* lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let has qualified either:
>
> "(a) As a direct responsibility employer as provided pursuant to ORS 656.407; or

> "(b) As a contributing employer as provided by ORS 656.411." (Emphasis supplied.)[2]

ORS 656.018 provides in part:

> "(1)(a) The liability of every employer who satisfies the duty required by subsection (1) of ORS 656.017 is exclusive and in place of all other liability arising out of compensable injuries to his subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794.
>
> "* * * * *
>
> "(2) The rights given to a subject worker and his beneficiaries for compensable injuries under ORS 656.001 to 656.794 are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under ORS 656.001 to 656.794 to bring suit against his employer for an injury."

Plaintiff argues that, if it applies, ORS 656.029 gives him the right to elect whether to pursue a personal injury action or proceed under the workers' compensation law against Northwest. We do not agree. ORS 656.018 provides that a complying employer's liabilities are exclusively those specified in ORS chapter 656. If the requirements of ORS 656.029 are met, that operates to make Northwest plaintiff's employer for this purpose.[3]

Plaintiff's primary argument is that, in order to demonstrate that ORS 656.029 applies, Northwest must show that it is "subject to this chapter as an employer," *i.e.*, that its

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[2] ORS 656.029 was amended by Or Laws 1981, ch 725, § 1, ch 854, § 4, and by Or Laws 1983, ch 397 § 1, ch 579, § 2a.

[3] Northwest argues that under ORS 656.020 plaintiff's remedy in tort is against J & N. That question is not presented here. Plaintiff also argues that an affidavit filed by Northwest showing that plaintiff filed a workers' compensation claim in California against J & N for his injury is sufficient to establish that J & N is a complying employer, thus making ORS 656.029 inapplicable. We disagree. The affidavit does not establish that J & N has met the requirements of former ORS 656.407 or former ORS 656.411, the provisions referred to in former ORS 656.029; the affidavit establishes only that plaintiff filed a claim in California.

relationship with defendant must meet the definition set forth in ORS 656.005(14):[4]

> " 'Employer' means any person, including receiver, administrator, executor or trustee, and the state, state agencies, counties, municipal corporations, school districts and other public corporations or political subdivisions, who contracts to pay a remuneration for and secures the right to direct and control the services of any person."

Plaintiff contends that Northwest has not demonstrated an employer-employe relationship *with him* or that it had the right to direct and control him. ORS 656.029 does not require such a showing. When the circumstances are as set forth in ORS 656.029, the employe of the person to whom the contract is let is *deemed* to be a subject worker of the person letting the contract. As Northwest argues, it is immaterial whether there is an actual employer-employe relationship between employers such as Northwest and workers such as plaintiff if the requirements of ORS 656.029 are met. The relationship is created by operation of law.

There are no genuine issues as to any material fact, and Northwest was entitled to judgment as a matter of law. ORCP 47C.

Affirmed.

[4] At the relevant time the definition was numbered ORS 656.005(16).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dixie Fitzpatrick, Claimant.

FITZPATRICK,
Petitioner,

v.

FREIGHTLINER CORPORATION,
Respondent.

(81-06326; CA A27129)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1983.

Janet A. Metcalf, Portland, argued the cause for petitioner. With her on the brief were English & Metcalf, Portland, and Douglas S. Green and Welch, Bruun & Green, Portland.

Scott M. Kelley, Portland, argued the cause for respondent. With him on the brief was Cheney & Kelley, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded with instructions to order acceptance of claim and for determination of penalties and attorney fees.

BUTTLER, P. J.

Claimant appeals an order of the Board which upheld employer's denial of payment of $738 in medical bills. We find the medical treatment to be compensable and reverse.

Claimant was found to be permanently and totally disabled by a previous decision of this court for disabilities of her left hand, thorax, right hand, right shoulder, back and colon. *Fitzpatrick v. Freightliner,* 62 Or App 762, 662 P2d 8, *rev den* 295 Or 297 (1983). She also suffers from a low-back injury for which employer has been found not responsible.

The medical treatment at issue was rendered by Dr. Setera, a chiropractor, who administered a variety of treatments to claimant's arms, right shoulder, upper, mid-and low-back. He testified that those treatments were for "the entire organism" and that he could not "differentiate or separate" treatment for claimant's compensable conditions from that administered for her non-compensable low-back problem. He never treated her low back only. That Dr. Setera may have, in the course of a unified treatment of claimant, benefitted her low-back condition by using procedures that are inseparable from those that benefitted her compensable conditions does not render the entire treatment non-compensable.

The Board erred in holding that employer was not responsible for payment of Dr. Setera's medical bill. Claimant is entitled to a penalty and attorney fees for employer's unreasonable resistance to payment of the medical bill, ORS 656.382(1), as well as an attorney fee for prevailing on a denied claim. 656.386(1).

Reversed and remanded with instructions to order acceptance of the claim and for determination of penalties and attorney fees.

No. 207 March 28, 1984 493

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent,
v.
HARRIS,
Appellant.
(50932; CA A27568)

Appeal from District Court, Washington County.

John J. Tyner, Jr., Judge.

On appellant's petition for attorney fees filed December 20, 1983.

Allen T. Murphy, Jr., and Richardson and Murphy, Portland, for the petition.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund, Salem, contra.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Petition allowed. $3,164 attorney fee awarded.

Warden, J., dissenting.

VAN HOOMISSEN, J.

Defendant, who prevailed on appeal when we reversed a district court judgment against him, now petitions for an award of attorney fees. The facts are set out in our opinion deciding the appeal. *SAIF v. Harris,* 66 Or App 165, 672 P2d 1384 (1983). For purposes of this opinion, it is enough to recite that SAIF filed an action in district court to recover a sum paid defendant for permanent partial disability, to which it was later determined he was not entitled, and the district court awarded SAIF summary judgment. We agreed with defendant that the district court lacked jurisdiction over the matter.

ORS 182.090 provides in relevant part:

> "(1) In any civil judicial proceeding involving as adverse parties a state agency as defined in ORS 291.002 and a petitioner, the court shall award the petitioner reasonable attorney fees and reasonable expenses if the court finds in favor of the petitioner and also finds that the state agency acted without a reasonable basis in fact or in law."

Here, SAIF, a state agency, sued defendant in district court. On appeal, we found in favor of defendant on jurisdictional grounds. Implicit in that finding was a finding that SAIF acted without a reasonable basis in fact or in law. Therefore, defendant is entitled to a reasonable attorney fee. ORS 182.090(1). We find that $3,164 is a reasonable attorney fee.

Petition allowed. $3,164 attorney fee awarded.

WARDEN, J., dissenting.

I dissent, because we did not expressly find in *SAIF v. Harris,* 66 Or App 165, 672 P2d 1384 (1983), that SAIF "acted without a reasonable basis or fact in law," ORS 182.090(1), and because, contrary to the assertion of the majority, such a finding is not implicit in our reversal of the judgment of the district court.

In *Johnson v. Employment Division,* 64 Or App 276, 283, 668 P2d 416 (1983), we construed identical language in

ORS 183.497(1)[1] to mean that either "the agency's action under the facts as found by the agency must be such that a reasonable agency would not have so acted" or that "an agency's construction of the law applicable to the case before it must be such that a reasonable agency would not have so construed the law."

Here, claimant was awarded $2,720 for permanent partial disability by a determination order of the Evaluation Division. After SAIF paid the award, it was set aside and the Division issued a new determination order, denying permanent partial disability. ORS 656.268(4) provides in pertinent part:

> "* * * Any determination [by the Evaluation Division] may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid."

Pursuant to those provisions, we have affirmed the offset of excessive temporary total disability payments against a claimant's permanent partial disability award. *Petshow v. Portland Bottling Co.*, 62 Or App 614, 661 P2d 1369 (1983), *rev den* 296 Or 350 (1984). We have also held that an insurer cannot act unilaterally to offset overpayments without receiving prior approval from the Workers' Compensation Board. *Wilson v. SAIF,* 48 Or App 993, 618 P2d 473 (1980).

However, we have not previously considered, and the legislature does not appear to have contemplated, this situation. SAIF was not seeking an "adjustment in compensation paid or payable *prior to the determination*"; it sought to recover an amount paid pursuant to an earlier erroneous determination, and there was no permanent disability award against which the payment could be credited. In short, there appears to be no way, within the framework of the Workers' Compensation statutes, for SAIF to recover the payment for

permanent partial disability made pursuant to the erroneous determination order. SAIF sought to do so by an action for money had and received. We recognized in *SAIF v. Harris, supra,* that "[a]lthough we have previously interpreted ORS 656.268(4), this is the first time we have addressed its application to trial court jurisdiction." We held that the trial court had no jurisdiction.

The majority, without any analysis, says that that finding implies that SAIF "acted without a reasonable basis in fact or in law" in this case of first impression. The majority must mean either that the facts (that claimant had been paid $2,720 to which he was not entitled) are such that no reasonable agency would have acted as SAIF did, *i.e.*, try to recover

[1] ORS 183.497(1) provides:

> "Notwithstanding ORS 183.495, in a judicial proceeding designated under subsection (2) of this section the court shall allow a petitioner reasonable attorney fees and expenses if the court finds in favor of the petitioner and determines that the state agency acted without a reasonable basis in fact or in law."

the wrongful payment, or that SAIF's construction of the law (that it could maintain an action for money had and received where it could find no statutorily provided method for it to recover the wrongful payment) is a construction that a reasonable agency would not have made. Certainly, the majority cannot mean the former. As to the latter, I have been unable to find either a case or a statute that proscribes state agencies from maintaining actions under the common law count of assumpsit for money had and received to recover money paid to an individual to which that individual has no legal right. The majority cites no authority so holding. Accordingly, it cannot be said that SAIF acted without a reasonable basis in fact or in law.

I would deny defendant's petition for attorney fees, because he is not entitled to them, rather than adding them to the sum he has already received, but to which he is not entitled. I dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ray Armstrong, Claimant.

ARMSTRONG,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(80-01476; CA A26582)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 11, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause for respondent. On the brief was Donna M. Parton, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem.

Before Gillette, Presiding Judge, and Warden and Young, Judges.

YOUNG, J.

Reversed and remanded to the Board with instructions to remand to the referee to take additional evidence.

YOUNG, J.

Claimant seeks reversal of a "republished" order of the Workers' Compensation Board denying his aggravation claim. He urges that the Board should have remanded the case to the referee for the taking of additional evidence. Respondent moves to dismiss on the ground that we lack jurisdiction. We deny the motion to dismiss and reverse and remand to the Board.

We have written two previous opinions on this claim. *Armstrong v. SAIF,* 58 Or App 602, 649 P2d 818, *rev den* 293 Or 801 (1982); *Armstrong v. SAIF,* 65 Or App 809, 672 P2d 397 (1983). In the first opinion we dismissed as untimely claimant's petition for review of the Board's order of December 31, 1981. On November 10, 1982, after our first opinion, the Board "republished" its original order; the current petition for review is from that "republished" order. In our second opinion we noted that a question had arisen whether the Board had ever properly mailed its order of December 31, 1981. If it had not, the order had not become final under ORS 656.295(8), and the second petition for review was (and is) properly before us; if the Board had mailed the first order, our dismissal of the petition for review of that order requires dismissal of the second petition for review. Because of SAIF's refusal to stipulate to the necessary facts, we remanded the case to the referee to take evidence limited to when, if ever, the Board mailed its order of December 31, 1981, and to report that evidence to us for our determination of the facts. The hearing was held on December 20, 1983, and the record is now before us. From it we find, without the slightest doubt, that the Board never mailed its order of December 31, 1981. That order therefore never became a final order, and the "republished" order of November 20, 1982, is the only final order in the case.[1]

Claimant's attorney testified at the hearing that he first learned of the December 31, 1981, order in May, 1982, when a related Board order led him to inquire into the situation. SAIF's attorney testified that the earliest copy of the order in SAIF's files appeared to be the one attached to claimant's first petition for review, which was filed in May, 1982. Both attorneys testified that their offices normally date

[1] We find it difficult to understand SAIF's actions in this case. A good-faith inquiry when the issue first arose in August, 1982, including a review of its own files, would have convinced it that the first order had not been mailed. Instead, SAIF insisted in its brief in this case that our first opinion was conclusive, despite the later information seriously questioning the facts on which it was based. When we requested SAIF to stipulate to the facts as presented in claimant's attorney's affidavit of August 31, 1982, it refused to do so, stating in part that it had no way to verify the information in the affidavit. This statement is incomprehensible to us, as the affidavit gave Kendall Barnes, then the Board's Chair, as the source of the information. In fact, SAIF's counsel (not the same counsel who filed the response to our request for a stipulation) testified at the hearing that he had talked with Barnes and that Barnes had confirmed most of the affidavit. At the hearing SAIF totally failed to present any evidence indicating that the order had been mailed. The most it expected to present, according to counsel's opening statement, was a possibility of a mailing in July or August, yet its own files showed no copy of the order received in those months. The opening statement was apparently based on a misunderstanding of what the Board's administrator's testimony would be. While SAIF rightfully resists claims on every proper ground, in this case it appears to be acting from pure obduracy. Its actions are of no benefit to this court, the claimant or itself.

stamp all incoming mail but that there is no copy of the order with an earlier date in their files. Claimant, in an affidavit of May 19, 1982, stated that he had no copy of the order in his papers and that to the best of his knowledge and belief he had never received it. The Board's administrator testified that a card on which the staff lists the date of all orders in the case for internal reference presently shows a date "12-31-82" and that that date (with its obvious clerical error) was not on the card when he examined it in August, 1982. He also testified that at that time there was no copy of the order in a particular Board internal file where there should have been one if the order had been mailed. He concluded in August, 1982, when he discovered these things, that the Board had not mailed the order. The Board issued 82 orders on December 31, 1981; it normally issues about 125 orders per month. The administrator also testified that, although he might have ordered a remailing of the order in July or August, 1982, he has no direct recollection of doing so. Claimant and SAIF stipulated that the appropriate clerical staff members would testify that they did not remail the order at that time.[2]

It appears that mailing of the order of December 31, 1981, was lost track of in an exceptionally heavy workload on New Year's Eve. Under ORS 656.295(8) mailing was

necessary for the order to become final, and it was never mailed. We have jurisdiction of the petition for review of the "republished" order of November 10, 1982.

Claimant suffered a compensable back injury in 1974. In 1977, the referee, after a hearing, awarded him permanent total disability, but the Board on review reduced the award to 75 percent permanent partial disability. Claimant later believed that his condition was worsening and filed a request for reopening of his claim; SAIF denied it. The referee, in November, 1980, upheld the denial on the ground that there was no medical evidence of worsening. In early December claimant sought Board review of the referee's decision. Soon afterwards, while the case was pending before the Board, he saw Dr. Johnson, a neurosurgeon, for the first time about his back problem.[3] In January, 1981, Dr. Johnson performed a myelogram and diagnosed a herniated intervertebral disc; he thereafter performed a laminectomy. Claimant then moved to reopen the hearing to consider Dr. Johnson's report. The Board denied the motion, stating that it was not convinced

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[2]SAIF objected to some of the evidence at the hearing on hearsay grounds and to the testimony of claimant's attorney as incompetent under the Evidence Code, presumably a reference to OEC 606-1. ORS 656.283(6) provides:

> "Except as otherwise provided in this section and rules of procedure established by the board, 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."

Technical hearsay objections have no place in a workers' compensation hearing. *Cf. Higley v. Edwards*, 67 Or App 488, ___ P2d ___ (1984) (discussing hearsay objections under the Administrative Procedures Act, ORS 183.450(1)). OEC 606-1 also does not apply to a workers' compensation hearing, so we need not decide whether the exceptions to the rule, which permit an attorney to testify in certain circumstances, would make claimant's attorney's testimony admissible. We overrule the objections, noting, however, that our ultimate finding would be the same if we excluded the challenged evidence.

[3]He had consulted Dr. Johnson before on unrelated matters.

that the evidence could not reasonably have been discovered and produced at the hearing. The Board noted that, although claimant's previous physicians had not diagnosed his condition properly, the condition was symptomatic before the hearing and thus was open to diagnosis. The Board thereafter entered its order affirming the referee.

Claimant's failure to present a correct medical diagnosis for his condition at the hearing is readily explainable; he had been to a number of physicians, none of whom suggested the need for surgery. The Board, according to its orderdenying remand, would apparently have claimant keep the record open until he finally found a physician who could discover the cause of his problems and suggest treatment. We do not think that a claimant should be required to have his case in limbo, and we

doubt that the Board would actually keep open large numbers of unresolved cases while claimantswandered from doctor to doctor seeking relief. This case is like *Egge v. Nu-Steel,* 57 Or App 327, 644 P2d 625, *rev den* 293 Or 456 (1982), in which we held that the Board should have remanded the case to the referee when the claimant, a month after the hearing, finally found a physician who could diagnose his problem. Although previous physicians had gained hints of claimant's problem, which they had not done in *Egge,* we do not think that an illiterate manual laborer in his early fifties should be required to pursue difficult medical leads, at least when his doctors have not suggested that he do so.

Reversed and remanded to the Board with instructions to remand to the referee to take additional evidence.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Delbert Hutchinson, Claimant.

HUTCHINSON,
Petitioner - Cross-Respondent,

v.

LOUISIANA-PACIFIC CORPORATION,
Respondent - Cross-Petitioner.

(79-07340; CA A24356)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 23, 1983.

Janet A. Metcalf, Portland, argued the cause for petitioner - cross-respondent. With her on the briefs were English & Metcalf, Welch, Bruun & Green, David J. Holander, Samuel J. Imperati and Douglas S. Green, Portland.

Patric J. Doherty, Portland, argued the cause for respondent - cross-petitioner. With him on the brief were Rankin, McMurry, VavRosky & Doherty, Dennis R. VavRosky and Ronald W. Atwood, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed in part and reversed in part on appeal; remanded to Board for determination of amount of overpayment; reversed on cross-appeal.

BUTTLER, P. J.

Claimant appeals and employer cross-appeals from an order of the Workers' Compensation Board. We affirm in part and reverse in part on the appeal, and reverse on the cross-appeal.

Claimant sustained a compensable injury to his back on October 25, 1978. Since that time, he has undergone a laminectomy on November 8, 1978, and three myelograms on November 3, 1978, August 8, 1979, and August 28, 1979. By a determination order of June 9, 1980, claimant was awarded temporary total disability (TTD) from October 25, 1978, to February 5, 1979, temporary partial disability (TPD) from February 6, 1979, to February 26, 1980, and 20 percent unscheduled permanent partial disability. A hearing was held on that determination order and on claimant's intervening aggravation claim. The referee affirmed the determination order, after modifying it by fixing the date on which claimant became medically stationary as October 16, 1979. He further held that claimant had not proven an aggravation or a need for pain center treatment. He awarded a penalty of 25 percent for employer's failure to pay the TPD ordered by the determination order from March 29, 1979, to October 10, 1979.

The Board modified the referee's order by deleting the award of TPD from March 30, 1979, through August 8, 1979, and the assessment of penalties for that period of time. It further held that claimant was entitled to a referral to the pain center and that his claim should be reopened upon his admission. The remainder of the referee's opinion was affirmed.

Claimant's first contention on his appeal is that the Board erred in holding that he was not entitled to TPD between March 30 and August 8, 1979, or to penalties and attorney fees for the employer's refusal to pay.[1] For the reasons stated below, we need not decide the merits of that contention; it is moot.

On November 16, 1979, the parties entered into a stipulation reciting that on October 1, 1979, employer had reinstated TTD retroactive to August 10, 1979, and had agreed to continue paying TTD thereafter until it was terminated "by law or by order." That stipulation stated that the claimant's

[1] Claimant contends that the referee had no authority to decide this issue, because he was not given notice of it prior to the hearing. However, claimant elected to proceed with the hearing on all of the issues; therefore, he has waived the right to object. *Stillman v. SAIF*, 45 Or App 701, 609 P2d 408 (1980).

right to receive TPD from March 30 to August 10, 1979, and his entitlement to penalties and attorney fees for the employer's failure to pay during that period of time were "expressly reserved for resolvance *[sic]* at the time a final hearing on this matter is scheduled." Thereafter, by a determination order of June 9, 1980, employer was ordered to pay TPD from February 6, 1979, through February 26, 1980. Employer contends that it relied reasonably on the prior stipulation in refusing to pay the TPD awarded by the determination order, because the parties had agreed that the issue of TPD for the period in question would be resolved at a "final hearing."[2] It reasons that a determination order does not involve a hearing and that it was reasonable to construe the stipulation as meaning that no payments would be required at least until a hearing before a referee resulted in an order directing payment. We agree that employer's reliance on the stipulation was reasonable; therefore, no penalties or attorney fees are due for its initial refusal to pay.

However, even under the broadest interpretation of the stipulation, employer was required to pay TPD if it was ordered by a referee following a hearing. OAR 436-54-310(3)(e) requires that an employer pay temporary disability compensation within 14 days of the date of an order. ORS 656.313(1) requires an employer to continue payments even though an appeal has been filed.[3] Despite the clear

mandate of both the statute and the administrative rule, employer refused to pay TPD, even after the referee had resolved the issue in claimant's favor. That failure constitutes an unreasonable delay in payment of compensation for which a penalty and attorney fees may be assessed.[4] ORS 656.262(10). Employer is required to pay the TPD that is owing for the period in question, plus whatever penalty and attorney fees may be assessed.

ORS 656.313(2) provides that an employer cannot recover from a claimant any compensation that is paid pending appeal and which is later held not to have been due. Because TPD should have been paid immediately after the referee's order and was not, it should have been paid pending review by the Board; therefore, regardless of whether employer is correct in asserting that the TPD claim was not proven, it must pay it at this time and is not entitled to an offset. For those reasons, we need not decide whether claimant

[2] We do not express any opinion as to whether employer's interpretation of the stipulation was correct. We hold only that it was reasonable.

[3] OAR 436-54-310(3)(e) provides:

"Timely payment of temporary disability benefits has been made when paid no later than the fourteenth day after: * * *

"* * * * *

"(e) Date of any determination or litigation order which orders temporary disability."

ORS 656.313(1) provides:

"Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."

[4] Employer is not excused from payment by the fact that the Board reversed the award. The obligation to pay arose immediately from the referee's order.

was entitled to TPD payments during the period in question.

We agree with the referee and the Board that the medical evidence establishes that claimant was medically stationary on October 16, 1979. Employer, therefore, is entitled to recover as an overpayment any amounts that were paid after that date. The record does not disclose how much temporary total disability compensation was actually paid or the exact dollar amount of the overpayment. Accordingly, we remand to the Board for a determination of the extent of overpayment. The remainder of claimant's contentions do not justify discussion.

Employer, in its cross-appeal, now concedes that the pain center treatment was justified. However, it argues that it should only be required to pay for that treatment as a medical expense under ORS 656.245(1) and not be required to reopen the claim. We agree. We concur in the referee's and the Board's conclusion that claimant failed to establish his aggravation claim. A claimant is entitled to a reopening and a redetermination of his claim only if he establishes a worsening of his condition or if he ceases to be enrolled and actively engaged in an authorized vocational rehabilitation program.

Johnson v. Industrial Indem., 66 Or App 640, 675 P2d 498 (1984). Because we agree with the referee's and Board's conclusion that claimant failed to establish his aggravation claim, he is not entitled to a reopening and a redetermination of his claim on admission to the pain center.

Affirmed in part and reversed in part on appeal and remanded to Board for determination of amount of overpayment; reversed on the cross-appeal.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charles W. Roller, Claimant.

ROLLER,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(82-00383; CA A26151)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 23, 1983.

Michael M. Bruce, Eugene, argued the cause for petitioner. With him on the supplemental brief was Lyle C. Velure, Eugene.

Mildred J. Carmack, Portland, argued the cause for respondent. With her on the briefs were Dennis S. Reese and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded for reinstatement of referee's opinion and order.

BUTTLER, P. J.

Claimant appeals an order of the Workers' Compensation Board that reversed the referee and affirmed employer's denial of further responsibility for claimant's diabetes. We reverse.

On January 11, 1980, claimant was injured when he hit his head and leg while working as a saw operator. Claimant's treating physician diagnosed his disability as diabetes mellitus. Following a denial by employer and a hearing, the referee ruled on May 11, 1980, that employer was responsible for claimant's diabetes. No appeal was taken from that order. Employer accepted the claim and provided benefits until January 5, 1982, when it issued a partial denial by which it disclaimed further responsibility for claimant's diabetes mellitus condition. That denial letter stated that employer continued to accept responsibility for the results of the January 11, 1980, injury, but denied future responsibility for the diabetes condition, because it had reached a stage where it would have been whether or not claimant had sustained the industrial injury. The letter went on to state that "there no longer is any identifiable residual effect on the diabetes from your industrial injury." Claimant requested a hearing on the denial, and the referee ordered that it be set aside. He further ordered employer to pay claimant penalties and attorney fees. On review, the Board reversed the referee's opinion and order and affirmed the denial.

Claimant contends that employer is bound by the original determination of compensability, which was not appealed. Clearly, employer has lost the right to deny compensability of the original claim. The issue here, however, is whether employer may issue a denial that only terminates *future* responsibility for a compensable condition before the extent of claimant's disability has been determined. In *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), the insurer attempted to revoke its prior acceptance of a claim as nondisabling on which it had paid medical benefits only. When the claimant attempted to reopen the claim, alleging an aggravation, SAIF denied compensability of the original claim. The court held that it could not do so, stating:

> "* * * It was only after claimant attempted to reopen his claim for aggravation that SAIF suddenly reversed its decision and denied compensability for the original claim. SAIF was too late. To allow the employer or the employer's insurer to engage in such vacillating activity would encourage degrees of instability in the workers' compensation system that we do not believe the statute contemplates. * * * If, as in this case,

the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability. * * *" 295 Or at 793.

Unlike the insurer in *Bauman*, employer is not attempting to revoke its original acceptance of the claim; rather, it is attempting to terminate future responsibility before the extent of claimant's disability has been determined. To permit employer to follow that procedure is tantamount to authorizing it to bypass a hearing on the extent of a claimant's disability and could preempt the resolution of an issue that is involved in determining the extent of disability. If the claimant does not request claim closure, the employer may do so. Under ORS 656.268(3),[1] an employer is permitted to issue a

notice of closure when the medical reports indicate to it that the claimant's condition has become medically stationary and that it has decided that the claim is nondisabling or is disabling but without permanent disability. The notice must be given to the claimant and the Department and must contain the specific information and advice of rights required by the statute.

If that is done, the claimant may require a determination order from the Evaluation Division and the orderly process of claim closure and determination of extent of disability is followed. *See Safstrom v. Riedel International, Inc.*, 65 Or App 728, 672 P2d 392 (1983). Here, employer's denial letter does not conform to the statute and has resulted in a bypassing of that orderly procedure.

[1] ORS 656.268(3) provides:

"When the medical reports indicate to the insurer or self-insured employer that the worker's condition has become medically stationary and the self-insured employer or the employer's insurer decides that the claim is nondisabling or is disabling but without permanent disability, the claim may be closed, without the issuance of a determination order by the Evaluation Division. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker and to the Workers' Compensation Department. The notice must inform the worker of the decision that no permanent disability results from the injury; of the amount and duration of temporary total disability compensation; of the right of the worker to request a determination order from the Evaluation Division within one year of the date of the notice of claim closure; of the aggravation rights and of such other information as the director may require. Within one year of the date of the notice of such a claim closure, a determination order subsequently shall be issued on the claim at the request of the claimant or may be issued by the Evaluation Division upon review of the claim if the division finds that the claim was closed improperly. If an insurer or self-insured employer has closed a claim pursuant to this subsection and thereafter decides that the claim has permanency, the insurer or self-insured employer shall request a determination order as provided in subsection (2) of this section. If an insurer or self-insured employer has closed a claim pursuant to this subsection, if the reasonableness of that closure decision is at issue in a hearing on the claim and if a finding is made at the hearing that the closure decision was not supported by substantial evidence, 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 owing between the date of original closure and the date upon which the claim is closed by determination order. The penalty shall not be less than $500."

To hold, as we do, that employer's partial denial was improper here does not preclude it from litigating the issue at the time of closure; neither does it affect employer's post-closure right to deny claims for specific medical treatments or for aggravation on the ground that they do not "result from the injury." ORS 656.262, 656.313(3).

Claimant has already established that his diabetes mellitus condition is compensable and that he is entitled to time loss and medical benefits. Employer may not summarily terminate those benefits by short-cutting the process of closing the claim by a determination of the extent of claimant's disability.

Reversed and remanded for reinstatement of referee's opinion and order.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Keith Phillips, Claimant.

PHILLIPS,
Petitioner,

v.

LIBERTY MUTUAL,
Respondent.

(80-06429; CA A27964)

On Judicial Review from the Workers' Compensation Board.

Argued and submitted November 28, 1983.

Diana Craine, Salem, argued the cause for petitioner. With her on the brief was Rolf Olson, Salem.

Keith D. Skelton, Portland, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

NEWMAN, J.

Reversed and remanded with instructions to reinstate referee's order.

Van Hoomissen, J., dissenting.

NEWMAN, J.

Claimant appeals an order of the Workers' Compensation Board that reversed the order of the referee and denied claimant permanent total disability. The Board awarded claimant 80% loss of his right leg and 60% loss of his left leg. We find that claimant is permanently and totally disabled.

Claimant was 60 at the time of the hearing. He is a high school graduate and attended a business school for six months. He has been a dishwasher, cook's helper, waiter, welder and truck driver. He is deaf in his right ear and wears a hearing aide in his left ear. Because of a previously broken jaw and denture problems, his speech is very difficult to understand. Since 1966, he was employed by the county as a janitor and by a daily newspaper as a route carrier delivering newspapers to distributors and to pay boxes.

He suffered compensable injuries to both knees when he fell while working for the newspaper on March 15, 1978. On June 25, 1978, he had surgery for a total right knee replacement. On November 22, 1978, he received a partial replacement of the left knee. On March 17, 1979, Dr. Chester, the surgeon, wrote that claimant "still has significant incapacities for protracted walking, standing, lifting, climbing stairs, squatting and the like. * * * [H]e will have limited function in terms of his work capacity and at best he will be able to perform work in a sedentary capacity." Claimant was examined by three doctors at Orthopaedic Consultants on May 9, 1979, who wrote that claimant "would not be able to return to any of his former occupations and is only capable of doing sedentary activities because of both knees."

In August, 1979, a vocational counselor wrote that while a "return to County employment as a Day Porter or Night Light Janitorial duties is possible," claimant has "no skills transferable to sedentary work and his age and other disabilities would be significant impairments to new unskilled entry level jobs." He found that claimant could not use a telephone. The counselor was "certain that nobody would hire him as a cook, truck driver, or security guard with his many disabilities." On October 5, 1979, Dr. Chester concluded that, although "gainful employment" was feasible "if he could find relatively sendentary work commensurate with his age and training," a return to his previous work was not possible.

The employer offered claimant work as an "inserter," an employe who places inserts into newspapers. An inserter must stand 85% of the work time. Dr. Chester wrote that he was unsure if claimant could do the job and recommended a trial period to see "if he is symptomatically able to do this." Claimant did not attempt the job but turned it down because of the requirement of standing. Later, in March, 1980, Dr. Chester wrote that "patient has effected a full adjustment to retirement." He added that "I really feel this is probably the best course of events for him."

The employer then considered offering claimant a job as a night watchman. On June 4, 1981, Dr. Chester wrote:

> "Assuming this to be a quite sedentary activity, I can see no reason why Keith Phillips would not be able to do this, as long as it did not involve significant stair climbing, or walking over protracted distances or that type of thing. It could be just the occupation for him. Hopefully he will see it that way, too."

On August 21, 1981, the employer created a new full-time position of night watchman and offered claimant the job. At the time of the hearing, the employer had not offered the job to anyone else. Although the majority of the night watchman's

time would be spent sitting, the job required that he walk through the two floors of the employer's plant every 30 or 45 minutes during an 8-hour work shift, five days a week. Claimant could use the freight elevator to go between floors with minimal use of the stairs. The walking circuit of the building is 1167 feet, or 2-1/2 city blocks. Claimant's uncontradicted testimony was that he could walk only two blocks at a time. He would also be required to use a telephone to report to the night management any unusual observations.

Claimant refused the night watchman's job. He told the business manager, "I don't think I can do it. I can't hear." The referee found:

> "* * * [C]laimant would be required to communicate with others, both face to face and by telephone, in the performance of his job duties. Because of his hearing and speech impediments he would have extreme difficulty doing so. As many of the reports in evidence indicate, claimant is very hard of hearing and is almost as difficult to understand. Having observed him carefully during the hearing I dare say it would be virtually impossible for him to communicate by telephone or CB radio."

Claimant asserts that he is permanently and totally disabled, even though he suffers from less than total physical incapacity, because of non-medical conditions including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as conditions of the labor market." *See Wilson v. Weyerhaeuser,* 30 Or App 403, 409, 567 P2d 567 (1977). The Board, with one member dissenting, believed that claimant had not met the burden of proof described in ORS 656.206(3).[1] The Board stated:

> "From this evidence we cannot affirmatively conclude either that claimant has the physical capacity to perform the offered night watchman job or that claimant lacks the physical capacity to perform that job. The Court of Appeals addressed a very similar situation in *Shaw v. Portland Laundry/Dry Cleaning,* 47 Or App 1041, 1044 (1980):
>
> > " 'At the hearing before the referee, the employer for whom claimant was working when she became disabled stated that a seamstress position was available in his plant and in effect offered the job to claimant. Claimant had prior experience as a seamstress. She never clearly answered, we find, questions about whether she thought she was able to do that work. There is some indication in the medical evidence that working as a seamstress may involve more sitting than claimant is capable of doing and may involve more manipulation of sewing machine controls with her feet and knees than claimant is capable of doing. Like so many other parts of this record, however, the evidence about claimant's ability to work as a seamstress is inconclusive.
> >
> > " 'In sum, the medical evidence does not show total disability, and claimant was offered a job that she may or may not be capable of doing. Under these circumstances,

[1] ORS 656.206(3) provides:

"The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

> we conclude that claimant's failure *at least to attempt* working as a seamstress is the most telling fact that forecloses a finding of total disability.' (Emphasis added.)
>
> "Likewise, in this case, we find that claimant was offered a job that he may or may not be capable of doing and conclude that claimant's failure *at least to try* working as a night watchman forecloses a finding of total disability under ORS 656.206(3)."

A claimant, however, need not make efforts to work if those efforts would be futile. As we stated in *Butcher v. SAIF,* 45 Or App 313, 318, 608 P2d 575 (1980):

> "We do not believe that the legislature intended that every injured worker, regardless of capacity to do so, must demonstrate an effort to become employed even where it is clear that such an effort would be in vain."

See also Munger v. SAIF, 63 Or App 234, 662 P2d 808 (1983); *Fitzpatrick v. Freightliner Corp.,* 62 Or App 762, 662 P2d 8 (1982); *Looper v. SAIF,* 56 Or App 437, 642 P2d 325 (1982). As the Board also stated, if the evidence affirmatively establishes that a claimant is not capable of performing the job, ORS 656.206(3) is not pertinent.

We find that, contrary to the circumstances in *Shaw v. Portland Laundry/Dry Cleaning,* 47 Or App 1041, 615 P2d 1134 (1980), cited by the Board, the evidence establishes affirmatively that claimant was unable to do the inserter job or the night watchman's job. It would have been futile for him to attempt the inserter job. The Board did not rule to the contrary. The medical evidence shows that he is unable to stand for the long periods of time that the job requires. The evidence also shows that it would have been futile for claimant to attempt to do the night watchman's job. Dr. Chester wrote that claimant might be able to do the job if it did not require "walking over protracted distances" and "assuming this to be a quite sedentary activity." It is not. Claimant could not have made the repeated walking inspections of the building that the job required. The referee found that it would be "virtually impossible" for him to communicate by telephone. The referee heard claimant's testimony, including that he could not do the night watchman's job, and the referee's determination is entitled to weight. *Emerson v. ITT Continental Baking Co.,* 45 Or App 1089, 1094, 610 P2d 282 (1980). We agree with the referee that claimant is permanently and totally disabled.

Reversed and remanded with instructions to reinstate the referee's order.

VAN HOOMISSEN, J., dissenting.

The issue is whether claimant is entitled to an award for permanent total disability. On *de novo* review, I would

affirm the order of the Workers' Compensation Board. Therefore, I dissent.

No physician has asserted that claimant cannot work or that he is permanently and totally disabled. He does not claim that he suffers from total physical incapacity. In March,

1979, his attending physician, Dr. Chester, indicated that claimant could do sedentary work. Orthopaedic Consultants agreed. In July, 1979, Dr. Chester reported that a return to claimant's *regular* work was guarded but that, in *claimant's* opinion, he would never work again. I understand that report to mean that it was claimant's subjective decision not to work, not Dr. Chester's conclusion that he could not work.[1]

In August, 1979, a vocational consultant indicated that work in selected jobs was possible, but that there was a "Social Security problem." In October, 1979, Dr. Chester reported that gainful employment in relatively sedentary work was feasible. In March, 1980, the vocational consultant reported that there were jobs claimant could do but that he refused to try them and that he had "retired" because of Social Security. Dr. Chester essentially agreed with that conclusion.[2] In June, 1981, Dr. Chester saw no reason why claimant could not accept employment as a night watchman "assuming this to be a quite sedentary activity. * * *. It could be just the occupation for him. Hopefully he will see it that way, too."[3]

The medical evidence does not support a finding that claimant is permanently and totally disabled from physical conditions of less than total incapacity, plus nonmedical conditions, which together result in permanent total disability. *See Wilson v. Weyerhaeuser,* 30 Or App 403, 409, 567 P2d 567 (1971). Neither does the record support a conclusion

that any efforts to obtain employment would be futile, or that he is not capable of performing either of the jobs offered to him by his employer. The record does not even come close to showing that it would have been futile for claimant even to *try* either job. Claimant must comply with ORS 656.206(3).[4]

Claimant's employer offered him two jobs, first, as an inserter, and second, as a night watchman. Detailed testimony, as well as a written job description, attest to the sedentary nature of the latter work. He refused even to attempt to perform either job. At best, the evidence is inconclusive as to whether he is capable of performing either job. Under those circumstances, I understand ORS 656.206(3)

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[1]Claimant appears to have a strong economic motiviation *not* to work.

[2]Dr. Chester's observation that claimant "has effected a full adjustment to retirement" and that "this is probably the best course of events for him" begs the question. Whether claimant should retire is not the issue. The issue is whether he is entitled to an award for permanent total disability.

[3]The record indicates that the employer created a new full-time position of night watchman and offered the job to claimant and that the employer was willing to accommodate his disabilities by making adjustments in the manner in which he was expected to perform his duties. For example, he would not be required to climb stairs; he could use the elevator.

This result will discourage employers from making work available to their disabled workers. That is not in anybody's best interests.

[4]ORS 656.206(3) provides:

"The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

to mean that claimant must at least *try* to work.[5]

I conclude that claimant has retired, is receiving social security and does not wish to jeopardize that income by working. I would therefore agree with the Board that his failure at least to attempt working forecloses a finding of total disability. ORS 656.206(3); *Laymon v. SAIF*, 65 Or App 146, 670 P2d 211, *rev den* 296 Or 411 (1983); *Shaw v. Portland Laundry/Dry Cleaning*, 47 Or App 1041, 615 P2d 1134, *rev den* 290 Or 157 (1980).

On its facts, this case cannot be distinguished from our decisions in *Home Ins. Co. v. Hall*, 60 Or App 750, 654 P2d 1167 (1982), *rev den* 294 Or 536 (1983); and *Willamette Poultry Co. v. Wilson*, 60 Or App 755, 654 P2d 1154 (1982), *rev den* 294 Or 569 (1983). In both of those cases, we reversed orders of the Board affirming referees' findings of permanent total disability.

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[5]The Board stated its policy approach in this kind of case: (1) If the evidence affirmatively establishes that the claimant is capable of performing the job, then ORS 656.206(3) forecloses an award for total disability; (2) if the evidence affirmatively establishes that the claimant is not capable of performing the job, then ORS 656.206(3) is irrelevant to an award for total disability; and (3) if, as in this case, the evidence is inconclusive, and the claimant may or may not be capable of performing the job, ORS 656.206(3) requires that the claimant do what is reasonable and try to perform the offered employment. I find no fault with the Board's policy or with its application in this case.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Daniel Leary, Claimant.

LEARY,
Petitioner,

v.

PACIFIC NORTHWEST BELL,
Respondent.

(80-01939; CA A23101)

Remanded from the Oregon Supreme Court, *Leary v. Pacific Northwest Bell*, 296 Or 139, 675 P2d 157 (1983).

Judicial Review from Workers' Compensation Board.

Submitted on remand December 20, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Katherine O'Neil, Portland, argued the cause for respondent. With her on the brief were William H. Replogle, and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

VAN HOOMISSEN, J.

Affirmed.

VAN HOOMISSEN, J.

This case was remanded by the Supreme Court, 296 Or 139, 675 P2d 157 (1983), to apply the objective standard of *McGarrah v. SAIF,* 296 Or 145, 675 P2d 159 (1983).[1] In our former opinion, 60 Or App 459, 465, 653 P2d 1293 (1982), we stated that "notwithstanding that his work-related stress appears largely to be his own reaction to his working conditions * * * we conclude that it is the major contributing cause of his disability and that it is therefore compensable." Our conclusion was based on a *subjective* test that was rejected by the Supreme Court in *McGarrah.*

In *Elwood v. SAIF,* 67 Or App 134, 137, 676 P2d 922 (1984), we found these questions to be relevant to a determination of the compensability of a mental stress claim:

> "1. What were the 'real' events and conditions of plaintiff's employment?
>
> "2. Were those real events and conditions capable of producing stress when viewed 'objectively,' even though an average worker might not have responded adversely to them?
>
> "3. Did plaintiff suffer a mental disorder?
>
> "4. Were the real stressful events and conditions the 'major contributing cause' of plaintiff's mental disorder?"

See McGarrah v. SAIF, supra; SAIF v. Gygi, 55 Or App 570, 574, 639 P2d 655, *rev den* 292 Or 825 (1982). We review *de novo,* ORS 656.298(6), and, in the light of *McGarrah,* now find that the claim is not compensable.

While some of the stress-causing conditions were real, others were imagined. Claimant was criticized by a number of supervisors for failing to keep his production up and for his resistance to working overtime. In *McGarrah v. SAIF, supra,* 296 Or at 164, the Supreme Court noted that an

employe's inability to keep pace with the job is "real stress."[2] Claimant was also reprimanded for arriving late and leaving early. One supervisor criticized him for going to a doctor without previously informing her so that she could make adjustments in her crew. Claimant also had difficulty adjusting to frequent changes in supervisors and changing work policies. When viewed objectively, those events could produce stress, even though an average worker might not have responded adversely to them.

However, much of claimant's stress was the result of

[1] In *McGarrah v. SAIF,* 296 Or 145, 165, 675 P2d 159 (1983), the Supreme Court stated:

> "The stressful conditions must actually exist on the job. That is, they must be real, not imaginary. The views of an average worker or average person or the perceptions by the claimant may be relevant, but are not determinative. The existence of legal cause of stress-related occupational disease must be determined objectively." (Footnotes omitted.)

See also Elwood v. SAIF, 67 Or App 134, 676 P2d 922 (1984); *SAIF v. Shilling,* 66 Or App 600, 675 P2d 1081 (1984).

[2] It might have been more accurate to describe the worker's situation as a "real stress-causing condition." *See SAIF v. Griffith,* 66 Or App 707, 712 n 2, 675 P2d 1092 (1984).

his unfounded perception that his employer was subjecting him to harassment and excessive supervision. He admitted that he was of a suspicious nature and that he felt the company at times tried to "mess with him." His supervisors testified that he was difficult to get along with, constantly challenged their authority and complained that he had been mistreated by the employer. They concluded that he had been treated no differently than other employes and that at times he was treated more leniently because of his irascible nature.

We stated in our former opinion, *supra,* 60 Or App at 463, that claimant's stress "appears to result primarily from his perception of the way he is treated by his supervisors * * *." Claimant told his doctors and the referee that he was affected by two principal stress factors: younger supervisors and female supervisors. The record shows, however, that, except for one female supervisor, all of claimant's supervisors were male and that all of his supervisors, although younger than he, had, with one exception, substantial supervisory experience. Moreover, claimant had expressed resentment against all of his supervisors. The stressful conditions that he asserted, supervisors without previous experience, harassment by supervisors, a company practice of hiring inexperienced young women as supervisors, were not in fact real.[3]

We conclude that most of the events and conditions of claimant's employment that produced stress were imagined. *See Elwood v. SAIF, supra,* n 3.

The only medical examiner who directly addressed the source of claimant's disability was Dr. Colbach. He concluded:

> "It doesn't appear that his work has forced him into any particularly stressful situations. But his selective perceptions of what is going on at work do cause him distress and do, in turn, contribute to his psychosomatic problems. These selective perceptions, of course, are unconscious results of his intellectual and personality limitations."

Claimant's treating physicians both indicated that his health problems were work-related. However, they focused on his physical infirmities. They were not primarily concerned with his mental condition; they did not independently examine him to determine the extent to which his reactions to employment were the result of his misperceptions of reality, nor was it expected that they would do so. From the record, it appears

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[3] Claimant's resentment against advancement of young people and women, to the extent that such advancement can be deemed a real stress factor, is not a stress factor to which claimant "is not ordinarily subject or exposed other than during a period of regular actual employment." *See* ORS 656.802(1)(a). As the board stated:

> "* * * [B]y the time an individual is in his 50's, as is claimant, a large and growing proportion of the population is younger. Many of these younger people have various positions of authority. This is in no way unique to the work environment. Furthermore, the phenomenon of women in positions of authority is not limited to the telephone company, but rather, in our changing contemporaneous society, is increasingly common. Claimant undoubtedly had difficulty coping with his own aging process and the changing world around him, but these stress factors he claims caused an occupational disease are really factors which any person claimant's age encounters everywhere. * * *"

Claimant's stressful exposure to young people and women on the job was more imagined than real. To the extent, however, that his disability is the result of his exposure to young people and women in positions of authority, those are conditions that he faces off the job as well as on the job.

that they simply accepted his opinion concerning the cause of his disability. *See Foley v. SAIF*, 29 Or App 151, 159, 562 P2d 593 (1977). The board's order denying compensation is affirmed.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation
of BILL R. ANDERSON, CLAIMANT.

BILL R. ANDERSON,

Petitioner,

v.

STATE ACCIDENT INSURANCE FUND,

Respondent.

(82-02459; CA A29098)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 6, 1984.

Janet A. Metcalf, Portland, argued the cause for petitioner. With her on the brief were January V. Roeschlaub, Mt. Angel, and English & Metcalf, Portland.

Donna Parton Garaventa, Assistant Attorney General, Salem, argued the cause and filed the brief for respondent. With her on the brief were Dave Frohnmeyer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

Order modified to eliminate provision concerning surgery; remanded for further proceedings.

FILED: May 2, 1984

PER CURIAM

Claimant appeals from a Workers' Compensation Board (Board) order affirming and adopting a decision of the referee. Recitation of the facts, and of the contentions of the parties, would not benefit bench or bar. We modify the "ORDER" portion of the referee's decision by deleting from the first paragraph thereof the words, " * * * and reopen the same at the time claimant submits to the surgery proposed by Dr. Poulson." The case is remanded to the Board for further proceedings to determine to what compensation, if any, claimant is entitled.

Order modified to eliminate provision concerning surgery; remanded for further proceedings.

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98 May 9, 1984 No. 280

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William Patterson, Claimant.

PATTERSON,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(80-00133; CA A25743)

Remanded from the Oregon Supreme Court, *Patterson v. SAIF,* 296 Or 235, 673 P2d 178 (1983).

Judicial Review from Workers' Compensation Board.

Submitted on remand December 28, 1983.

John Silk, Jerome F. Bischoff, and Bischoff & Strooband, P.C., Eugene, appeared for petitioner.

Donna M. Parton, Associate Appellate Counsel and Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, appeared for respondent.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

This case is here on remand from the Supreme Court for reconsideration in the light of *McGarrah v. SAIF,* 296 Or 145, 675 P2d 159 (1983). *Patterson v. SAIF,* 296 Or 235, 673 P2d 178 (1983). We initially affirmed the Workers' Compensation Board's order denying compensability. We again affirm the Board's order.

Claimant was employed as a bus driver for a school district from 1978 until October, 1979. In October, 1979, he suffered an anxiety attack manifested by shortness of breath, chest pains and nausea. All of the physicians who examined claimant agree that he has no physical disability but suffers from psychiatric aliments indicated by hypochondria, anxiety and depression. Claimant identified several instances of criticism by his supervisor which he considered unwarranted, but he described these incidents as "relatively minor." He contends that his disability first manifested itself on October 25, 1979, and is compensable as an injury or an occupational disease. He asserts that the precipitating event of October 25, 1979, was on-the-job stress that produced his anxiety attack and his present disability.

In October, 1979, claimant discovered that his operator's license had expired. His supervisor told him he would have to be relicensed and retrained and would not be paid until he was properly licensed. While claimant was taking a driving test, he experienced the symptoms later identified as the anxiety attack. Claimant argues that, whether the October 25, 1979, event is characterized as an injury or the cause of an occupational disease it was a work condition that constituted the major contributing cause of his disability.

The confrontation between claimant and his supervisor could well be objective work stress. *McGarrah v. SAIF, supra.* However, claimant focused on the stress of taking a driving test as the principal cause of his disability, and he testified that the criticisms from his supervisor were relatively minor events. There was no medical evidence that identified any on-the-job stress as the major contributing cause of claimant's disability.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Geoffrey Bisbey, Claimant.

BISBEY,
Petitioner,

v.

THEDFORD et al,
Respondents.

(82-04779; CA A28995)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 14, 1984.

David J. Edstrom, Portland, argued the cause and filed the brief for petitioner.

Cynthia S. C. Shanahan, Portland, argued the cause for respondent Doris B. Thedford. On the brief were Ridgway K. Foley, Jr., Brian M. Perko and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

No appearance for respondent SAIF Corporation.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Affirmed.

GILLETTE, P. J.

Claimant appeals from an order of the Workers' Compensation Board affirming the referee's determination that claimant is not covered by the Workers' Compensation Law. We affirm.

Doris Thedford owns and operates the Pioneer Motel in Portland, consisting of eight units and a house in which Mrs. Thedford resides. On February 28, 1982, claimant and his grandfather contacted Mrs. Thedford, suggesting that several trees at the motel needed topping and trimming. They represented to her that they were experienced tree surgeons. The parties agreed that claimant would perform the required work for a flat fee of $100. Claimant provided all his own equipment.

While claimant was descending from the first tree, his safety rope broke and he fell, suffering severe injuries. He filed a workers' compensation claim. Neither Mrs. Thedford nor Pioneer Motel had Workers' Compensation insurance. SAIF denied the claim, determining that claimant is not a subject worker and that the Pioneer Motel is not a subject employer. The referee affirmed SAIF's denial, finding that claimant is a nonsubject, casual worker employed by a non-subject employer under ORS 656.027(3) and also that he is an

independent contractor not covered by the Workers' Compensation Law.[1] The Board affirmed and adopted the referee's order. This appeal followed.

Claimant's employment status is the determinative issue in this case. However, we need not determine whether claimant is an independent contractor or a worker, because even if he were to meet the statutory definition of "worker," ORS 656.005(28),[2] he would be exempt from coverage as a casual worker employed by a nonsubject employer.

ORS 656.027 provides in part:

> "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:
>
> "* * * * *
>
> "(3) 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.
>
> "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."

ORS 656.023 defines a "subject employer" as:

> "Every employer employing one or more subject workers in the state * * *."

In this case, the evidence indicates that claimant was employed for part of one day for a flat fee of $100. Therefore, if he were a "worker" under ORS 656.005(28), his employment would have beeen "casual," as defined in ORS 656.027(3). The evidence also establishes that the Pioneer Motel had no employes; Mrs. Thedford did all the work herself. Because the motel had no subject employes, it was not a subject employer at the time of claimant's injury. *See Konell v. Konell,* 48 Or App 551, 617 P2d 313 (1980), *rev den* 290 Or 449 (1981). It follows that claimant is a nonsubject worker under either paragraph of ORS 656.027(3) and, therefore, not covered by the Workers' Compensation Law.[3] The claim was properly denied.

Affirmed.

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[1] We note that the referee's conclusion that claimant was both a casual worker under ORS 656.027 and an independent contractor is erroneous. Those classifications are mutually exclusive. If a person is an independent contractor, then he is not a worker as defined in ORS 656.005(28). He, therefore, cannot be a casual worker as defined in ORS 656.027(3).

[2] ORS 656.005(28) provides:

> "(28) 'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution."

[3] Because we hold that the Pioneer Motel was a nonsubject employer, we need not determine whether claimant's work was in the course of the trade, business or profession of the motel.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gayle A. Bush, Claimant.

BUSH,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(81-00585; CA A28602)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 1, 1984.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Donna Parton Garaventa, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

WARDEN, J.

Reversed; referee's order reinstated.

WARDEN, J.

Claimant appeals from an order of the Workers' Compensation Board that reversed the referee's order and held that claimant had failed to prove that his myocardial infarction was compensable. On *de novo* review, we reverse.

Claimant was employed as a log truck driver. On October 16, 1980, he suffered a myocardial infarction while driving a log truck. He filed a claim which was denied by SAIF, the employer's insurer, on December 17, 1980. The referee found the claim compensable and remanded it to SAIF for acceptance and payment of compensation until closure pursuant to ORS 656.268. The Board reversed.

To establish a compensable heart injury case, a claimant must prove by a preponderance of the evidence that the work activity was both the legal and medical cause of the heart attack. *Coday v. Willamette Tug and Barge,* 250 Or 39, 440 P2d 224 (1968); *Carter v. Crown Zellerbach Corp.,* 52 Or App 215, 627 P2d 1300, *rev den* 291 Or 368 (1981). The usual exertion of a worker's job is sufficient to establish legal causation, *Carter v. Crown, supra,* 52 Or App at 219; that question is not at issue here. The dispositive question is whether there is medical causation, that is, whether the exertion involved in the work activity was a material contrib-

uting cause of the myocardial infarction. Medical causation must be established by medical experts. *Foley v. SAIF,* 29 Or App 151, 156, 562 P2d 593 (1977).

Before reaching that question, however, we must address the credibility of claimant's report of the factual circumstances immediately preceding the infarction. At the hearing, claimant testified that, on the date of the infarction, his log truck nearly collided with a small foreign car that ran a red light at an intersection. He indicated that he first felt intense fear and then extreme anger because of that event and that, 10 to 15 minutes later, he experienced the onset of symptoms. This history of acute stress, however, apparently was not related to any of claimant's doctors until May, 1982, over 18 months after the infarction. Because that information critically affects the medical testimony, the credibility of claimant concerning this incident is of crucial importance.

Here, the referee expressly found claimant credible. Conversely, the Board found him not credible, noting that his story about the near accident was uncorroborated, and expressed doubt that the incident had occurred. When credibility is an important issue, this court generally gives great weight to the referee's findings. *Condon v. City of Portland,* 52 Or App 1043, 1046, 629 P2d 1324, *rev den* 291 Or 662 (1981); *Anfilofieff v. SAIF,* 52 Or App 127, 627 P2d 1274 (1981). *De novo* review of the record also satisfies us that claimant's account of the details of the near accident is not unreasonable and, accepting claimant as credible, we find that it occurred. No evidence was offered to refute the fact that it occurred, even though the record indicates that claimant was interviewed by a SAIF investigator. His delay in recounting it and its omission from the early medical histories is understandable in the light of the more immediate concerns of claimant and his physicians with his health and the facts of the heart attack itself, rather than concern with details of his work before the heart attack occurred. We do not find it unusual for the latter concern to arise only after compensability of a claim becomes an issue. Accordingly, we conclude that the medical evidence must be considered in the light of the reporting physician's knowledge or lack of knowledge of that information.

The medical evidence includes reports from three physicians who saw claimant close to the time of the infarction. Two of them did not believe it to be work-related. Dr. Norris, the emergency room physician at Douglas Community Hospital where claimant was taken following his heart attack, indicated that he did not think it "was particularly a result of him driving a log truck" but was "more a result of his life style, hereditary factors, and his perhaps sedentary activities." Dr. Robinhold, who performed an angiogram, reported that claimant described what was for him a rather usual day; because Dr. Robinhold did not know that there was any unusual or extraordinary stress connected with claimant's work on the date in question, he felt that the infarction was only an effect of underlying coronary artery disease. Dr. Leslie, who treated claimant following his heart attack, indicated that the infarc-

tion "occurred while driving and under working conditions and that this is possibly a materially contributing cause to the condition." A fourth physician, Dr. Kloster, who reviewed the

medical reports as a consultant, expressed the opinion that claimant's work activity was not a material contributing cause to development of the infarction, but that his heart attack was caused by pre-existing and underlying coronary artherosclerosis.

The report of Dr. Leslie is equivocal and therefore is of little value in resolving the medical causation issue. It appears from the record that Drs. Norris, Robinhold and Kloster, as well as Dr. Leslie, were unaware of claimant's near accident. The persuasiveness of the opinions of those physicians, based as they are on incomplete information, is therefore diluted considerably. *Foley v. SAIF, supra,* 29 Or App at 156-57.

The only medical evidence that addressed the relationship between claimant's near accident and the infarction appears in the report and testimony of Dr. Wysham, a cardiologist, who examined claimant in May, 1982. He explained that, in a person with pre-existing artheriosclerosis, acute stress can increase the pulse rate and cause a clot to form or either a rupture of the plaque in a coronary artery or a spasm of the artery, resulting in occlusion of the artery and causing an infarction. He testified that he believed that the near accident related by claimant was, for him, an acute episode of emotional strain and that it was probably a major precipitating factor.

We find that the opinion of Dr. Wysham sufficiently establishes a medical nexus between claimant's work conditions and his infarction. Claimant has sustained his burden of proof of medical causation. We conclude that claimant's infarction is compensable.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Jo Wanda Orman, Claimant.

ORMAN,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(WCB No. 82-03671; CA A29152)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 10, 1984.

Diana Craine, Salem, argued the cause for petitioner. On the brief was Rolf Olson, Salem.

Darrell E. Bewley, Appellate Counsel, SAIF, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed; order of referee reinstated.

WARREN, J.

Claimant appeals an order of the Workers' Compensation Board which reversed the referee and upheld the employer's denial of claimant's aggravation claim. We reverse.

Claimant sustained a compensable injury on December 22, 1976, which resulted in a March, 1980, award of 25 percent unscheduled disability to her neck, shoulder and upper back. On May 5, 1981, she began employment as a data entry clerk. That job required her to enter data into a computer, reading material placed at her left and then turning to place the information in the machine, causing extensive use of and stress on her neck and resulting in pain. The employer attempted to alter the working environment by lowering the terminal and also by placing the input material on the top of the machine instead of to the left. That decreased the repeated back and forth movement but required claimant to lean back in her chair in order to read the data placed several inches above her head. She complained of increasing pain in her neck and eventually ceased her employment. An aggravation claim was made and denied by SAIF. The referee reversed the denial as to the neck and upper back but affirmed it as to the lower back and ordered penalties against SAIF for unreasonable denial. The Board reversed the referee and upheld SAIF's denials.

After review of the evidence, we find that claimant has met her burden of proving an aggravation of her compensable condition. The only medical evidence which is relevant

to her physical condition is that in the reports of her treating chiropractor, Dr. Layman,[1] who started treating claimant in November, 1980. In a report of June 28, 1982, he stated:

> "On February 11, 1982, the patient returned with disabling and painful symptoms that included visual problems, neck discomfort and hand numbness. The increase in symptomology appears to be elicited from her work. This patient has to type off of a screen and the constant repetitive, rapid, cervical rotation eight hours a day aggravated her preexisting

> cervical condition and has made this condition acutely worse. * * * In order to clarify any confusion I would like to emphasize the following: *This patient continues to suffer from the same injury as that on December, 1976; this condition is chronic and worse today than at that time; there has been no new injury, only an aggravation of the existing one* from repetitive rapid, cervical rotation; finally, I see no improvement in this condition in the future and therapy will be palliative from here on." (Emphasis supplied.)

The Board rejected the conclusions of Dr. Layman on three grounds. First, it held that it was "far from clear exactly what portion of claimant's cervical problems were caused by the 1976 injury." Second, because Dr. Layman has only treated claimant since November, 1980, the Board concluded he could not state whether she is worse than in March, 1980. Third, the Board noted an alleged inconsistency between Dr. Layman's reports and reports of the psychiatrists and psychologists which stated that it is not possible objectively to verify claimant's subjective complaints and that claimant's personality seems to result in some exaggeration of those complaints. On *de novo* review, we do not agree that the reasons given by the Board justify giving Dr. Layman's opinion no weight.

It is not necessary for a claimant to establish "exactly what portion" of her condition is related to the compensable condition. Dr. Layman states that there is no new injury and that claimant continues to suffer from the same compensable injury which is now worse. That is sufficient. Furthermore, doctors who have not seen a claimant for the original claim are often called on to express an opinion based on their knowledge of the claimant as to whether a condition has worsened. Although the fact that a physician does not examine claimant immediately after the original claim may affect the weight which the report is to be given as against the reports of other doctors who did examine her, it cannot be used as a basis for totally discounting that kind of evidence when that is all that is presented. That is particularly true where, as here, Dr. Layman documents a significant worsening of claimant's condition which occurred during the period of time when he treated claimant.

The Board's third reason for discounting Dr. Layman's opinion that psychiatrists and psychologists have noted

[1] All of the other medical reports which were submitted by SAIF are those of treating psychiatrists and psychologists. Those reports only document that claimant's mental condition is medically stable and show little relevance to a claim for physical disability.

that claimant has a tendency to exaggerate some of her complaints does not persuade us to give Dr. Layman's opinion no weight. To the contrary, we conclude that his report supports an objective worsening of claimant's condition related to her work after the last award of compensation.

Reversed; order of referee reinstated.

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272 May 9, 1984 No. 304

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gerhard von Kohlbeck, Claimant.

von KOHLBECK,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(82-03170, 82-08310; CA A28533)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 6, 1984.

Leo R. Probst, Portland, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Appellate Counsel, SAIF, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed; referee's order reinstated.

WARREN, J.

Claimant appeals an order of the Workers' Compensation Board that reversed the referee and upheld the employer's denial of claimant's back condition. We reverse and reinstate the referee's order.

Claimant had a history of occasional back problems since 1964 that involved merely an ache is his lower right side after heavy labor and would disappear the next day. Claimant never saw a doctor for his back condition and had no back problems from 1978 until 1982. He was employed as a grounds keeper and maintenance man. On January 8, 1982, the bleachers on which he was walking moved, his foot was caught and he fell over backwards to the gym floor. Claimant worked with no problems after that accident until January 11, 1982, when he was putting plywood down for flooring and found

that he could not straighten up. He saw Dr. Perry on January 18, 1982. X-rays revealed that he has degenerative disc disease and osteoarthritic spurring of lumbar bodies. Dr. Perry concluded:

> "* * * I think that there is no question that there was a pre-existing back problem but that the injury [in January, 1982] certainly aggrevated *[sic]* a basically degenerative condition."

Dr. Perry noted that no objective evidence of a worsening due to the accidents can be obtained, because there were no x-rays taken before the accidents.

Dr. Perry referred claimant to Dr. Parsons, who concluded that claimant's complaints in March, 1982, were related to his January, 1982, accidents. Dr. Parsons further stated that the 1982 injuries had caused pain at the site of pre-existing arthritic changes but did not worsen the arthritis. The employer presented no reliable medical evidence indicating that claimant's current condition was not related to the industrial accidents.[1]

We find that claimant has met his burden of proving a causal connection between the accidents and his current disability by a preponderance of the evidence. *Verment v. Nordstrom-Best,* 20 Or App 261, 531 P2d 288, *rev den* (1975). The Board held that claimant had only proven an increase in pain as a result of the accidents and concluded: "An increase in symptomatology without a concomitant worsening of the underlying condition is not compensable." After the Board order, the Supreme Court considered the compensability of pain and held:

> "* * * Pain is compensable only if it results in impairment of the function of the body and therefore pain must be considered when that determination is made. * * *" *Harwell v. Argonaut Insurance Co.,* 296 Or 505, 510, ___ P2d ___ (1984).

Both Dr. Perry and Dr. Parsons agree that the accidents resulted in an increase in claimant's pain. He was totally asymptomatic for five years before the injuries and has been unable to work due to back pain since the injuries. Clearly, claimant's disabling pain results in an impairment of the function of his body and the injury is compensable. The Board erred in affirming the employer's denial of claimant's back condition.

Reversed; referee's order reinstated.

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[1] Employer did submit a report by Dr. Noall that said that the accidents were not related to claimant's current condition. However, the history in the report indicates that Dr. Noall believed that the accidents had occurred six years before the pain instead of six days. Therefore, that report is of no probative value. *Miller v. Granite Construction Co.,* 28 Or App 473, 476, 559 P2d 944 (1977).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Norman Wright, Claimant.

WRIGHT,
Petitioner,

v.

INDUSTRIAL INDEMNITY COMPANY,
Respondent.

(82-01105; 82-02772; CA A28208)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 14, 1983.

Karston H. Rasmussen, Eugene, argued the cause for petitioner. On the brief was Michael M. Bruce, Salem.

Marshall C. Cheney, Portland, argued the cause and filed the brief for respondent. On the brief was Ridgway K. Foley, Jr., P.C., Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Reversed and remanded for further proceedings.

VAN HOOMISSEN, J.

Claimant appeals from an order of the Workers' Compensation Board that found that he is not entitled to compensation because he is not an employe covered by the Oregon Workers' Compensation Act. The Board relied on *Hollingsworth v. May Trucking,* 59 Or App 531, 651 P2d 188, *rev den* 294 Or 212 (1982). We reverse and remand.

Claimant, a long-haul truck driver, is employed by May Trucking Company (May). He submitted claims for a back injury sustained when he fell from his truck in Washington state and for a hearing loss he alleged was work-related. The carrier denied both claims on the ground that he was not an employe covered under ORS ch 656.[1] *See Langston v. K-*

[1] ORS 656.027 provides:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(5) A worker engaged in the transportation in interstate commerce of goods, persons or property for hire by rail, water, aircraft or motor vehicle, and whose employer has no fixed place of business in this state.

ORS 656.126(1) provides:

"If a worker employed in this state and subject to ORS 656.001 to 656.794 temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of his employment, he, or his beneficiaries if the injury results in death, is entitled to the benefits of ORS 656.001 to 656.794 as though he were injured within this state."

Mart, 56 Or App 709, 711, 642 P2d 1205, *rev den* 293 Or 235 (1982). The referee and the Board agreed.

The evidence here shows a substantial increase in the contacts May has had with Oregon since *Hollingsworth* was decided in 1982. Our decision in *Hollingsworth* is no longer controlling. There, the claimant was hired in Idaho. At that time, May had approximately 100 drivers, only 10 percent of whom lived outside Idaho. Paychecks were issued from Idaho, and Idaho income taxes were withheld. The claimant parked his truck at a truck stop in Aurora, Oregon, where May employed an area coordinator. The coordinator received his instructions from Idaho, and May's drivers only contacted him if their trips terminated near Aurora. The claimant was rarely dispatched from Aurora, and he performed not more

than 25 percent of his work in Oregon. *See Jackson v. Tillamook Growers Coop,* 39 Or App 247, 592 P2d 235 (1979). On those facts, we held in 1982 that the claimant had failed to establish he was a permanent Oregon employe covered by ORS ch 656. We stated:

> "* * * [R]esidence in Oregon alone is insufficient to make a worker an Oregon employe. Moreover, the occasional receipt of dispatches in Oregon does not establish pemanent employment in Oregon, when those dispatches were relayed from May's office in Idaho and were sent only if claimant's trip terminated in the Aurora area. The time spent driving in Oregon, as compared to other states, was insufficient to raise a presumption that Oregon was claimant's regular base of employment or to render all trips out of Oregon 'temporary.' Claimant agreed to accept trips in any state; no understanding existed between him and May that Oregon was to be his permanent area of employment. * * *" *Hollingsworth v. May Trucking, supra,* 59 Or App at 535.

Since 1982, the facts have changed. Claimant applied for and received his job at May's office in Aurora. May has opened a truck terminal in Brooks, Oregon, where several full-time employes work. Approximately half of its 120 drivers start and complete their trips there.[2] It bases a large number of trucks at Brooks, and they are serviced and repaired there. Employes at May's other major terminal, in Idaho, are not normally permitted to perform routine service on trucks based at Brooks. All trips originating in Oregon are dispatched through the Brooks terminal, although they are coordinated with Idaho. May's drivers operating out of its Brooks terminal receive layover pay when they are laid over anywhere other than Brooks. *See Jackson v. Tillamook Growers Coop, supra,* 39 Or App at 250. Thus, May has a "fixed place of business in this state." *See* ORS 656.027(5); *Giltner v. Commodore Contract Carriers,* 14 Or App 340, 345, 513 P2d 541 (1973). While

[2] A short time after May established its Brooks terminal, it established a separate Idaho corporation, Drivers' Employment Services, Inc. (DES). All of May's drivers became employes of DES. DES was formed at the behest of Industrial Indemnity, May's carrier, as a way for May to decrease its workers' compensation costs. The referee concluded that the incorporation and transfer of employes was a "straw" transaction and that May is the true employer. *See Epton v. Moskee Investment Co.,* 180 Or 86, 93, 174 P2d 418 (1946). The Board did not address that finding. It appears that the Board concluded that May is the employer, and May has not contested that conclusion.

claimant's paychecks come from Idaho, May withholds Oregon income tax. Claimant is a permanent resident of Oregon. He began working for May in 1979. Approximately one-third of the miles he logged last year were in Oregon. One-third of his trips originated in Oregon. One-fourth of his destinations and one-tenth of his dispatches have been in or to Oregon. There is no evidence that he spends more time in any other state than he spends in Oregon. Any activity claimant engages in outside Oregon is incidental to his Oregon employment. *See Kolar v. B & C Contractors,* 36 Or App 65, 583 P2d 562 (1978). We conclude that claimant is a permanent Oregon employe.

It is to be expected that long-haul truck drivers will spend substantial time working outside their home states. For that reason, they present a unique class of employes. It would be unfair to deny them their home state's workers' compensation benefits when, as here, a significant portion of their work is performed in their home state.

Reversed and remanded for further proceedings.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Guadalupe Rivera, Claimant.

RIVERA,
Petitioner,

v.

R & S NURSERY et al,
Respondents.

(82-02812; CA A29073)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 14, 1984.

Raul Soto-Seelig, Portland, argued the cause and filed the brief for petitioner.

Allan M. Muir, Portland, argued the cause for respondents. With him on the brief were Dennis S. Reese and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Reversed and remanded with instructions to pay disability award; denial of penalties under ORS 656.262(9) affirmed.

YOUNG, J.

Claimant was awarded permanent partial disability for ten percent loss of a leg. He asserts that the endorsement

of the check from respondent Argonaut Insurance Company (Argonaut) in payment of the award was forged and that he never received payment. Claimant appeals the order of the Workers' Compensation Board affirming the referee, which found that claimant had failed to prove that he did not receive the proceeds of the award. He also appeals the denial of penalties and attorney fees under ORS 656.262(10). On *de novo* review we find that claimant established by a preponderance of the evidence that he did not receive payment. The denial of penalties and attorney fees is affirmed.

Claimant, a Mexican national, was employed by respondent R & S Nursery in May, 1980, when he broke his leg. On October 20, 1981, a determination order was issued awarding permanent partial disability. Argonaut issued a check for $1,596 in payment of the award and mailed it to claimant's address as shown in the company file. Claimant returned to Mexico. It is not clear whether he moved before or after the check was issued. Some time in December, 1981, claimant's attorney informed Argonaut that claimant had not received the check. A "stop payment" order was too late; the check had been cashed by a bank other than the drawee bank on November 16, 1981.

Argonaut requested that claimant complete a declaration of forgery and have the document notarized. The statement recites:

> "The signatures thereon purporting to be those of the undersigned * * * are not the signatures of the undersigned, nor were said signatures written or authorized or ratified by the undersigned. Nor were said checks issued or delivered by the undersigned, and that said signatures are forgeries; that the undersigned has received no part of the proceeds of said checks, nor has the undersigned received any benefit, either directly or indirectly, resulting from such payment; that the undersigned has no knowledge of the circumstances surrounding, nor the person who committed, said forgeries * * * I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT."

The document is dated and signed by "Guadalupe Rivera" and indicates that it was executed at claimant's home in Mexico. The document is not notarized. Apparently the drawee bank refused to accept the document without notarization, and Argonaut in turn refused to issue another check in the absence of the notarization.

The referee found that sufficient evidence was presented to establish that the endorsement on the check is a forgery. However, the referee determined that claimant failed to prove that he did not receive the proceeds of the check.

OAR 436-54-310(1) provides:

> "Benefits shall be deemed paid when deposited in the U.S. Mail addressed to the last known address of the worker or beneficiary * * *."

The Board concluded that Argonaut had presented testimony

sufficient to prove that the check had been mailed to claimant's last known address and that the burden of going forward with the evidence then shifted to claimant. The Board then determined:

> "Although there was testimony to the effect that claimant's signature was in fact a forgery, as the referee noted, no evidence was presented establishing that claimant did not in fact receive the proceeds from the check or that the check was not signed by someone in his behalf."

We disagree with the Board's factual finding. The statement signed by claimant states that he received no benefit from the payment, either directly or indirectly. That statement was admitted as evidence at the hearing. There is nothing in the record to indicate that claimant received the proceeds. The basis for Argonaut's refusal to issue a second check is claimant's failure to have the declaration of forgery notarized. While such a request may be reasonable and expeditious concerning the relationship between the insurer and its bank, notarization of a declaration of forgery is not required by the Workers' Compensation statutes as a predicate to the receipt of a disability award. We find that claimant proved non-payment and that he is entitled to payment. We

also find that Argonaut's conduct does not justify the imposition of penalties under ORS 656.262(10).

Reversed and remanded with instructions to pay the disability award. The denial of penalties under ORS 656.262(10) is affirmed.

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312 May 9, 1984 No. 312

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ray Forrest, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner,

v.

FORREST,
Respondent.

(81-02535; CA A29392)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 14, 1984.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for petitioner.

Diana Crain, Salem, argued the cause for respondent. On the brief was Rolf Olson, Salem.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

The issue is whether SAIF is foreclosed from denying claimant medical services under ORS 656.245(1). The medical evidence is that claimant's knee condition, which was repaired by surgery, preexisted and was not caused by the compensable injury. The referee, affirmed by the Board, determined that the issue had "been adjudicated" and that SAIF had been found to be responsible by that adjudication. Accordingly, SAIF's denial was set aside, and it appeals. We affirm.

In 1973, claimant injured his left knee in a nonindustrial motorcycle accident. In 1976, he injured the same knee on the job. He filed a claim, which resulted in an award of 10 percent loss of the left leg. In March, 1979, a referee increased the award to 25 percent permanent partial disability of the left leg. The principal basis for the increased award was the referee's finding that the on-the-job knee injury resulted in a seven degree loss of extension. The referee stated in the order:

> "I am of the opinion claimant's left leg disability exceeds the amount of ten percent loss. Dr. Embick is quite concerned about the extension loss as between just prior to this injury and the present time. He measured this at seven degrees which he indicates is 'considerable.' In addition to the loss of motion, claimant also suffers constant pain in the knee. He has fallen on several occasions since this injury occurred due to the extension loss. I think this shows some measure of just how significant this loss is."

The order was not appealed.

Claimant had continuing problems with his knee, and he had surgery in March, 1980, to regain extension. As a result of the surgery, it was determined that the loss of extension was due to the motorcycle accident and not the on-the-job injury. SAIF reopened the claim in April, 1980, and accepted the new claim as an aggravation. Subsequently, SAIF requested a determination of disability pursuant to ORS 656.268. In January, 1981, a determination order awarded claimant an additional ten percent permanent partial disability for the leg injury. He requested a hearing on the determination order. In August, 1981, SAIF issued a denial letter:

> "We received a request to reopen your claim due to aggravation. After additional review and consideration of all

> medical reports now available, it appears this reopening was in error as your surgery of January 31, 1980, was performed to correct a preexisting intra-articular fracture of your left knee and was therefore, unrelated to the injury for which this claim was filed. It is for this reason * * * this partial denial of this surgical procedure is made."

Claimant then amended his request for hearing to include the denial.

The referee determined that the evidence indicated that claimant's on-the-job fall probably did not cause the loss of extension. The referee noted, however, that the March, 1979, order specifically found that claimant had lost seven degrees of extension due to the on-the-job injury and that claimant was awarded a compensable disability on the basis of that extension loss. The referee ruled that the loss of extension had been adjudicated and is the "law of the case," foreclosing denial of medical services on that basis.

ORS 656.245(1) specifically requires that medical services must be for "conditions resulting from the injury."[1] *See Francoeur v. SAIF,* 17 Or App 37, 40, 520 P2d 477, *rev den* (1974). It is the claimant's burden to show that the medical services were for conditions resulting from the industrial injury. *McGarry v. SAIF,* 24 Or App 883, 888, 547 P2d 654 (1976). SAIF argues that claimant failed to carry that burden, because the evidence is that the surgery corrected a condition that was not caused by the industrial injury.

In *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), SAIF had accepted Bauman's claim for a bursitis-type condition. The condition worsened, and he underwent surgery to repair a tear in the right rotator cuff. SAIF denied the aggravation claim for the surgery, on the basis that Bauman's shoulder condition was a symptom of a preexisting degenerative disease. Bauman's claim had resulted in an arrangement of compensation which was not challenged by a request for

hearing or otherwise. The Supreme Court determined that it was not permissible for SAIF to reconsider and deny the previously accepted claim.

The reasoning in *Bauman* applies here. The loss of extension was determined to be a compensable disability. That finding was not appealed. The surgery was to correct that disability. The referee and the Board were correct in concluding that SAIF may not at this point deny the aggravation claim based on loss of knee extension.

Affirmed.

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[1] ORS 656.245(1) provides in part:

"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. * * *"

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jerry L. Proctor, Claimant.

PROCTOR,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(WCB No. 82-04509; CA A28615)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 6, 1984.

Brian R. Whitehead, Eugene, argued the cause for petitioner. On the brief were Evohl F. Malagon, and Malagon & Associates, Eugene.

Darrell E. Bewley, Appellate Counsel, SAIF, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

Claimant appeals an order of the Workers' Compensation Board that held that he is barred by a disputed claim settlement and stipulation from recovering on a psychological claim. We affirm.[1]

Claimant sustained a compensable injury on November 8, 1976, which resulted in pain in his arm and shoulder. During the course of treatment for this physical injury, he was evaluated by several psychiatrists, who concluded that he suffers from a preexisting personality disorder but reached inconsistent conclusions as to whether the preexisting disorder was aggravated by his industrial injury.

On July 19, 1980, the parties entered into a stipulation that resolved all issues then pending. Pursuant to this stipulation, claimant was awarded 10 percent scheduled disability for his left arm. The agreement stated that his "claim for an alleged psychological condition related to claimant's industrial injury * * * [was] fully compromised and settled * * *." The claim was to remain in a denied status. Claimant was paid $1,000 for settling the psychological claim.

In this proceeding, claimant, in an apparent attempt to avoid the effect of the settlement, contends that the

[1] We have reviewed claimant's other assignments of error which deal with his aggravation claim and conclude that they do not merit discussion.

condition which originally was disputed and settled was different from the currently diagnosed condition. Specifically, he says that the $1,000 he received in 1980 was for a particular psychological condition, *i.e.*, psychogenic pain disorder. He argues that he is now suffering from dysthemia, which he characterizes as a new and separately compensable condition. Because this disability occurred after the stipulation, claimant asserts, it could not have been settled by the stipulation, and he has a right to establish the new claim.

Claimant is correct that he could recover if he establishes that, after the stipulation, he had developed a new psychological condition related to his compensable injury. However, on the basis of our review of the medical reports, we find that he has failed in his burden to prove a new condition.

We agree with the Board's perception of the case. Granted, there is medical evidence that claimant "has experienced a worsening of his psychological and emotional condition." However, a close examination of the evidence makes it clear that claimant's present depressive neurosis was, in fact, a diagnosed condition in 1980, when the parties entered into their settlement. Indeed, a presettlement report of one of the psychiatrists contains an opinion that the injury and the depression are related by the fact that the depression occurred so close to the injury.

We find no evidence that claimant suffers a new psychological disability stemming from his physical disability which is not the natural result of the psychological disability that existed at the time of the stipulation. Depression is the focus of his malady, both before and after the stipulation. To rule in claimant's favor would be to require SAIF to pay again for what it has already paid.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jonathan Wallace, Claimant.

WALLACE,
Petitioner,

v.

INDUSTRIAL INDEMNITY COMPANY et al,
Respondents.

(81-11546; CA A28285)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 20, 1983.

Ronald L. Bohy, Salem, argued the cause for petitioner. On the brief was Linda C. Love, Salem.

Marshall C. Cheney, Jr., Portland, argued the cause for respondents. With him on the brief was Ridgway K. Foley, Jr., Portland, P.C.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

Reversed and remanded for further proceedings. *Wright v. Industrial Indemnity Co.*, 68 Or App 302, ___ P2d ___ (1984).[1]

[1] Our holding is that May Trucking is a covered employer on these facts. It does imply a decision on any other issue.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Elmer Maddocks, Claimant.

MADDOCKS,
Petitioner,

v.

HYSTER CORPORATION,
Respondent.

(82-01631; CA A29544)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 21, 1984.

John Silk, Eugene, argued the cause for petitioner. With him on the brief was Bischoff & Strooband, P.C., Eugene.

Scott H. Terrall, Portland, argued the cause for respondent. On the brief were Meyers & Terrall, and Daniel L. Meyers, Portland.

Before Joseph, Chief Judge, and Warren and Rossman, Judges.

JOSEPH, C. J.

Reversed on partial denial; affirmed on extent of disability.

Cite as 68 Or App 372 (1984)

JOSEPH, C. J.

Claimant appeals an order of the Board which upheld the employer's "partial denial" of claimant's muscle disease claim and found that he has sustained no permanent disability. We reverse the denial and affirm on the extent of disability.

On November 4, 1981, claimant was working as a forklift mechanic for Hyster Corporation when he felt a

straining sensation in his arms as he handled a 200 pound drive wheel. Thereafter, he was hospitalized for a marked swelling in his forearms, with weakness and tenderness, which caused his arms to look somewhat "like Popeye's." He was released from the hospital three days later and was eventually diagnosed as having idiopathic rhabdomyolysis, a muscle disease whose specific cause is unknown. He returned to work on January 24, 1982, and was able to work without problems until April 16, 1982, when he was laid off.

On February 4, 1982, employer wrote claimant:

> "This letter is a partial denial of your workers' compensation claim. The intent is to accept responsibility for treatment of your preexisting condition only between November 4, 1981, and January 25, 1982, and responsibility for any permanent impairment as a result of the event of November 4, 1981."

Claimant requested a hearing on the denial. A determination order issued on March 15 for an award of 10 percent scheduled disability for each of claimant's forearms. Claimant then amended the request for hearing to challenge the adequacy of the award. The referee affirmed the employer's denial and vacated the permanent disability award. On review, the Workers' Compensation Board affirmed the referee.

The "partial denial" was invalid, *Roller v. Weyerhaeuser Co.*, 67 Or App 583, ___ P2d ___ (1984); *Safstrom v. Riedel International, Inc.*, 65 Or App 728, 672 P2d 392 (1983), and is of no force and effect. However, a determination order did issue, from which an appeal was taken. We agree with the Board's determination that claimant has not established any permanent disability.

Reversed on partial denial; affirmed on extent of disability.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ruth A. Coddington, Claimant.

CODDINGTON,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(81-05848; CA A28716)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 1, 1984.

Richard T. Kroop, Albany, argued the cause for petitioner. With him on the brief was Emmons, Kyle, Kroop, Kryger & Alexander, P.C., Albany.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

Reversed and remanded with instructions to reinstate referee's order.

NEWMAN, J.

Claimant appeals an order of the Workers' Compensation Board that reversed the referee and denied claimant's aggravation claim. We reverse.

Claimant is 47 and has been a bus driver since 1968. She has degenerative disc disease and a history of back problems. She had no back pain in the last half of 1980, however, and accompanied her husband on a month-long motorcycle trip during that summer. On January 13, 1981, she suffered a compensable injury at work when she slipped and fell. Her family doctor, Dr. Altizer, diagnosed a back sprain and referred her to Dr. McGee, a back specialist, who diagnosed ligament and sacroiliac joint damage. She received treatment for pain throughout January and February, 1981. In late February and March, she rode as a passenger with her husband on short motorcycle trips. Although she was not pain-free, she felt that she should return to work. On March 2, 1981, Dr. Altizer released her to return to work and did not see her again until late April.

Claimant experienced pain after returning to work on March 9, 1981. On April 10, 1981, Dr. Altizer reported to insurer:

> "Please be advised that this patient was seen for final evaluation of her low back sprain sustained on January 13, 1981 in an office visit on March 2, 1981. The patient was getting along well enough at that time that she had been pain-free without physiotherapy in the form of ultrasound treatment and was able to be up and about, accomplishing household duties with caution. She felt that she was capable of returning to her duties as a school bus driver safely, and that she would be able to accomplish the arm movement and the trunk motions necessary for adequate road surveillance. She was still moving about somewhat gingerly.
>
> "The patient's condition now is essentially medically stationary. There should be no additional residuals from her work injury superimposed on her pre-existing back disease."

In mid-April, 1981, she had the flu, and while trying to sleep at home on April 23, 1981, she suffered a spasmodic "twitch" and felt a sudden stabbing pain. On May 5, Dr. McGee did a myelogram, recommended a laminectomy and, on May 7, removed a herniated disc.

On May 22, 1981, Dr. Altizer wrote to insurer and explained that, when she had used the term "medically stationary," she meant that "the patient's condition currently being treated has reached a point at which no further acute medical care is needed, and that the patient is capable of returning to gainful employment." The doctor had reexamined her office records and learned that claimant had received ultrasound treatments in her office for her back on March 12 and April 3 and thus was "not totally asymptomatic." The doctor concluded:

> "[I]n reading the record subsequent to my report to you of April 10 * * * Mrs. Coddington's ability to return to work was subsequently proven to be wrong by virtue of her recurrence of symptoms so shortly after her return to work."

On June 5, SAIF denied claimant's aggravation claim, stating that the surgery was the result of the April 23 off-the-job incident and the "underlying degenerative back disease which pre-existed your industrial injury."

On October 10, 1981, Dr. Altizer wrote to insurer:

> "I thought I had made it entirely clear in my previous letter, which you have in your possession, that I feel very strongly there is a direct causal relationship between the preceding industrial injury and the very minimal trauma that Mrs. Coddington experienced at the time of her final episode of pain leading to her surgery. I do not believe that the kind of jerking that Mrs. Coddington described as occurring just as she fell asleep and experienced pain would be enough to damage a disc that had not previously been very significantly damaged. If such small trauma could herniate a normal disc, the majority of people in the world would have had disc surgeries."

The doctor viewed the April 23, 1981, incident as "sort of a minor additional episode which was the straw that broke the camel's back." Dr. McGee was in substantial agreement with Dr. Altizer. On October 9, 1981, he wrote to insurer:

> "[I]n all medical probability the patient did suffer injury to intervertebral disc with episodes of not only back pain but nerve root irritation prior to a final additional bulging or herniation of disc material. Although this final bulging or herniation process historically was not directly related to her work duties, I would have no difficulty in agreeing that the patient's earlier industrial injury was a material contributing cause. The patient as you know developed severe pain symptoms and weakness which necessitated surgical decompression."

The referee reversed SAIF's denial of the aggravation claim and found that the industrial injury was a material contributing cause of the disc herniation:

> "The denial of June 5, 1981 for aggravation was in error. The denial cites an off-the-job incident as being responsible for the need for surgery. The off-the-job incident in the view of both Dr. Altizer and Dr. McGee was not a new and intervening injury. The industrial injury remained a material contributing cause of the need for surgery. The other ground for the denial was the underlying degenerative back disease which pre-existed the industrial injury. There is no question that claimant indeed had pre-existing degenerative back disease, but when an industrial trauma causes a material worsening of such a condition, as occurred in this case, the claim is properly compensable to the same extent as if the trauma was imposed on a sound back."

The Board reversed the referee. It commented that Dr. McGee had changed his opinion during the deposition to assert that the industrial injury was not a material cause of claimant's worsened condition. It relied on Dr. Norton, who stated that the influence of the industrial injury on the herniation was "of no identifiable significance." It discounted Dr. Altizer's testimony, because she was not claimant's "back doctor" and had expressed "inconsistent" opinions about the cause of the herniation. The Board also thought that Dr. Altizer's testimony was not consistent with the facts of claimant's return to school bus driving and her motorcycle travel during the same period.

In *Grable v. Weyerhaeuser Company*, 291 Or 387, 401, 631 P2d 768 (1981), the court stated:

> "* * * 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 establishes that the on-the-job injury is a material contributing cause of the worsened condition."

Claimant asserts that the compensable injury in January, 1981, was a material, contributing cause of the worsened condition represented by the herniated disc. We agree.

The Board misinterpreted Dr. McGee's testimony. On cross-examination in his deposition, he testified that the motorcycle trips that claimant took in February and March, 1981, made the industrial injury "not as significant." However, he did not conclude, as the Board states, that the January injury was "probably not a material cause of claimant's subsequent worsened disc condition." Rather, he repeated his belief that the industrial injury was a significant factor in her herniated disc, which was also Dr. Altizer's opinion.

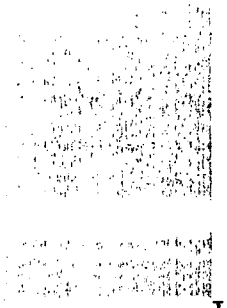
Dr. Norton, who examined the claimant for insurer, reviewed the file and found that claimant had a "naturally progressive degenerative disc disease at the L4-5 level which was symptomatic as early as 1976." He concluded:

> "The influence of the job incident in causing the disc herniation appears to be of no identifiable significance. The condition was pre-existing, the work incident was minor, the condition is demonstrated by x-ray to have progressed from 1978 until the work incident. The work incident caused no identifiable change in the clinical course other than to cause a temporary exacerbation of symptomatology. This is well documented in * * * the clinical records of Dr. Altizer, who specifically noted as a return to the pre-level status of symptomatology. The recurring pains and symptoms thereafter relate with medical probability to a continuation of the degenerative disease process and its complicating nuclear herniation."

Dr. Norton misinterpreted Dr. Altizer's report. Her opinion on April 10, 1981, was not that claimant had returned to a "pre-level status of symptomatology" or that she had "fully recovered." Dr. Altizer indicated on April 10 that claimant was able to do household chores "with caution" and was still moving about "somewhat gingerly." On May 22, 1981, Dr. Altizer explained that her April 10 opinion was based on her misconceptions that claimant was no longer receiving medical treatment and that a return to work would not reaggravate her injury. Apparently, she also did not know that claimant had experienced pain after returning to work on March 9.

Moreover, even if the degenerative disc disease were the principal cause of the herniation, the compensable injury was a material contributing cause of the April, 1981, worsening. A "material contributing cause" need not be the sole or principal cause. *Peterson v. Eugene F. Burrill Lumber,* 294 Or 537, 660 P2d 1058 (1983). The insurer is responsible for compensating for all worsened conditions resulting from the original injury. ORS 656.273(1). We find from the medical testimony that the January, 1981, incident was a material contributing cause of the herniation.

Reversed and remanded with instructions to reinstate referee's order.

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